CENTERS FOR	MEDICARE & MEDIC	_	OMB NO. 0938-039					
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED			
		155733	B. WING		09/18/2024			
			<u> </u>		<u> </u>			
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD					
		_	119 N INDIANA AVE					
COLONIA	AL NURSING HOM	E	CROW	CROWN POINT, IN 46307				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)			
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI					
TAG		LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE			
E 0000								
_ 5555								
Bldg								
Diag.	An Emergency Pres	paredness Survey was	E 0000	sup="">th, 2024, to the annua	1			
		diana Department of Health in	E 0000	licensure survey completed	'			
	accordance with 42	-		September 18th, 2024. The fa	cility			
	accordance with 42	C1 IX 703.73.		also requests that our plan of	lointy			
	Survey Date: 09/18/	/2024		correction be considered for p	aner			
	Survey Date. 09/16/	1		review compliance. The facility	· ·			
	Facility Number: 00	00360		submit any evidence as reque				
	Provider Number: 1			to validate compliance.	เอเซน			
	AIM Number: 1002			to validate compilance.				
	7 MINI INGILIOGI. 1002	.,,0310						
	At this Emergency	Preparedness survey, Colonial						
		found not in compliance with						
	_	dness Requirements for						
		caid Participating Providers						
	and Suppliers, 42 C							
	and Suppliers, 42 C	FR 465.75						
	The facility has 55	certified beds. At the time of						
	the survey, the cens							
	the survey, the cens	us was 33.						
	Quality Review con	npleted on 09/23/24						
E 0041	/82 15(e) /82 72	(e), 485.542(e), 485.62						
SS=F	` ,	LTC Emergency Power						
Bldg	i lospital CALL allu	LTO Lineigency Fower						
Diag. =	Based on record rev	view and interview, the facility	E 0041	/p>	10/15/2024			
		the emergency power system	L 0041	What corrective action(s) will be				
	_	in the Health Care Facilities		accomplished for those reside				
	•	nd Life Safety Code in		found to have been affected b				
		CFR 483.73(e)(2). This		the deficient practice;	y			
		ould affect all occupants.		·All residents could potential	llv			
	deficient practice et	outa arreet air occupants.		be harmed by the alleged defi	-			
	Findings include:			practice but none were identifi				
	r manigs menae:			1 .				
	Rosed on massed	view with the Administrator		A generator testing occurred o	ווע			
				09/24/2024				
and Maintenance Director on 09/18/24 between 09:23 a.m. and 12:15 p.m., the generator lacked			How other regident having a tra-					
		-		How other resident having the	· [
	monuny load and w	reekly visual testing required		potential to be affected by the				
	l			I .	I			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

TITLE

Jennifer Short Administrator 10/01/2024

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	EMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155733		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/18/2024	
	PROVIDER OR SUPPLIER		119 N	ADDRESS, CITY, STATE, ZIP COD INDIANA AVE VN POINT, IN 46307		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	(X5) COMPLETION DATE	
IAU	by LSC and NFPA time of record revie acknowledged that for the generator. The findings was re	110. Based on interview at the two, the Maintenance Director documentation was missing eviewed with the Administrator irector at the exit conference.	IAU	same deficient practice will be identified and what corrective action(s) will be taken; All residents residing in the facility could potentially be affected by the alleged deficie practice. An audit of the genetesting was conducted on 09/27/2024 for the monthly lotesting and as well as the visit weekly check Additional education was provided to the Maintenance Director to ensure testing is be completed What measures will be put integrated by the made to ensure that the deficient practice does not read will be made to ensure that the deficient practice does not restrict of has been developed to monitor monthly load testing weekly visual checks How the corrective actions with monitored to ensure the deficient practice does not recur; A performance improvement has been initiated that randor audits. This Quality Assurance Audit Tool will be completed the Maintenance Director/Designee Weekly for three weeks; then monthly for three months, then quarterly in three. In the event any further concerns are identified the issue at the process.	ent rator ad ual eing fo nges e cur; nd ing nt and ll be ient tool nly e	

