| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155289 | A. BUILDING -- B. WING | 07/27/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| COLONIAL OAKS HEALTH CARE CENTER | 4725 S COLONIAL OAKS DR MARION, IN 46953 |

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| E 0000<br><br>Bldg. -- | An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.<br><br>Survey Date: 07/27/22<br><br>Facility Number: 000186<br>Provider Number: 155289<br>AIM Number: 100266300<br><br>At this Emergency Preparedness survey, Colonial Oaks Health Care Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 127 and had a census of 98 at the time of this survey.<br><br>Quality Review completed on 07/29/22 | E 0000 | We at the facility are hereby respectfully requesting this agency consider paper compliance/desk review for compliance for the following plan of correction as opposed to a post survey revisit. We are willing to submit any and all documentation as requested to assure our credible compliance with the deficiencies noted in the following CMS-2567. We are hereby providing our plan of correction. Submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. The plan of correction is provided as evidence of the facility's desire to comply with regulations and continue to provide quality care. Please accept this plan of correction as our credible allegation of compliance.<br>="" p=""><br>="" p=""> | |
| K 0000<br><br>Bldg. 01 | A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). | K 0000 | We at the facility are hereby respectfully requesting this agency consider paper compliance/desk review for compliance for the following plan | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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| | Survey Date: 07/27/22<br><br>Facility Number: 000186<br>Provider Number: 155289<br>AIM Number: 100266300<br><br>At this Life Safety Code survey, Colonial Oaks Health Care Center 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.<br><br>This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and hard-wired smoke detectors in the resident rooms. The facility has a capacity of 127 and had a census of 98 at the time of this survey.<br><br>Due to a significant COVID-19 presence in the facility (35 residents) at the time of this survey, resident rooms 227-245 were not surveyed.<br><br>All areas where the residents have customary access were sprinklered. All areas providing facility services was sprinklered, except a garage used for the storage of maintenance supplies.<br><br>Quality Review completed on 07/29/22 | | of correction as opposed to a post survey revisit. We are willing to submit any and all documentation as requested to assure our credible compliance with the deficiencies noted in the following CMS-2567. We are hereby providing our plan of correction. Submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. The plan of correction is provided as evidence of the facility's desire to comply with regulations and continue to provide quality care. Please accept this plan of correction as our credible allegation of compliance.<br>="" p=""><br>="" p=""> | |
| K 0222<br>SS=E<br>Bldg. 01 | NFPA 101<br>Egress Doors<br>Egress Doors<br>Doors in a required means of egress shall not be equipped with a latch or a lock that | | | |

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| | requires the use of a tool or key from the egress side unless using one of the following special locking arrangements:<br>CLINICAL NEEDS OR SECURITY THREAT LOCKING<br>Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times.<br>18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6<br>SPECIAL NEEDS LOCKING ARRANGEMENTS<br>Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation.<br>18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4<br>DELAYED-EGRESS LOCKING ARRANGEMENTS<br>Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by | | | |

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| | an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system.<br>18.2.2.2.4, 19.2.2.2.4<br>ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS<br>Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted.<br>18.2.2.2.4, 19.2.2.2.4<br>ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS<br>Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system.<br>18.2.2.2.4, 19.2.2.2.4 | | | |
| | Based on observation and interview, the facility failed to ensure the means of egress through the main exit and therapy exit were readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect over 60, staff and visitors if needing to exit the facility.<br><br>Findings include:<br><br>Based on observations during a tour of the facility with the Maintenance Supervisor and Administrator on 07/27/22 between 12:20 p.m. and 3:30 p.m., the (1) main front exit door and the (2) | K 0222 | /p><br><br>No residents experienced adverse reactions to this deficient practice. All residents have the potential to be affected by this deficient practice. Identified doors have been corrected by placing the exit door code next to the keypad. The Maintenance Supervisor/designee will complete observations of the exit doors three times a week for four weeks, then two times a week for four weeks, then weekly thereafter to ensure codes are present and visible. The observations will be documented on the TELS Preventative Maintenance Log. Any concerns noted will receive immediate | 08/11/2022 |

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| | exit door near the Therapy area, both marked as facility exits, were magnetically locked and could be opened by entering a four digit code but the code was not posted at the exits. The Maintenance Supervisor stated that this was done to reduce the elopement possibilities.<br><br>This finding was acknowledged by the Maintenance Supervisor at the time of observation and again at the exit conference with the Maintenance Supervisor and Administrator present.<br><br>3.1-19(b) | | follow-up. Monitoring will continue until substantial compliance is achieved as determined by the Quality Assurance committee. After consecutive compliance is achieved, the Maintenance Supervisor/designee will randomly complete the observation to ascertain continued compliance at lease biannually. The Maintenance Supervisor/designee report of monitoring will be forwarded to the Administrator for monthly QA review and the plan of action will be adjusted accordingly. | |
| K 0321<br>SS=E<br>Bldg. 01 | NFPA 101<br>Hazardous Areas - Enclosure<br>Hazardous Areas - Enclosure<br>Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door.<br>Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.<br>19.3.2.1, 19.3.5.9<br><br>Area Automatic Sprinkler<br>Separation N/A | | | |

