CENTERS FOR	MEDICARE & MEDIC	AID SERVICES				OM	B NO. 0938-039	
STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	<u></u>	COMPL	ETED	
		155733	B. WI	NG		07/20/	/2023	
		1	<u> </u>	STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF P	PROVIDER OR SUPPLIER	R			NDIANA AVE			
COLONIA	AL NURSING HOM	E			N 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 SHOUNDED TO THE APP) TAG DEFICIENCY)		TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
E 0000								
DI-I								
Bldg	A E	1 C	F 00	100	11.5			
	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in			000	/b> ="" b="">			
	accordance with 42				= D= > ="" b="">			
	accordance with 42	CTR 483.73.			="" b="">			
	Survey Date: 07/20/2023				="" b="">			
	F 32 M 1 0							
	Facility Number: 000360							
	Provider Number: 155733 AIM Number: 100290370							
	Anvi Number: 100	290370						
	At this Emergency	Preparedness survey, Colonial						
	Nursing Home was							
	Emergency Preparedness Requirements for							
	Medicare and Medicaid Participating Providers							
	and Suppliers, 42 C	CFR 483.73						
	The facility has 55	certified beds. At the time of						
	the survey, the cens	sus was 35.						
	Quality Review cor	mpleted on 07/24/23						
E 0041	482.15(e), 483.73	(e), 485,625(e)						
SS=F		LTC Emergency Power						
Bldg	•	tion for Participation:						
	` '	d standby power systems.						
	` '	implement emergency and						
	•	stems based on the						
		et forth in paragraph (a) of						
	this section and in							
		et forth in paragraphs (b)(1)						
	(i) and (ii) of this s	ection.						
	§483.73(e), §485.	625(e)						
	, ,, ,	d standby power systems.						
	, ,	and the CAH] must						
	-	ency and standby power						
		the emergency plan set						
LABORATOR	Y DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SI	IGNATURE	ì	TITLE		(X6) DATE	

(X6) DATE

Jennifer Short Administrator 08/21/2023

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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	OF CORRECTION	IDENTIFICATION NUMBER 155733	A. BU	A. BUILDING COM		COMPL 07/20/	ETED
	PROVIDER OR SUPPLIEF			119 N IN	ADDRESS, CITY, STATE, ZIP COD NDIANA AVE N POINT, IN 46307		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION (a) of this section.		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	§482.15(e)(1), §48 Emergency gener generator must be the location requir Care Facilities Co Interim Amendme 12-4, TIA 12-5, ar Code (NFPA 101 Amendments TIA and TIA 12-4), an structure is built o structure or buildin 482.15(e)(2), §488 Emergency gener The [hospital, CAI implement the em inspection, testing requirements four Facilities Code, N Code. 482.15(e)(3), §488 Emergency gener and LTC facilities] source to power e have a plan for ho power systems op emergency, unles *[For hospitals at §483.73(g), and C The standards inc this section are ap reference by the D Federal Register i 552(a) and 1 CFR	83.73(e)(1), §485.625(e)(1) ator location. The elocated in accordance with rements found in the Health de (NFPA 99 and Tentative ints TIA 12-2, TIA 12-3, TIA and TIA 12-6), Life Safety and Tentative Interim 12-1, TIA 12-2, TIA 12-3, d NFPA 110, when a new in when an existing ing is renovated. 3.73(e)(2), §485.625(e)(2) ator inspection and testing. Hand LTC facility] must be ergency power system in and [maintenance] and in the Health Care in FPA 110, and Life Safety 3.73(e)(3), §485.625(e)(3) ator fuel. [Hospitals, CAHs it hat maintain an onsite fuel in mergency generators must in wit will keep emergency poterational during the					

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CENTERS FOR MEDICARE & MEDICAID SERVICES					ON	IB NO. 0938-039	
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPLETED	
		155733	B. WI	NG		07/20	/2023
			-	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF	PROVIDER OR SUPPLIE	R		119 N II	NDIANA AVE		
COLONI	AL NURSING HOM	ЛE		CROW	N POINT, IN 46307		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	•	You may inspect a copy at the CMS					
		ource Center, 7500 Security					
		nore, MD or at the National					
		cords Administration					
	1 '	rmation on the availability of					
		ARA, call 202-741-6030, or					
	go to:	<i>(</i> *)					
		res.gov/federal_register/code					
		lations/ibr_locations.html.					
		this edition of the Code are					
	incorporated by reference, CMS will publish a						
		Federal Register to					
	announce the cha	<u> </u>					
	1 ' '	Protection Association, 1					
	Batterymarch Pa						
	Quincy, MA 0216 1.617.770.3000.	os, www.mpa.org,					
		ılth Care Facilities Code,					
	1 ''	ued August 11, 2011.					
	· ·	rim amendment (TIA) 12-2 to					
	1 ' '	August 11, 2011.					
		FPA 99, issued August 9,					
	2012.	11 A 33, Issued August 3,					
		IFPA 99, issued March 7,					
	2013.	ii i A 39, issued ividion i,					
		FPA 99, issued August 1,					
	2013.	117(33, 133ded 7(dgd3t 1,					
		IFPA 99, issued March 3,					
	2014.	ii i 7 (oo, loodod Maron o,					
	-	ife Safety Code, 2012					
	edition, issued Au						
		NFPA 101, issued August					
	11, 2011.						
	· ·	IFPA 101, issued October					
	30, 2012.	,					
	· ·	FPA 101, issued October					
	22, 2013.						
		IFPA 101, issued October					

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22, 2013.