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AND PLAN OF CORRECTION IDENTIFICATION NU		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BUILDI	LE CONSTRUCTION NG <u></u>	COMPLE	(X3) DATE SURVEY COMPLETED	
		155733	B. WING		- 09/18/2	2024	
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 119 N INDIANA AVE CROWN POINT, IN 46307				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREF TA	CROSS-REFERENCED TO THE AF	OULD BE	(X5) COMPLETION DATE	
TAU	REGULATORY	K ESC IDENTIFYING INFORMATION	1/4	will be immediately corradditional training will be Results of the audit will reviewed at the Quality Meeting at least quarter By what date the system changes will be made: 10/15/2024	e initiated. be Assurance ly.	DAIL	
K 0000							
Bldg. 01	Licensure Survey of Department of Head 483.90(a). Survey Date: 09/18 Facility Number: 09/18 Facility Number: 100 At this Life Safety Home was found in Requirements for In Medicare/Medicaid Life Safety from Finational Fire Protectife Safety Code (In Health Care Occup) Colonial Nursing In with a basement of was built at three disputies of the safety and the safety from Safety Code (In Health Care Occup) Colonial Nursing In With a basement of was built at three disputies of the safety from Safety Code (In Health Care Occup)	00360 155733 290370 Code survey, Colonial Nursing ot in compliance with	K 0000	sup="">th, 2024, to the licensure survey comple September 18th, 2024. also requests that our p correction be considere review compliance. The submit any evidence as to validate compliance.	eted The facility lan of d for paper facility will		

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 155733 B. WING 09/18/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 119 N INDIANA AVE COLONIAL NURSING HOME **CROWN POINT. IN 46307** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE the corridors and in resident rooms. The facility has 55 certified beds. All 55 beds are dually certified for Medicare and Medicaid. At the time of the survey, the census was 33. All areas where the residents have customary access and areas providing facility services were sprinklered. Quality Review completed on 09/23/24 K 0161 **NFPA 101** SS=F **Building Construction Type and Height** Bldg. 01 Based on observation and interview, the facility K 0161 /bk161> 10/15/2024 was not an acceptable type of construction as required by NFPA 101 - 2012 edition, Sections An independent company, 19.1.6.1, 4.5.8 and NFPA 220 - 2012 edition, RTM, completed an FSES review Section 4.1, 4.1.1 and Table 4.1.1. This deficient in 2021 and determined all the practice could affect all residents, staff and Interstitial spaces of the basement visitors. levels and 2nd floor will require the installation of smoke and heat Findings include: detectors. The new smoke detection system was installed in Based on observation with the Maintenance 2023 by Safecare. Director and Administrator on 09/18/2024 during a A new FSES score was tour of the facility from 12:26 p.m. to 1:26 p.m., completed on May 14, 2024 observation of the unprotected wood structure showing the new system that is revealed that the type of construction of the currently in place giving the zones building was Type V (000) and the building was a passing FSES score. two stories. Type V (000) is not an acceptable How other resident having the type of construction for a two-story existing potential to be affected by the healthcare building. Based on interview at the time same deficient practice will be of observation, the Administrator acknowledged identified and what corrective

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the unprotected construction.

The finding was discussed with the Maintenance

Director and Administrator at exit conference.

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action(s) will be taken;

