STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155733	A. BUILDING 00 B. WING	04/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COLONIAL NURSING HOME	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00428577. Complaint IN00428577 - Federal/state deficiencies related to the allegations are cited at F842. Survey dates: April 15, 2024 Facility number: 000360 Provider number: 155733 AIM number: 100290370 Census Bed Type: SNF/NF: 35 Total: 35 Census Payor Type: Medicaid: 25 Other: 10 Total: 35 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 4/16/24.	F 0000	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective April 25, 2024, to the Complaint Survey completed on April 15, 2024. We respectfully request a desk review for paper compliance.	
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jennifer Short	Administrator	04/25/2024

Any defiencystatement 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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	§483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or			

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	(ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.			
	Based on interview and record review, the facility failed to ensure a resident's medical record was complete and accurate related to incontinence care logs, for 1 of 3 residents reviewed for incontinence care. (Resident B) Finding includes: Resident B's closed record was reviewed on 4/15/24 at 10:37 a.m. Diagnoses included, but were not limited to, acute respiratory failure, heart failure, and bipolar disorder. The resident was admitted to the facility on 12/20/23 and discharged on 1/18/24. The Discharge Minimum Data Set (MDS) assessment, dated 1/18/24, indicated the resident was cognitively intact for daily decision making, was occasionally incontinent of bowel and bladder and required assistance with toileting.	F 0842	F842: Resident Records - Identifiable Information It is the practice of this facility that we ensure that residents' medical records are complete and accurate. *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;* Resident B discharged on 1/18/2024 *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 who are provided incontinence care have the	04/25/2024

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	A Care Plan, dated 12/22/23, indicated the resident had an activity of daily living (ADL) self-care performance deficit related to activity intolerance, chronic obstructive pulmonary disease, and respiratory failure. Interventions included, but were not limited to, the resident required staff participation for use of the toilet, transfers, repositioning and turning in bed, and eating. The January 2024 Tasks indicated ADL-Toilet Use had a frequency of every shift. There were no entries on 1/10/24. There was one entry on 1/5/24, 1/6/24, 1/9/24, 1/13/24, 1/14/24, and 1/18/24. There were two entries on 1/2/24, 1/3/24, 1/7/24, 1/8/24, 1/12/24, 1/17/24. During an interview on 4/15/24 at 12:20 p.m., the Nurse Manager indicated the resident was incontinent and required incontinence care provided by the staff. The staff should have documented at least every shift for incontinence care provided, which would include how much assistance they required and whether they were continent or incontinent. At a minimum, documentation should have been three times a day at the end of each shift. During an interview on 4/15/24 at 12:37 p.m., the Director of Nursing indicated she had no further information to provide. During an interview on 4/15/24 at 12:57 p.m., the Administrator indicated the staff had reported that charting was not always accessible during their shifts, so the facility had implemented a tablet to use for charting. She was unable to provide any additional information. This citation relates to Complaint IN00428577.		potential to be affected by the alleged deficient practice. The ADL tasks were audited on all incontinent residents to ensure documentation was scheduled and completed at least every shift. *What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;* The facility policy and procedure “Activities for Daily Living, Supporting” was reviewed by the IDT. In-servicing was completed with certified nursing assistants and nurses on the policy and on auditing for completion of ADL documentation before the end of each shift A performance improvement tool has been developed to audit completion of ADL charting for toilet use and bowel and bladder continence for residents on each shift. *How the corrective actions will be monitored to ensure the deficient practice does not recur;* A performance improvement tool has been initiated that randomly audits (5) residents at random to assure ADL charting is completed. This Quality Assurance Audit Tool will be completed by the Director of Nursing/Designee weekly for three weeks; then monthly for three months, then quarterly x three. In the event any further concerns are identified the issue	

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	3.1-50(a)(1)		will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly. *By what date the systemic changes will be made:* 4/25/2024	