(xiii) NFPA 110, Standard for Emergency and

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	OF CORRECTION	IDENTIFICATION NUMBER 155733	A. BUILDING COMPL		COMPLETED 07/20/2023
	PROVIDER OR SUPPLIER AL NURSING HOMI		119 N I	ADDRESS, CITY, STATE, ZIP COD INDIANA AVE IN POINT, IN 46307	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR Standby Power Sy including TIAs to c 2009	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION vstems, 2010 edition, chapter 7, issued August 6,	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
	failed to implement requirements found Code, NFPA 110, a accordance with 42 deficient practice confined in the Findings include: Based on records reduction Director on 07/20/2 p.m., the generator stesting and weekly wand NFPA 110. Based on record review, the Findings includes the Maintenance Director on the	view and interview, the facility the emergency power system in the Health Care Facilities and Life Safety Code in CFR 483.73(e)(2). This build affect all occupants. view with the Regional 3 between 09:59 a.m. and 12:05 lacked certain monthly load visual checks required by LSC sed on interview at the time of Regional Director stated that rector position had been nonthly and weekly inspection during the missing times. eviewed with the Regional conference.	E 0041	E041 (F) Hospital CAH and L Emergency Power It is the practice of this facility we ensure that residents are from misappropriation/exploit based on developed policies procedures. What corrective action(s) will accomplished for those reside found to have been affected I deficient practice; • All residents could potential harmed by the alleged deficie practice. A generator testing occurred on 07/31/2023 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 generatesting was conducted on 07/31/2023. Additional education was provided to the Maintena Director to ensure testing is be completed What measures will be put in place and what systemic chawill be made to ensure that the deficient practice does not re • The IDT reviewed policy and procedure on Generator Test	that free ation and be ents by the ly be ent erator ation ance being to nges ne cur; d

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155733	(X2) MULTIPI A. BUILDIN B. WING	LE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED 07/20/2023
	PROVIDER OR SUPPLIE		119	EET ADDRESS, CITY, STATE, ZIP COD ON INDIANA AVE OWN POINT, IN 46307	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIL TAG	CROSS-REFERENCED TO THE APPRO	dent tool nitor veekly will be efficient Int tool domly ince ed by for for for ly x her issue ed and nitiated. surance
K 0000					
Bldg. 01	Licensure Survey		K 0000	/b> ="" b=""> ="" b=""> ="" b="">	

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	of correction (X1) PROVIDER/SUPPLIER/CLIA (IDENTIFICATION NUMBER (155733)	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01		SURVEY LETED 1/2023
	PROVIDER OR SUPPLIER AL NURSING HOME	119 N II	ADDRESS, CITY, STATE, ZIP COD NDIANA AVE N 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 CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPF DEFICIENCY)	TION LD BE ROPRIATE	(X5) COMPLETION DATE
	Provider Number: 155733 AIM Number: 100290370				
	At this Life Safety Code survey, Colonial Nursing Home was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. Colonial Nursing Home is a two-story building with a basement of Type V (000) construction that was built at three different times. The original building was constructed in 1906 with additions constructed in 1986 and 1994. The building is fully sprinklered and there is supervised smoke detection located in the corridors, spaces open to 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 35. All areas where the residents have customary access and areas providing facility services were sprinklered. Quality Review completed on 07/24/23				
K 0161 SS=F Bldg. 01	NFPA 101 Building Construction Type and Height Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5				

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	of correction identification number 155733	A. BUILDING B. WING	01	COMPLETED 07/20/2023
	PROVIDER OR SUPPLIER AL NURSING HOME	119 N I	ADDRESS, CITY, STATE, ZIP COD NDIANA AVE N 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
	Construction Type 1 I (442), I (332), II (222) Any number of stories			
	non-sprinklered and sprinklered			
	2 II (111) One story non-sprinklered			
	Maximum 3 stories sprinklered			
	3 II (000) Not allowed non-sprinklered			
	4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111)			
	7 III (200) Not allowed non-sprinklered			
	8 V (000) Maximum 1 story sprinklered			
	Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5)			
	Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and			
	dates of approval. Complete sketch or attach small floor plan of the building as appropriate. Based on observation and interview, the facility	K 0161	/b>	08/15/2023
	was not an acceptable type of construction as required by NFPA 101 - 2012 edition, Sections 19.1.6.1, 4.5.8 and NFPA 220 - 2012 edition,		It is the practice of this facility we ensure that residents are fi from misappropriation/exploita	ree
	Section 4.1, 4.1.1 and Table 4.1.1. This deficient practice could affect all 35 residents.		based on developed policies a procedures.	and
	Findings include:		What corrective action(s) will accomplished for those	I De

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		155733	B. W	NG		07/20/2023	
				CEREE	ADDRESS SITE OF THE SID SOF		
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
001.01	AL AULIDOINIO LION	A.E.			INDIANA AVE		
COLONI	AL NURSING HOM	/IE		CROW	'N POINT, IN 46307		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
					residents found to have been	n	
	Based on observati	ion with the Regional Director			affected by the deficient		
	on 07/20/2023 dur	ing a tour of the facility from			practice;		
	12:10 p.m. to 2:12	p.m., observation of the			An independent compa	ny,	
	unprotected wood	structure revealed that the type			RTM, completed an FSES		
	of construction of	the building was Type V (000)			review in 2021 and determine	ed	
	and the building w	as two stories. Type V (000) is			all the Interstitial spaces of t	he	
	_	ype of construction for a			basement levels and 2nd flo		
	two-story existing	healthcare building.			will require the installation o	ıf	
		C .			smoke and heat detectors. T		
	This finding was c	onfirmed by the Regional			new smoke detection system	n	
	Director at the time				was installed as well as a		
		•			sprinkler system in 2023 by		
	3.1-19(b)				Safecare.		
					· A new FSES score will I	be	
					completed on 8/7/2023. This		
					has been scheduled at the		
					earliest date possible. The n	ew	
					FSES should reflect the new		
					system that will be a passing	a	
					score.		
					How other resident having to	he	
					potential to be affected by the		
					same deficient practice will		
					identified and what corrective		
					action(s) will be taken;		
					All residents residing in the	ne	
					facility could potentially be		
					affected by the alleged		
					deficient practice but none		
					were identified . Administrat	ion	
					will review FSES		
					documentation and will revie	ew	
					annually as needed.		
					What measures will be put in	nto	
					place and what systemic		
					changes will be made to ens	sure	
					that the deficient practice do		
					not recur:		