facility could potentially be

·All residents residing in the

affected by the alleged deficient practice but none were identified

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155733	B. W	NG		09/18/	
NAME OF P	ROVIDER OR SUPPLIER	8	STREET ADDRESS, CITY, STATE, ZIP COD				
			119 N INDIANA AVE				
COLONIA	AL NURSING HOM	E	CROWN POINT, IN 46307				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	3.1-19(b)				·Administration will review F	SES	
					documentation annually and a	S	
					needed.		
					What measures will be put into)	
					place and what systemic chan	ges	
					will be made to ensure that the	Э	
					deficient practice does not rec	ur;	
					·The IDT reviewed CMS		
					guidelines on Use of fire safet	у	
					evaluation system (FSES)		
					·A performance improvemer	nt	
					tool has been developed to		
					monitor that FSES and its		
					accuracy		
					How the corrective actions will	l be	
					monitored to ensure the defici	ent	
					practice does not recur;		
					A performance improvement to	ool	
					has been initiated that random	nly	
					audits. This Quality Assurance)	
					Audit Tool will be completed b	у	
					the Maintenance		
					Director/Designee Weekly for		
					three weeks; then monthly for		
					three months, then quarterly x		
					three. In the event any further		
					concerns are identified the iss	ue	
					will be immediately corrected		
					additional training will be initia	ted.	
					Results of the audit will be		
					reviewed at the Quality Assura	ance	
					Meeting at least quarterly.		
					By what date the systemic		
					changes will be made: 10/15/2	2024	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>			COMPLETED	
		155733	B. W	WING		09/18/2024	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 119 N INDIANA AVE CROWN POINT, IN 46307				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID		NEGLIDERIC IV. AND OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG DEFICIENCY)		.16	DATE	
K 0225	NFPA 101						
SS=E	_	okeproof Enclosures					
Bldg. 01							
5	Based on observation	on and interview, the facility	$ _{K0}$	225	K225 Stairways and		10/15/2024
		d maintain exit stairs and exit			Smokeproof Enclosures		10/10/2021
	-	ccordance with NFPA 101 -			What corrective action(s) will I	be	
		ons 19.2, 19.2.1, 19.2.2.3, 7.1.3.2,			accomplished for those reside		
		7.1.10, 7.1.10.1, 7.2.2, 7.2.2.1,			found to have been affected b		
		7.2.2.3.3.1, 7.2.2.3.3.4, 7.2.2.2,			the deficient practice;	-	
		1, 7.2.2.5.3, 7.2.2.5.3.1, 7.2.2.5.3.2,			Requesting compliance w	vith	
	7.7.3, 7.7.3.4, 7.2.2.	3.6, 7.2.2.3.6.1, 7.2.2.3.6.2, 8.2			alleged deficiency through the		
	and Table 7.2.2.2.1.	1 (b). This deficient practice			Safety Equivalency granted		
	could affect approxi	imately 12 residents and staff.			through the FSES was comple	eted	
					and a passing score was		
	Findings Include:				achieved. These stairs would	only	
					be used in an emergency	-	
	Based on observation	ons with the Administrator			situation, i.e. fire evacuation a	nd	
	and Maintenance D	irector on 09/18/2024 during a			do reach the sidewalk downst	airs	
	tour of the facility f	rom 12:26 p.m. to 1:26 p.m., the			for egress to outside the build	ing.	
	following was disco	overed:			Installation occurred from	an	
	a) the exit stair by re	oom 201 was not enclosed in			independent contractor, Life		
		on. The door to the stair did			Safety of all additional work		
	not have fire resista				needed to be upgrade the sme	oke	
	•	201 consisted of metal open			detection system. Total covera	age	
		ces. The landing and all of the			smoke detection included the		
		etal open grate where there was			installation of automatic smok	е	
	_	etal and a 1 inch gap between			detection in all rooms, halls,	_	
	-	ieces. This building is a			storage areas, basements, att		
	healthcare occupand	•			lofts, space above suspended		
		201 continued down from the			ceilings, and other subdivision		
		sers to the bottom of the stair			and accessible spaces as wel		
		ent landing. The approximately			the inside of all closets, elevat		
		reeded the allowable maximum			shafts, ,enclosed stairways, d		
	12 foot distance bet				waiter shafts, and chutes. The		
		201 only had a 30 inch clear			facility has an updated FSES		
		equired minimum 36 inch clear			of May 14, 2024 that reflects t	ne	
	width.				updated system.		
	Those findings	dispussed with the			How other resident having the		
	These findings were	or and Administrator at exit			potential to be affected by the		
					I SOME DEDICIEM DISCUIR WIND DE		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 01 COMPLETED				
		155733	B. WING 09/18/2024				