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155733	(X2) MULTIPLE C A. BUILDING B. WING		
	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 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
				The IDT reviewed CMS guidelines on Use of fire safe evaluation system (FSES) A performance improvement tool has been developed to monitor that FSES and its accuracy How the corrective actions who be monitored to ensure the deficient practice does not recur; A performance improvement tool has been initiated that randomly audits. This Quality Assurance Audit Tool will be completed by the Maintenand Director/Designee Weekly for three weeks; then monthly for three months, then quarterly three. In the event any further concerns are identified the issue 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: 08/15/2023	ety ent vill ce r or
K 0225 SS=E Bldg. 01	Stairways and Sm Stairways and Sm as exits are in acc 18.2.2.3, 18.2.2.4	okeproof Enclosures okeproof Enclosures okeproof enclosures used ordance with 7.2. 19.2.2.3, 19.2.2.4, 7.2 on and interview, the facility	K 0225	K225 Stairways and Smokenr	oof 08/15/2023

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	
		155733	B. Wl	ING		07/20/	2023
NAME OF D	DOWNER OF CURRINE			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER				NDIANA AVE		
COLONIA	AL NURSING HOM	E		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	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE
failed to provide and maintain exit stairs and exit stair enclosures in accordance with NFPA 101 -				Enclosures	414		
2012 edition, Sections 19.2, 19.2.1, 19.2.2.3, 7.1.3.2,				It is the practice of this facility			
		7.1.10, 7.1.10.1, 7.2.2, 7.2.2.1,			we ensure that residents are f from misappropriation/exploits		
		7.2.2.3.3.1, 7.2.2.3.3.4, 7.2.2.2,			based on developed policies a		
		1, 7.2.2.5.3, 7.2.2.5.3.1, 7.2.2.5.3.2,			procedures.	ariu	
		3.6, 7.2.2.3.6.1, 7.2.2.3.6.2, 8.2			What corrective action(s) will	II be	
		1 (b). This deficient practice			accomplished for those		
		imately 6 of the 35 residents.			residents found to have been	n	
					affected by the deficient		
					practice;		
	Based on observation	ons with the Regional Director			· Requesting compliance		
on 07/20/2023 during a tour of the facility from				with alleged deficiency			
		o.m., the following was			through the Life Safety		
	discovered:				Equivalency granted through	1	
	a) the exit stair by r	oom 201 was not enclosed in			the FSES is completed and a	l	
	fire rated construction	on. The door to the stair did			passing score is achieved.		
	not have fire resista				These stairs would only be		
		201 consisted of metal			used in an emergency		
		surfaces. The landing and all			situation, i.e. fire evacuation	-	
		ere metal open-grate where			using the fire sled and these		
	_	piece of metal and a 1 inch gap			stairs do reach the sidewalk		
		h metal pieces. This building is			downstairs for egress to out	side	
	a healthcare occupa	-			the building.		
		201 continued down from the			· Installation occurred fro	om	
	without an intermitt	sers to the bottom of the stair			an independent contractor,		
		ent landing. The pot distance exceeded the			Safe Care of all additional	·ho	
		1 12 foot distance between			work needed to be upgrade to		
	landing.	1 12 100t distance between			smoke detection system. To coverage smoke detection	ıaı	
		201 only had a 30 inch clear			included the installation of		
		equired minimum 36 inch clear			automatic smoke detection i	n	
	width.	-1 S minimum 5 0 men erem			all rooms, halls, storage area		
					basements, attic, lofts, space		
	These findings were	e confirmed by the Regional			above suspended ceilings, a		
		s of discovery and exit			other subdivisions and		
	conference.	-			accessible spaces as well as	;	
					the inside of all closets,		
	3.1-19(b)				elevators, shafts, ,enclosed		
					stairways, dumb waiter shaft	ts,	

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155733	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 07/20/2023
	ROVIDER OR SUPPLIE		119 N	ADDRESS, CITY, STATE, ZIP COD INDIANA AVE 'N POINT, IN 46307	•
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	CTION (X5) ULD BE COMPLETION COMPLETION DATE
				and chutes. The fires sy panel was updated as well as a selection of the updated system. How other resident have potential to be affected same deficient practice identified and what corrective deficient practice but not were identified. Administration and will annually as needed. What measures will be place and what systemic changes will be made to that the deficient practice identified and what systemic changes will be made to that the deficient practice identified. Administration and will annually as needed. What measures will be place and what systemic changes will be made to that the deficient practice into trecur; 'The IDT reviewed CM guidelines on Use of fire evaluation system (FSE). A performance improves tool has been developed monitor that FSES and in accuracy. How the corrective action be monitored to ensure deficient practice does recur; A performance improves tool has been initiated to randomly audits. This Quite in the corrective in the corrective action in the corrective in the corrective action in the corrective action in the corrective action is accuracy.	retem rell by acility ses on ing the by the will be rective in the reterive one stration review put into co co ensure ce does S e safety S) vement d to its ons will the not ment hat

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Event ID:

SPP121

Facility ID: 000360

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	OF CORRECTION	IDENTIFICATION NUMBER 155733	A. BUILDING B. WING	01	COMPLETED 07/20/2023
	ROVIDER OR SUPPLIER AL NURSING HOME		119 N I	ADDRESS, CITY, STATE, ZIP COD NDIANA 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
K 0291 SS=F Bldg. 01	duration is provide accordance with 7 18.2.9.1, 19.2.9.1 Based on records refailed to ensure 8 of tested monthly. See functional testing sh with a minimum of weeks between tests and (5) Written records the authority having	og g of at least 1-1/2-hour d automatically in	K 0291	Assurance Audit Tool will be completed by the Maintenand Director/Designee Weekly for three weeks; then monthly for three months, then quarterly three. In the event any further concerns are identified the issue 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: 8/15/2023 K291 (F) Emergency Lighting It is the practice of this facility we ensure that residents are fifrom misappropriation/exploitabased on developed policies a procedures. What corrective action(s) will accomplished for those residents found to have been affected by the deficient practice; All residents could potentially be harmed by the alleged deficient practice but all alleged deficient practice all	OB/15/2023 that ree tion and II be

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DEPARTMENT	OF HEALTH AND HU!	MAN SERVICES
CENTERS FOR	MEDICARE & MEDIC	AID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLETED				
		155733	B. W	ING		07/20/2023	
				CTREET A	DDDFGG CITY CTATE ZID COD		
NAME OF P	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
001.001	AL NUIDOINO LION	ı c		119 N INDIANA AVE CROWN POINT, IN 46307			
COLONIA	AL NURSING HOM	IE		CROW	N POINT, IN 46307		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROWINED'S BLAN OF CODDECTION	(.	X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	COMPI	LETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DA	TE
		vation during a tour of the			none were identified. A		
		gional Director on 07/20/23			emergency battery testing		
	I -	and 12:05 p.m., documentation			occurred on 08/01/2023		
		ond test for May 2023 and June			occurred on 00/01/2023		
	I -	ery powered emergency lights			How other resident having th		
		for review. Based on an			potential to be affected by th		
		ne of record review, the			same deficient practice will be		
		stated that the Maintenance			identified and what corrective		
	_	ad been recently filled and the			action(s) will be taken;	-	
		been conducted during the			·All residents residing in th		
	transitioning.	. ocen conducted during the			facility could potentially be	-	
	dansidoning.				affected by the alleged		
	This finding was re	eviewed with the Regional			deficient practice. An audit o	_f	
	Director during the	_			the emergency lighting were	'	
	Director during the	exit conference.			conducted on 08/01/2023.		
	3.1-19(b)				·Additional education was		
	3.1-19(0)						
					provided to the Maintenance		
					Director to ensure testing is		
					being completed.		
					What measures will be put in	to	
					place and what systemic		
					changes will be made to ens		
					that the deficient practice do	es	
					not recur;		
					·The IDT reviewed		
					emergency testing protocol		
					·A performance improveme	nt	
					tool has been developed to		
					monitor emergency lighting		
					testing		
					How the corrective actions w	rill	
					be monitored to ensure the		
					deficient practice does not		
					recur;		
					A performance improvement		
					tool has been initiated that		
					randomly audits. This Quality	,	
						'	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED		
		155733	B. WING		07/20/2023	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 119 N INDIANA AVE CROWN POINT, IN 46307			
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		
K 0346 SS=F Bldg. 01	NFPA 101 Fire Alarm System Fire Alarm - Out o Where required fir services for more period, the author be notified, and th evacuated or an a provided for all pa shutdown until the been returned to s 9.6.1.6 Based on record rev failed to provide 1 of the protection of res to be followed in th has to be placed out more in a twenty fo	f Service re alarm system is out of than 4 hours in a 24-hour ity having jurisdiction shall e building shall be pproved fire watch shall be rties left unprotected by the ries alarm system has service. riew and interview, the facility of 1 correct written policy for sidents indicating procedures e event the fire alarm system of service for four hours or ur hour period in accordance 0.6.1.6. This deficient practice	K 0346	Assurance Audit Tool will be completed by the Maintenance Director/Designee Weekly for three weeks; then monthly for three weeks; then monthly for three months, then quarterly three. In the event any further concerns are identified the issue 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: 8/15/2023 K346 (F) Fire Alarm System-Out of Service It is the practice of this facility the ensure that residents are from misappropriation/exploitated based on developed policies and procedures. What corrective action(s) will	08/15/2023 hat ee ion and	

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accomplished for those

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155733		A. BUILDING 01 B. WING		COMPLETED 07/20/2023	
		133733	B. WI			07/20/2023	
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
COLONI	AL NURSING HOM	1 =			INDIANA AVE 'N POINT, IN 46307		
	AL NORGING HOW	IL		CINOV	101 0101, 110 40307		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	,	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE	
TAG	Findings include:	R LSC IDENTIFTING INFORMATION		IAU	residents found to have bee		
	i manigs merade.				affected by the deficient	1	
	Based on record re	view with the Regional Director			practice;		
	on 07/20/23 between	en 09:59 a.m. and 12:05 p.m.,			All residents could		
		written fire watch policy in the			potentially be harmed by the		
		arm system outage/impairment			alleged deficient practice, bu		
		located. Based on interview at			none were identified. A writte		
		review, the Regional Director ity does have a fire watch			policy for fire watch policy w put into place on 07/31/2023.		
		the documentation was unable			put into place on 07/31/2023.		
		he time of the survey.			How other resident having the	he	
		Ç			potential to be affected by the		
		ussed with the Regional			same deficient practice will		
	Director at exit con	aference.			identified and what corrective	⁄e	
					action(s) will be taken;		
	3.1-19(b)				·All residents residing in th	ie	
					facility could potentially be affected by the alleged		
					deficient practice. An audit of	of	
					the fire watch policy was	,	
					conducted on 07/31/2023.		
					· 1:1 education was provide	ed	
					to the Maintenance Director		
					ensure fire watch policy was	in	
					place and available		
					What measures will be put in	nto	
					place and what systemic		
					changes will be made to ens	ure	
					that the deficient practice do	es	
					not recur;		
					•The IDT reviewed the fire		
					watch policy •A performance improvement	ont	
					tool has been developed to	7111	
					monitor the fire watch policy	, is	
					in place		
					How the corrective actions v	vill	
1	1				be monitored to ensure the		