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
COLONII		E			NDIANA AVE		
COLONIA	AL NURSING HOM	<u> </u>		CROW	N POINT, IN 46307		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	conference.	R LSC IDENTIFYING INFORMATION		TAG	identified and what corrective		DATE
	conference.				action(s) will be taken;		
	3.1-19(b)				·All residents residing in the		
	2.1 15(0)				facility could potentially be		
					affected by the alleged deficie	nt	
					practice. Administration will re		
					FSES documentation annually		
					and as needed.		
					What measures will be put into)	
					place and what systemic chan		
					will be made to ensure that the	_	
					deficient practice does not rec		
					·The IDT reviewed CMS		
					guidelines on Use of fire safet	y	
					evaluation system (FSES)		
					·A performance improvemer	nt	
					tool has been developed to		
					monitor that FSES and its		
					accuracy		
					How the corrective actions will		
					monitored to ensure the defici	ent	
					practice does not recur; A performance improvement to	ool	
					has been initiated that random		
					audits. This Quality Assurance	-	
					Audit Tool will be completed b		
					the Maintenance	•	
					Director/Designee Weekly for		
					three weeks; then monthly for		
					three months, then quarterly x		
					three. In the event any further		
					concerns are identified the iss		
					will be immediately corrected a		
					additional training will be initia	ted.	
					Results of the audit will be		
					reviewed at the Quality Assura	ance	
					Meeting at least quarterly.		
					By what date the systemic		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED		
		155733	B. W	B. WING			09/18/2024	
				STREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF F	PROVIDER OR SUPPLIER	L			NDIANA AVE			
COLONIA	AL NURSING HOM	E			N POINT, IN 46307			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	ID		DROWINEDS BY AN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFI		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TC	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
					changes will be made: 10/15/2	2024		
K 0353	NFPA 101							
SS=E	Sprinkler System -	- Maintenance and Testing						
Bldg. 01								
		on and interview, the facility	K 0	353			10/15/2024	
		f 2 sprinkler heads in the			K353 (F) Sprinkler System-			
		d 1 of 1 in basement resident			Maintenance and Testing			
		of paint accordance with LSC			What corrective action(s) will be			
		11 edition, at 5.2.1.1.1 sprinklers			accomplished for those reside			
	_	s of leakage; shall be free of			found to have been affected b	У		
		naterials, paint, and physical			the deficient practice;			
	1 -	be installed in the correct			·All residents could potential			
		-right, pendent, or sidewall).			be harmed by the alleged defi-			
		1.1.2 any sprinkler that shows			practice. The facility checked			
	1 -	following shall be replaced: (1)			pipe sprinkler system's gauge			
		ion (3) Physical Damage (4) glass bulb heat responsive			and has safecare checking all			
		g (6) Painting unless painted by			valves on 10/09/2024 as well a			
		acturer. This deficient practice			having the two valves replaced were identified	ı mat		
	_	imately 16 residents and staff.			were identified			
	could affect approxi	inflatery 10 residents and starr.			How other resident having the	1		
	Findings include:				potential to be affected by the			
	i maniga merauer				same deficient practice will be			
	Based on observation	on with the Maintenance			identified and what corrective			
	Director and Admin	nistrator on 09/18/24 between			action(s) will be taken;			
	12:26 p.m. and 1:26	p.m., one sprinkler head in a			All residents residing in the			
		es/resource office in the			facility could potentially be			
	basement was obser	ved to have foreign			affected by the alleged deficie	nt		
	material/paint on the	e deflector that was not from			practice.			
	the manufacturer. F	urthermore, the resident			The facility checked the pip	е		
	bathroom in the bas	ement, next to the conference			sprinkler system's gauges and	ł		
	room, had white for	reign material on the sprinkler			has safecare checking all valv	es		
	head. The material l	looked like overspray from			on 10/09/2024 as well as havi	ng		
	_	eon plate had been painted.			the two valves replaced that w	ere		
		at the time of observation, the			identified			
		or acknowledged the materials			·1:1 education was provided	to		
	_	heads. He agreed that the			the Maintenance Director to			
	_	uld not have any foreign			ensure the pipe sprinkler syste	∍m's		
	material on them.				gauges and valves are checke	∍d		