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155733	ľ	JILDING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 07/20/2023	
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP COD 119 N INDIANA AVE CROWN POINT, IN 46307			
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R I SC IDENTIFYING INFORMATION		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System Sprinkler System Automatic sprinkler are inspected, test accordance with I Inspection, Testin Water-based Fire Records of syster inspection and test secure location and a) Date sprinkler b) Who provided	·		TAG	deficient practice does not recur; A performance improvement tool has been initiated that randomly audits. This Quality Assurance Audit Tool will be completed by the Maintenar Director/Designee Weekly for three weeks; then monthly for three months, then quarterly three. In the event any furthe concerns are identified the issue 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: 8/15/2023	ty e nce or for y x	DATE
1	c) Water system	supply source					

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPLETED	
		155733	B. W	ING		07/20/	2023
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 119 N INDIANA AVE CROWN POINT, IN 46307				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	BROWDERIC DI ANI 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 APPROPRIA	TC	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	.16	DATE
	coverage for any rautomatic sprinkle 9.7.5, 9.7.7, 9.7.8, Based on record reversiled to maintain 1 accordance with LS automatic sprinkler and maintained in a Standard for the Instandard for the Instandar	and NFPA 25 view and interview, the facility of 1 sprinkler system in C 9.7.5. LSC 9.7.5 requires all systems shall be inspected ccordance with NFPA 25, pection, Testing, and ter-Based Fire Protection , 2011 edition, Table 5.1.1.2 ed frequency of inspection and 6.2.4.1 states gauges on wet ms shall be inspected monthly systems (5.2.4.2) shall be ensure normal water or air aintained. NFPA 25 13.3.2.1 be inspected weekly or s or supervised (13.3.2.1.1) to be inspected monthly. This build affect all occupants. Eview with the Regional 3 between 09:59 a.m. and 12:05 monthly inspection of the wet m's gauges and valves for the ring an interview at the time of Regional Director stated that neges with Maintenance been in the process of pections were not done. umentation of a monthly ection were unable to be	K 0	353	K353 (F) Sprinkler System-Maintenance and Testing It is the practice of this facility we ensure that residents are from misappropriation/exploita based on developed policies a procedures. What corrective action(s) win accomplished for those residents found to have been affected by the deficient practice; All residents could potentially be harmed by the alleged deficient practice but none were identified. The facility checked the pipe sprinkler system's gauges a valves on 08/01/2023 How other resident having the potential to be affected by the same deficient practice will identified and what corrective action(s) will be taken; All residents residing in the facility could potentially be affected by the alleged deficient practice. An audit of the pipe sprinkler system's gauges and valves on 08/01/2023. 1:1 education was provide to the Maintenance Director ensure the pipe sprinkler	ree ation and II be n t t nd	08/15/2023

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155733	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 07/20/2023
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 119 N INDIANA AVE CROWN POINT, IN 46307		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION ference.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROF DEFICIENCY) system's gauges and valve	BE COMPLETION DATE
	3.1-19(b)			checked What measures will be purplace and what systemic changes will be made to e that the deficient practice not recur; A performance improve tool has been developed to monitor pipe sprinkler systemic checked How the corrective actions be monitored to ensure the deficient practice does not recur; A performance improvement tool has been initiated that randomly audits. This Quatassurance Audit Tool will completed by the Maintens Director/Designee Weekly three weeks; then monthly three months, then quarte three. In the event any furth concerns are identified the issue 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: 8/1	t into Insure does ment o Item's Ing S will e t Insure It Insu

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155733		JILDING	onstruction 01	(X3) DATE (COMPL 07/20 /	ETED
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 119 N INDIANA AVE CROWN 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)	TE	(X5) COMPLETION DATE
K 0354 SS=F Bldg. 01	extent and duration been determined, are inspected and recommendations management or duration and the fire depart having jurisdiction the sprinkler system than 10 hours in a building or portion evacuated or an aprovided until the returned to service 18.3.5.1, 19.3.5.1, Based on record reversal failed to provide 1 of the event the autom placed out-of-service 24-hour period in a 9.7.5. LSC 9.7.6 recomprocedures comply the Standard for the Maintenance of Wasystems. NFPA 25 procedures that the follow. A.15.5.2 (4) consist of trained period the affected a extinguishers and the fire department consider. During the should not only be sure that the other following such as eguare available and fur	or Out of Service er system is impaired, the n of the impairment has areas or buildings involved risks are determined, are submitted to esignated representative, tment and other authorities have been notified. Where is out of service for more 24-hour period, the of the building affected are pproved fire watch is sprinkler system has been	K 0	354	K354 (F) Sprinkler System-Oof Service It is the practice of this facility we ensure that residents are from misappropriation/exploita based on developed policies a procedures. What corrective action(s) will accomplished for those residents found to have been affected by the deficient practice; All residents could potentially be harmed by the alleged deficient practice. A written policy for fire watch policy was put into place on 07/31/2023 How other resident having the potential to be affected by the same deficient practice will to	that ree tion and <i>I be</i>	08/15/2023

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED
		155733	B. WING 07/20/2023			07/20/2023
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD	
NAME OF P	PROVIDER OR SUPPLIER	L			NDIANA AVE	
COLONIA	AL NURSING HOM	E			N POINT, IN 46307	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
	facility.				identified and what correctiv	⁄e
					action(s) will be taken;	
					·All residents residing in th	ne
	Findings include:				facility could potentially be	
	Dogad on monored mor	ion with the Decimal Director			affected by the alleged	
		riew with the Regional Director n 09:59 a.m. and 12:05 p.m., no			deficient practice. An audit of)1
		written fire watch policy in the			the fire watch policy was conducted on 07/31/2023.	
		impairment or outage was able			· 1:1 education was provide	ed
		time of record review. Based			to the Maintenance Director	
		time of record review, the			ensure fire watch policy was	
		tated that the facility does			place and available	
	_	olicy and documentation could			•	
	have been misplace	d and acknowledged			What measures will be put in	nto
	documentation was	unable to be found during the			place and what systemic	
	survey.				changes will be made to ens	ure
					that the deficient practice do	oes
	_	issed with the Regional			not recur;	
	Director at exit conf	ference.			·The IDT reviewed the fire	
					watch policy	
	3.1-19(b)				·A performance improveme	ent
					tool has been developed to	
					monitor the fire watch policy	' IS
					in place How the corrective actions v	will
					be monitored to ensure the	VIII
					deficient practice does not	
					recur;	
					· ,	
					A performance improvement	
					tool has been initiated that	
					randomly audits. This Qualit	у
					Assurance Audit Tool will be	•
					completed by the Maintenan	
					Director/Designee Weekly fo	
					three weeks; then monthly fo	
					three months, then quarterly	
					three. In the event any further	er
					concerns are identified the	
					issue will be immediately	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155733		X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY A. BUILDING 01 COMPLETED B. WING 07/20/2023				
	PROVIDER OR SUPPLIER		119 N	STREET ADDRESS, CITY, STATE, ZIP COD 119 N INDIANA AVE CROWN POINT, IN 46307		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODE)	OBE COMPLETION	
K 0761 SS=F Bldg. 01				corrected and additional training will be initiated. Results of the audit will b reviewed at the Quality Assurance Meeting at lea quarterly. By what date the systemichanges will be made: 8/4	e st	
	interview, the facili inspection and testi assemblies were co 19.1.1.4.1.1 commu fire barriers require permitted only in co by approved self-cl (See also Section 8 required to have a f 8.3.4.2 shall be pro labeled fire door as assemblies and thei including all frames and sills in accorda NFPA 80, Standard Opening Protective specified in this Co door assemblies shall be by the AHJ. NFPA assemblies shall be sides to assess the cassembly. NFPA 80 the following items	on, records review, and ty failed to ensure annual ng of 7 of 7 fire door mpleted in accordance of LSC micating openings in dividing d by 19.1.1.4.1 shall be orridors and shall be protected osing fire door assemblies. 3.) LSC 8.3.3.1 Openings fire protection rating by Table tected by approved, listed, semblies and fire window or accompanying hardware, se, closing devices, anchorage, nee with the requirements of for Fire Doors and Other se, except as otherwise de. NFPA 80 5.2.1 states fire all be inspected and tested not and a written record of the signed and kept for inspection 80, 5.2.4.1 states fire door visually inspected from both overall condition of door 0, 5.2.4.2 states as a minimum, shall be verified: or breaks exist in surfaces of	K 0761	It is the practice of this facion we ensure that residents a from misappropriation/expl based on developed policies procedures. What corrective action(s) accomplished for those residents found to have the affected by the deficient practice; All residents could potentially be harmed by alleged deficient practice none were identified. An inspection of the 7 fire do was conducted on 08/01/2 How other resident having potential to be affected by same deficient practice widentified and what correlaction(s) will be taken; All residents residing in facility could potentially the affected by the alleged deficient practice. An audithe 7 fire doors was conducted to the resident practice. An audithe 7 fire doors was conducted to the resident practice.	re free loitation les and will be loeen the loors 2023 g the ly the lill be loctive In the loee	

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155733		(X2) MULTIPLE C A. BUILDING B. WING	construction 01	(X3) DATE SURVEY COMPLETED 07/20/2023	
	PROVIDER OR SUPPLIEF		119 N	ADDRESS, CITY, STATE, ZIP COD INDIANA AVE VN POINT, IN 46307	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	either the door or fr	rame. light frames, and glazing beads		on 08/01/2023	
		rely fastened in place, if so		· 1:1 education was provid to the Maintenance Director	
	equipped.	ory rustened in place, it so		ensure all 7 fire doors are	
		e, hinges, hardware, and		checked annually	
	1 1	reshold are secured, aligned,			
	and in working ord	er with no visible signs of		What measures will be put in	nto
	damage.			place and what systemic	
	(4) No parts are mis			changes will be made to ens	
	` '	s do not exceed clearances		that the deficient practice de	oes
	listed in 4.8.4 and 6			not recur;	
	(6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position.			·The IDT reviewed fire doo	r
				checklist	
		is installed, the inactive leaf		·A performance improvem	ent
	closes before the ac			tool has been developed to monitor the fire door checks	
		are operates and secures the		Infolitor the life door checks	•
	door when it is in the	-		How the corrective actions v	will
		vare items that interfere or		be monitored to ensure the	
		are not installed on the door or		deficient practice does not	
	frame.			recur;	
	(10) No field modif	fications to the door assembly		A performance improvement	t
	have been performe	ed that void the label.		tool has been initiated that	
		edge seals, where required, are		randomly audits. This Qualit	ty
		their presence and integrity.		Assurance Audit Tool will be	e
	This deficient pract	ice could affect all residents.		completed by the Maintenan	
	T. 1			Director/Designee Weekly fo	
	Findings include:			three weeks; then monthly for	
	Događ on rogard roj	view with the Perional Director		three months, then quarterly	
		view with the Regional Director en 09:59 a.m. and 12:05 p.m., no		three. In the event any further concerns are identified the	er
		n annual inspection for the (7)		issue will be immediately	
		s was available for review.		corrected and additional	
		on during the tour between		training will be initiated.	
		2 p.m., there are (7) one hour fire		Results of the audit will be	
	•	ne two stair wells. Based on		reviewed at the Quality	
		ne of records review and		Assurance Meeting at least	
	observation, the Re	gional Director stated the		quarterly.	
		spection could have been			
	conducted, but doc	umentation could not be		By what date the systemic	