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155733	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	COM	e survey pleted 8/2024	
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 119 N INDIANA AVE CROWN POINT, IN 46307				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION HOULD BE APPROPRIATE	(X5) COMPLETION DATE	
		eviewed with the Maintenance dministrator during the exit		What measures will be place and what system will be made to ensure deficient practice does The IDT reviewed th sprinkler system check. A performance improvement ool has been developed monitor pipe sprinkler significant gauges and valves are checked How the corrective action monitored to ensure the practice does not recurred to the practice does not recurred to a performance improvement has been initiated that audits. This Quality Assaudit Tool will be computed three weeks; then mon three months, then quality three. In the event any concerns are identified will be immediately con additional training will be Results of the audit will reviewed at the Quality Meeting at least quarter and will be made: By what date the syste changes will be made:	inic changes in that the inot recur; ne policy on is ovement ed to system's being ions will be ne deficient r; ement tool randomly surance bleted by ekly for attelly x further I the issue rected and be initiated. I be of Assurance erly.		
K 0531 SS=E Bldg. 01	NFPA 101 Elevators						

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DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 09/18/2024 155733 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 119 N INDIANA AVE COLONIAL NURSING HOME CROWN POINT, IN 46307 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Based on record review and interview, the facility K 0531 K531 [E] Elevators 10/15/2024 failed to maintain testing of 1 of 1 elevator What corrective action(s) will be firefighter recall in accordance with 9.4.6, Elevator accomplished for those residents Testing. LSC 9.4.6.2 states that all elevators with found to have been affected by fire fighters' emergency operations in accordance the deficient practice: with 9.4.3 shall be subject to a monthly operation All residents could potentially with a written record of the findings made and be harmed by the alleged deficient kept on the premises as required by ASME practice but none were identified. A17.1/CSA B44, Safety Code for Elevators and A monthly test for firefighter recall Escalators. This deficient practice would affect all was conducted on September 5th, occupants. 2024 Findings include: How other residents that have the potential to be affected by Based on record review with the Maintenance the same defective practice will Director and Administrator on 09/18/24 between be identified and what 09:23 a.m. and 12:15 p.m., the monthly testing for corrective action(s) will be the elevator firefighter recall was missing testing taken: for 8 of 12 months. The months of September & December of 2023 along with March through Potentially all residents August 2024 were not documented. Based on could be affected but none were interview at the time of record review, the identified. A monthly test for Maintenance Director acknowledged the lack of firefighter recall was conducted on documentation. He stated that the firefighter recall September 5th, 2024 testing for the elevator was tested on a monthly basis, however he did not document it on the What measures will be put into testing log in the life safety book. place and what systemic changes will be made to ensure The finding was reviewed with the Administrator that the deficient practice does and Maintenance Director during the exit not recur: conference. Monthly firefighters recall 3.1-19(b) test was conducted IDT reviewed procedure for monthly recall testing for elevators

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How the corrective action(s) will be monitored to ensure the deficient practice will not recur,

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155733	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/18/2024	
	ROVIDER OR SUPPLIER		119 N	ADDRESS, CITY, STATE, ZIP COD INDIANA AVE /N POINT, IN 46307		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
				i.e., what quality assurance program will be put into place	ce:	
				An audit will be completed by maintenance or designee on elevator firefighters for three weeks; then monthly for three months, then quarterly x three the event any further concern identified the issue will be immediately corrected and additional training will be initial Results of the audit will be reviewed at the Quality Assur Meeting at least quarterly.	e. In s are ated.	
				The date the systemic chan will be completed: 10/15/202	-	
K 0761 SS=F Bldg. 01	Based on observation interview, the facilities inspection and testing assemblies were considered by 19.1.1.4.1.1 communities barriers requires permitted only in consideration.	on, records review, and by failed to ensure annual and of 7 of 7 fire door annual accordance of LSC anicating openings in dividing and by 19.1.1.4.1 shall be corridors and shall be protected being fire door assemblies.	K 0761	K761 (F) Maintenance, Inspection, and Testing- Doo What corrective action(s) will accomplished for those reside found to have been affected to the deficient practice; ·All residents could potentia be harmed by the alleged defi	be ents by	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3)			(X3) DATE SU	3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. Bl	A. BUILDING <u>01</u> CO			ED	
		155733	B. W	B. WING		09/18/2024		
		l .		CTREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIEF	₹						
COLONI	AL NILIDOING HOM	_		119 N INDIANA AVE				
COLONIA	AL NURSING HOM	E		CROWN POINT, IN 46307				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE C	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	(See also Section 8.	.3.) LSC 8.3.3.1 Openings			practice. A inspection of the 7	fire		
	required to have a f	ire protection rating by Table			doors was conducted on			
	8.3.4.2 shall be prot	tected by approved, listed,			09/23/2024			
	labeled fire door as	semblies and fire window						
		r accompanying hardware,			How other resident having the	,		
	including all frames	s, closing devices, anchorage,			potential to be affected by the			
	and sills in accorda	nce with the requirements of			same deficient practice will be	,		
		for Fire Doors and Other			identified and what corrective			
		s, except as otherwise			action(s) will be taken;			
	_	de. NFPA 80 5.2.1 states fire			·All residents residing in the			
		all be inspected and tested not			facility could potentially be			
		and a written record of the			affected by the alleged deficie	nt		
		signed and kept for inspection			practice. An audit of the 7 fire			
	1 -	80, 5.2.4.1 states fire door			doors was conducted on			
		visually inspected from both			09/23/2024.			
		overall condition of door						
	1	0, 5.2.4.2 states as a minimum,			What measures will be put int			
	the following items			place and what systemic changes				
	_	or breaks exist in surfaces of			will be made to ensure that th			
	either the door or fr				deficient practice does not red			
		light frames, and glazing beads			·The IDT reviewed the fire d	oor		
		ely fastened in place, if so			policy			
	equipped.				·A performance improvemen	nt		
	1 1	e, hinges, hardware, and			tool has been developed to			
		eshold are secured, aligned,			monitor the fire watch policy is	in		
		er with no visible signs of			place			
	damage.				How the corrective actions will			
	(4) No parts are mis	_			monitored to ensure the defici	ent		
	1 ' '	s do not exceed clearances			practice does not recur;			
	listed in 4.8.4 and 6					_		
		g device is operational; that is,			A performance improvement t			
		npletely closes when operated			has been initiated that randon			
	from the full open p				audits. This Quality Assurance			
	1 ' '	is installed, the inactive leaf			Audit Tool will be completed b	y		
	closes before the ac				the Maintenance			
		are operates and secures the			Director/Designee Weekly for			
	door when it is in th	-			three weeks; then monthly for			
		vare items that interfere or			three months, then quarterly x			
		are not installed on the door or			three. In the event any further			
	frame.				concerns are identified the iss	ue		

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155733	JILDING	nstruction 01	(X3) DATE COMPI 09/18	
	PROVIDER OR SUPPLIE		119 N II	NDDRESS, CITY, STATE, ZIP COD NDIANA AVE N POINT, IN 46307		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPLICATION OF THE APPLICATION CROSS-REFERENCED TO THE APPLICATION OF THE		N (X5) BE COMPLETION DATE	
	have been performed (11) Gasketing and inspected to verify	ed that void the label. edge seals, where required, are their presence and integrity. tice could affect all residents.		will be immediately corrected additional training will be init Results of the audit will be reviewed at the Quality Assumenting at least quarterly.	iated.	
	Findings include:			By what date the systemic changes will be made: 10/15	5/2024	
	and Maintenance D 09:23 a.m. and 12:1 annual inspection for the past 12 me The last documented inspection was date checklist dated Oct list stairway assemble make sure there we worked properly. He not list the other ne inspected on the she during the tour between there are (6) one-he two stair wells. The fire door assembly storage/transfilling the time of record representation Director stated that the facility earlier if fire door assemblie documented. He further done an inspection The finding was dis Director and Administration of the finding was dis Director and Administration.	room. Based on interview at eview, the Maintneance the fire marshals office was in the year and checked certain s, however none of it was rther stated that he has not				
K 0914 SS=F	NFPA 101 Electrical Systems	s - Maintenance and				