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155733	l í	JILDING	nstruction 01	(X3) DATE : COMPL 07/20/	ETED
	PROVIDER OR SUPPLIER			119 N IN	ADDRESS, CITY, STATE, ZIP COD NDIANA 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)	ΓE	(X5) COMPLETION DATE
	provided at the time	e of the survey.			changes will be made: 8/15/2	023	
	Director at exit conf	ussed with the Regional ference.					
	3.1-19(b)						
K 0914 SS=F Bldg. 01	Testing Electrical Systems Testing Hospital-grade recolocations and whe anesthesia is adminitial installation, and defined by docume Receptacles not lithese locations are exceeding 12 more (LIM), if installed, less than or equal the LIM test switch activates both visual LIM circuits with a manual test is per than or equal to 12	s - Maintenance and ceptacles at patient bed are deep sedation or general ainistered, are tested after replacement or servicing. is performed at intervals ented performance data. sted as hospital-grade at the tested at intervals not another. Line isolation monitors are tested at intervals of to 1 month by actuating the per 6.3.2.6.3.6, which that and audible alarm. For the per best of the performance data intervals less and another the performance data.					
	renovation to the e Records are main associated repairs containing date, ro results. 6.3.4 (NFPA 99)	.2 after any repair or electric distribution system. tained of required tests and s or modifications, com or area tested, and on, record review and	K 09	014	It is the practice of this facility	that	08/15/2023
	interview, the facili grade electrical rece sleeping rooms wer	ty failed to ensure non-hospital eptacles at 29 of 29 resident e tested at least annually. dare Facilities Code 2012 Edition,	K 05	914	we ensure that residents are fi from misappropriation/exploita based on developed policies a procedures.	ree tion	08/13/2023

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155733		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/20/2023				
NAME OF PROVIDER OR SUPPLIER COLONIAL NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP COD 119 N INDIANA AVE CROWN 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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE			
TAG	Section 6.3.4.1.3 state hospital-grade, at parallel locations where deed anesthesia is adminimitervals not exceed Section 6.3.3.2, Rec Rooms requires the receptacle shall be of The continuity of the electrical receptacle polarity of the hot an each electrical receptacle receptacles of the electrical receptacles on records review by p.m., and 2:12 sleeping rooms common-hospital-grade on records review by p.m., no documentate electrical receptacles were tested annually time of the observation of the	attes receptacles not listed as attent bed locations and in p sedation or general istered, shall be tested at ling 12 months. Additionally, reptacle Testing in Patient Care physical integrity of each confirmed by visual inspection. The grounding circuit in each is shall be verified. Correct and neutral connections in oracle shall be confirmed; and the grounding blade of each is except locking-type is not less than 115 grams (4 ent practice could affect all ones during a tour of the facility director on 07/20/23 between it p.m., the facility's 29 resident tained four to six electrical receptacles. Based etween 09:59 a.m. and 12:05 tion was available to show is in resident sleeping rooms by Based on interview at the citon and records review, the confirmed all of the electrical resident sleeping rooms were and stated annual testing per alle Testing requirements could do within the past 12 months, and documentation.	TAG	What corrective action(s) was accomplished for those residents found to have been affected by the deficient practice; All residents could potentially be harmed by the alleged deficient practice. A inspection of electrical receptacles conducted on 08/04/2023 How other resident having the potential to be affected by the same deficient practice will identified and what correctification(s) will be taken; All residents residing in the facility could potentially be affected by the alleged deficient practice. An audit the electrical receptacles conducted on 08/04/2023 1:1 education was provide to the Maintenance Director ensure all electrical receptacles are being inspected What measures will be put if place and what systemic changes will be made to entitat the deficient practice dinot recur; The IDT reviewed policy delectrical receptacles. A performance improvem tool has been developed to monitor the electrical receptacle testing	ill be en e the he be ve he of led to into sure oes			

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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 <u>01</u> B. WING		01	COMPLETED 07/20/2023		
155733		B. WI			077207	2023		
NAME OF I	PROVIDER OR SUPPLIER	2			ADDRESS, CITY, STATE, ZIP COD NDIANA AVE			
COLONIA	AL NURSING HOM	E			N POINT, IN 46307			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)			
TAG	3.1-19(b)	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE	
					How the corrective actions of be monitored to ensure the deficient practice does not recur; A performance improvement tool has been initiated that randomly audits. This Qualit Assurance Audit Tool will be completed by the Maintenan Director/Designee Weekly for three weeks; then monthly for three months, then quarterly three. In the event any further concerns are identified the issue 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: 8/15/2023	y ce r or		
K 0918 SS=F Bldg. 01	Electrical Systems System Maintena The generator or source and assoc of supplying servi 10-second criteric monthly test, a pre annually confirm t safety and critical and testing of the	s - Essential Electric Syste s - Essential Electric nce and Testing other alternate power iated equipment is capable ce within 10 seconds. If the in is not met during the ocess shall be provided to his capability for the life branches. Maintenance generator and transfer ormed in accordance with			0/13/2023			

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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			COMPL	COMPLETED	
155733		155733	B. W	B. WING			07/20/2023	
				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF PROVIDER OR SUPPLIER				119 N INDIANA AVE				
COLONI	AL NURSING HOM	E		CROW	N POINT, IN 46307			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE	
	NFPA 110.							
		e inspected weekly,						
		oad 30 minutes 12 times a						
		intervals, and exercised						
	-	onths for 4 continuous hours.						
		nder load conditions include						
		ated cold start and ual transfer of all EES				ļ		
		nducted by competent enance and testing of stored						
	-	rces (Type 3 EES) are in						
		NFPA 111. Main and feeder						
		re inspected annually, and a						
		dically exercising the						
		tablished according to						
		uirements. Written records						
		nd testing are maintained						
		ble. EES electrical panels						
		arked, readily identifiable,						
		n normal power circuits.						
	-	ssibility of damage of the						
		r source is a design						
	consideration for	-						
	6.4.4, 6.5.4, 6.6.4	(NFPA 99), NFPA 110,						
	NFPA 111, 700.1	,						
	Based on record re-	view and interview, the facility	K 0	918	It is the practice of this facility	that	08/15/2023	
	failed to maintain a	complete written record of			we ensure that residents are fi	ree		
	monthly generator	load testing for 2 of 12 months			from misappropriation/exploita	tion		
		ion for 8 of 52 weeks. Chapter			based on developed policies a	ınd		
	6.4.4.1.1.4(a) of 20	12 NFPA 99 requires monthly			procedures.			
		ator serving the emergency			What corrective action(s) wil	l be		
	_	be in accordance with NFPA			accomplished for those			
		or Emergency and Standby			residents found to have been	า		
	_	hapter 8. NFPA 110 8.4.2			affected by the deficient			
		erator sets in service to be			practice;	ļ		
		nce monthly, for a minimum of			·All residents could	ļ		
		1 8.4.1 requires an Emergency			potentially be harmed by the			
		em (EPSS) including all			alleged deficient practice. A			
		nents, shall be inspected			inspection of electrical	ļ		
	weekly and exercis	ed monthly. Chapter 6.4.4.2 of			receptacles conducted on			