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	of correction (X1) PROVIDER/SUPPLIER/CLIA (IDENTIFICATION NUMBER (155733)	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 09/18/2024	
	PROVIDER OR SUPPLIER AL NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP COD 119 N INDIANA AVE CROWN POINT, IN 46307			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	unaware the testing needed to be completed. Furthermore, the Administrator stated that the resting might have been completed this year by other personnel, but she was unsure where the documentation could be. The finding was reviewed with the Maintenance Director and Administrator at exit conference. 3.1-19(b)		A performance improvement thas been initiated that random audits. This Quality Assurance Audit Tool will be completed by the Maintenance Director/Designee Weekly for three weeks; then monthly for three months, then quarterly at three. In the event any further concerns are identified the iss will be immediately corrected additional training will be initial Results of the audit will be reviewed at the Quality Assura Meeting at least quarterly. By what date the systemic changes will be made: 10/15/2	nly e by ue and ted. ance	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 7 of 12 months and weekly inspection for 4 of 52 weeks. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. NFPA 110 8.4.2 requires diesel generator sets in service to be exercised at least once monthly, for a minimum of 30 minutes. Section 8.4.1 requires an Emergency Power Supply System (EPSS) including all	K 0918	K918 (F) Electrical Systems- Essential Electric Systems What corrective action(s) will I accomplished for those reside found to have been affected b the deficient practice; ·All residents could potential be harmed by the alleged defi practice but none were identifi A generator testing occurred of 09/24/2024 How other resident having the	ents y lly cient ied. on	

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AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		01	COMPLETED	
155733		B. W	B. WING			/2024	
		<u> </u>		CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R					
COLONI	AL NURSING HOM	ı		119 N INDIANA AVE CROWN POINT, IN 46307			
COLOINI	AL NURSING HOW			CROW	N FOINT, IN 40307		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	appurtenant components, shall be inspected weekly and exercised monthly. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection,				potential to be affected by the		
					same deficient practice will be)	
				identified and what correc			
	performance, exercising period, and repairs for the				action(s) will be taken;		
	generator to be regi	ularly maintained and available			·All residents residing in the		
	for inspection by th	ne authority having			facility could potentially be		
	jurisdiction. This d	eficient practice could affect all			affected by the alleged deficient		
	occupants.				practice. An audit of the generator		
					testing was conducted on		
	Findings include:				09/27/2024 for the monthly load		
					testing and as well as the visu	ıal	
	Based on record re-	view with the Administrator			weekly check		
	and Maintenance Director on 09/18/24 between				·Additional education was		
	09:23 a.m. and 12:15 p.m., no documentation was				provided to the Maintenance		
	available for the months between January 2024				Director to ensure testing is being		
	and August 2024 to show the generator set in				completed		
	service was exercis	ed at least once monthly, for a					
	minimum of 30 minutes. Also, the generator				What measures will be put int	o	
	weekly inspection log showed that documentation				place and what systemic changes		
	for the following w	eeks were missing			will be made to ensure that th	е	
	a) September 24-Se	eptember 30 of 2023			deficient practice does not red	cur;	
	b) October 22-Octo	ober 28 of 2023			·The IDT reviewed policy ar	nd	
	c) November 26-De	ecember 2 of 2023			procedure on Generator Testi	ng	
	d) December 24-De	ecember 30 of 2023			protocol		
	Based on interview	at the time of record review,			·A performance improveme	nt	
		irector acknowledged that			tool has been developed to		
	there were weekly	inspections missing and further			monitor monthly load testing	and	
	stated that he was n	not at the facility during that			weekly visual checks		
	time and was unsur	re if the inspections had been			How the corrective actions will	ll be	
	completed. He furtl	her clarified that he was			monitored to ensure the defic	ient	
		enerator needed to be exercised			practice does not recur;		
	under load each mo	onth.			A performance improvement	tool	
					has been initiated that randon	nly	
	The finding was re-	viewed with the Administrator			audits. This Quality Assurance	е	
	and Maintenance Director during the exit conference. 3.1-19(b)				Audit Tool will be completed by	у	
					the Maintenance		
					Director/Designee Weekly for		
					three weeks; then monthly for	•	

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three months, then quarterly x three. In the event any further

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155733	(X2) MULTIPLE C A. BUILDING B. WING	O1	(X3) DATE SURVEY COMPLETED 09/18/2024
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD	
COLONI	AL NURSING HOM	E		VN POINT, IN 46307	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				concerns are identified the iss will be immediately corrected additional training will be initial Results of the audit will be reviewed at the Quality Assur Meeting at least quarterly. By what date the systemic changes will be made: 10/15/	and ated. rance
K 0920 SS=E Bldg. 01	Extens Based on observation failed to ensure 2 of as a substitute for fine equipment with a high NFPA-70/2011, 400 permitted in 400.7 finot be used for (1) a	0.8 state unless specifically lexible cords and cables shall as a substitute for fixed wiring.	K 0920	K920 (E) Electrical Systems Power Cords and Extension What corrective action(s) will accomplished for those reside found to have been affected to the deficient practice; Extension cords and powe	s be ents by
	residents and staff. Findings include: Based on observation with the Maintenance	on during a tour of the facility ce Director and Administrator n 12:26 p.m. and 1:26 p.m., two		strips were removed from all rooms in the facility •Electrician will be coming of on 10/4/2024 to add in outlets two locations identified so no extension cords would be need in that area	s for
	plugged into and su near the first floor n minifridge (high po plugged into and po activities/resource on interview at the the Administrator acknoplugged into the frid	power draw equipment) were pplied power by a power strip curses station. Furthermore, a wer draw equipment) was ewered by a power strip in the office in the basement. Based time of observation, the bowledged the items were eldes. She further stated that remove all power strips in the		How other resident having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents residing in the facility could potentially be affected by the alleged deficie practice. An audit of the power strips and extension cords was conducted on 9/20/2024. 1:1 education was provide	e ent er as

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		COMPLETED		
155733		155733	B. WING		09/18/2024		
NAME OF PROVIDER OR SUPPLIER COLONIAL NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP COD 119 N INDIANA AVE CROWN POINT, IN 46307				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)		
PREFIX		ICY MUST BE PRECEDED BY FULL	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION		
TAG	`	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE			
		viewed with the Maintenance		the Maintenance Director to			
	Director and Administrator at exit conference.			ensure facility is free from			
			extension cords and power str		ps		
	3.1-19(b)			extension cords and power can			
	. /			What measures will be put into			
				place and what systemic changes			
				will be made to ensure that the	· I		
				deficient practice does not recu	ır;		
				·The IDT reviewed the power			
				strip and extension cord policy			
				·A performance improvement	t		
				tool has been developed to			
				monitor the fire watch policy is	in		
				place.			
				How the corrective actions will	he		
				monitored to ensure the deficient			
				practice does not recur;			
				A performance improvement to	nol		
				has been initiated that randomle			
				audits. This Quality Assurance	*		
				Audit Tool will be completed by			
				the Maintenance			
				Director/Designee Weekly for			
				three weeks; then monthly for			
				three months, then quarterly x			
				three. In the event any further			
				concerns are identified the issu	ie		
				will be immediately corrected a	nd		
				additional training will be initiate	ed.		
				Results of the audit will be			
				reviewed at the Quality Assura	nce		
				Meeting at least quarterly.			
				Described data #			
				By what date the systemic			
				changes will be made: 10/15/2	024		

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