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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 07/20/2023 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 NFPA 99 requires a written record of inspection, 08/04/2023 performance, exercising period, and repairs for the generator to be regularly maintained and available How other resident having the for inspection by the authority having potential to be affected by the jurisdiction. This deficient practice could affect all same deficient practice will be occupants. identified and what corrective action(s) will be taken; Findings include: ·All residents residing in the facility could potentially be Based on records review with the Regional affected by the alleged Director on 07/20/23 between 09:59 a.m. and 12:05 deficient practice. An audit of p.m., no documentation was available for the the electrical receptacles month of May and June of 2023 to show the conducted on 08/04/2023 generator set in service was exercised at least · 1:1 education was provided once monthly, for a minimum of 30 minutes. Also, to the Maintenance Director to the generator weekly inspection log showed the ensure all electrical last weekly inspection was conducted on 05/19/23 receptacles are being and no other weekly inspections were conducted inspected since. Based on an interview at the time of record review, the Regional Director stated that the What measures will be put into Maintenance Director position had recently been place and what systemic filled and the inspections were not conducted changes will be made to ensure during the time of transitioning. that the deficient practice does not recur; The findings were reviewed with the Regional The IDT reviewed policy on Director during the exit conference. electrical receptacles. ·A performance improvement 3.1-19(b)tool has been developed to

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recur;

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How the corrective actions will be monitored to ensure the deficient practice does not

A performance improvement tool has been initiated that randomly audits. This Quality **Assurance Audit Tool will be** completed by the Maintenance

monitor the electrical receptacle testing

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	OF CORRECTION	IDENTIFICATION NUMBER 155733	A. BUILDING B. WING	01	COMPLETED 07/20/2023			
NAME OF PROVIDER OR SUPPLIER COLONIAL NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP COD 119 N INDIANA AVE CROWN 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 B CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E COMPLETION			
K 0920 SS=D Bldg. 01	NFPA 101 Electrical Equipme Extens Electrical Equipme Extension Cords Power strips in a p used for compone patient-care-relate (PCREE) assembl assembled by qua the conditions of 1 the patient care via non-PCREE (e.g., except in long-tern do not use PCREE meet UL 1363A or for non-PCREE in (outside of vicinity) non-patient care ro other UL standard used with general cords are not used	ent - Power Cords and ent - Power Cords and eatient care vicinity are only ents of movable d electrical equipment		Director/Designee Weekly three weeks; then monthly three months, then quarter three. In the event any furt concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at leas quarterly. By what date the systemic changes will be made: 8/15/2023	for for ly x her			

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	<u></u>		COMPLETED		
155733		B. WING 07/20/2023				/2023	
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		BROWINEDIS DI ANI OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
TAG	temporarily are recompletion of the installed and meet 10.2.3.6 (NFPA 98 (NFPA 70), 590.3 (Based on observation failed to ensure 3 of as a substitute for fine equipment with a hin NFPA-70/2011, 400 permitted in 400.7 finot be used for (1) at This deficient praction 5 residents and staff. Findings include: Based on observation with the Regional Et 12:10 p.m. and 2:12 draw equipment) and equipment) was plut by an extension corroffice. Furthermore power strip that sup Additionally, the pominifridge was dais strip. Based on interreview, the Regional were misused power extension cord and observation.	moved immediately upon purpose for which it was as the conditions of 10.2.4. 2), 10.2.4 (NFPA 99), 400-8 (D) (NFPA 70), TIA 12-5 on and interview, the facility of 3 power strips were not used exed wiring to provide power and current draw. 2).8 state unless specifically dexible cords and cables shall as a substitute for fixed wiring. Since could affect approximately of the facility decretor on 07/20/23 between a p.m., a refrigerator (high power and microwave (high power draw gged into and supplied power d in the Admissions/Activities applied power to a minifridge. The power strip used for the condition of the time of record and Director agreed that there are strips and removed the power strips upon assed with the Regional	K 09		K920- Electrical Equipment- Power Cords and Extensions It is the practice of this facility we ensure that residents are f from misappropriation/exploita based on developed policies a procedures. What corrective action(s) wil accomplished for those residents found to have been affected by the deficient practice; All noncompliant extension cords and power strips were removed from all rooms in the facility 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 deficient practice but none were identified. An audit of the power strip and extension cords was conducted on 08/03/2023. 1:1 education was provide to the Maintenance Director ensure facility is free from extension cords and power	that ree ation and II be n ne he be re	08/15/2023

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NAME OF PROVIDER OR SUPPLIER COLONIAL NURSING HOME STREET ADDRESS, CITY, STATE, ZIP COD 119 N INDIANA AVE CROWN POINT, IN 46307						
	119 N INDIANA AVE					
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMP	(X5) MPLETION DATE					
What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; 'The IDT reviewed the power strip and extension cord policy 'A performance improvement tool has been developed to monitor noncompliant power strips and extension cords 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. This Quality Assurance Audit Tool will be completed by the Maintenance Director/Designee Weekly for three weeks; then monthly for concerns are identified the issue 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: 8/15/2023						

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