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| | a. Boiler and Fuel-Fired Heater Rooms<br>b. Laundries (larger than 100 square feet)<br>c. Repair, Maintenance, and Paint Shops<br>d. Soiled Linen Rooms (exceeding 64 gallons)<br>e. Trash Collection Rooms (exceeding 64 gallons)<br>f. Combustible Storage Rooms/Spaces (over 50 square feet)<br>g. Laboratories (if classified as Severe Hazard - see K322)<br>Based on observation and interview, the facility failed to maintain protection of 1 of 1 hazardous areas where a hot oil popcorn popper would be used. This deficient practice could affect staff and up to 15 residents in the Activities area.<br><br>Findings include:<br><br>Based on observations and interview during a tour of the facility with the Maintenance Supervisor and Administrator on 07/27/22 between 12:20 p.m. and 3:30 p.m., a hot oil popcorn popper was being stored in the Activities Area. When asked where the machine was used the Maintenance Supervisor and Administrator stated the hot oil popcorn popper was used in the Activities Area. The Activities Area did not have a self-closing device installed on the two doors into the corridor and was open to the corridor. Based on interview at the time of observation, the Maintenance Supervisor and Administrator acknowledged the aforementioned condition and stated they would protect the corridor.<br><br>This finding was acknowledged by the Maintenance Supervisor at the time of observation and again at the exit conference with the Maintenance Supervisor and Administrator present. | K 0321 | No residents experienced adverse reactions to this deficient practice. All residents have the potential to be affected by this deficient practice. The popcorn machine was sold and is no longer on facility grounds. The Maintenance Supervisor/designee will complete observations of hazardous areas three times a week for four weeks, then two times a week for four weeks, then weekly thereafter to ensure closure doors are operating properly. The observations will be documented on the TELS Preventative Maintenance Log. Any concerns noted will receive immediate follow-up. Monitoring will continue until substantial compliance is achieved as determined by the Quality Assurance committee. After consecutive compliance is achieved, the Maintenance Supervisor/designee will randomly complete the observation to ascertain continued compliance at lease biannually. The Maintenance Supervisor/designee report of | 08/11/2022 |

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| | 3.1-19(b) | | monitoring will be forwarded to the Administrator for monthly QA review and the plan of action will be adjusted accordingly. | |
| K 0374 SS=E Bldg. 01 | NFPA 101<br>Subdivision of Building Spaces - Smoke Barrie<br>Subdivision of Building Spaces - Smoke Barrier Doors<br>2012 EXISTING<br>Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors.<br>19.3.7.6, 19.3.7.8, 19.3.7.9<br>Based on observation and interview, the facility failed to ensure 2 of 5 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.8 requires doors in smoke barriers shall comply with LSC Section 8.5.4. LSC 8.5.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation. This deficient practice could affect 40 residents.<br><br>Findings include:<br><br>Based on observations and interview during a tour of the facility with the Maintenance Supervisor and Administrator on 07/27/22 between 12:20 p.m. and 3:30 p.m., the (1) double door set of smoke barrier doors on the Walnut | K 0374 | No residents experienced adverse reactions to this deficient practice. Residents residing on the Walnut and Chestnut hallways have the potential to be affected by this deficient practice. Both identified doors have been corrected by Maintenance Supervisor/designee. The Maintenance Supervisor/designee will complete observations of the smoke barrier doors three times a week for four weeks, then two times a week for four weeks, then weekly thereafter to ensure codes are present and visible. The observations will be documented on the TELS | 08/11/2022 |

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| | Hall and (2) the double door set of smoke barrier doors on the Chesnutt Hall did not close completely and latch when tested 3 times. Based on interview during the time of observations, the Maintenance Supervisor acknowledged these smoke barrier doors did not close completely and latch but that they had recently been tested and worked fine.<br><br>This finding was acknowledged by the Maintenance Supervisor at the time of observation and again at the exit conference with the Maintenance Supervisor and Administrator present.<br><br>3.1-19(b) | | Preventative Maintenance Log. Any concerns noted will receive immediate follow-up. Monitoring will continue until substantial compliance is achieved as determined by the Quality Assurance committee. After consecutive compliance is achieved, the Maintenance Supervisor/designee will randomly complete the observation to ascertain continued compliance at lease biannually. The Maintenance Supervisor/designee report of monitoring will be forwarded to the Administrator for monthly QA review and the plan of action will be adjusted accordingly. | |
| K 0511 SS=E Bldg. 01 | NFPA 101<br>Utilities - Gas and Electric<br>Utilities - Gas and Electric<br>Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life.<br>18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2<br>Based on observation, the facility failed to ensure 1 of 1 electrical junction boxes was installed and maintained in a safe operating condition. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 314.28(3) (c) states junction boxes shall be provided with covers compatible with the box and suitable for the conditions of use. Where used, metal covers shall comply with the grounding requirements of | K 0511 | Outdoor light was fixed by re-anchoring light to the building and sealing with caulk. No residents experienced adverse reactions related to this deficient practice. All residents residing in the facility have the potential to be affected by this deficient practice. The Maintenance Supervisor/designee will complete outdoor light observations weekly. | 08/11/2022 |

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| | 250.110. This deficient practice could affect staff and 15 residents in the Therapy Area.<br><br>Findings include:<br><br>Based on observations and interview during a tour of the facility with the Maintenance Supervisor and Administrator on 07/27/22 between 12:20 p.m. and 3:30 p.m., above the ceiling near the Therapy Exit Door the Exit light sign had exposed wires with wire nuts not secured in a junction box. The Maintenance Supervisor stated that a junction box would need to be set and the wires to the Exit Light secured inside the box.<br><br>This finding was acknowledged by the Maintenance Supervisor at the time of observation and again at the exit conference with the Maintenance Supervisor and Administrator present.<br><br>3.1-19(b) | | The observations will be documented on the TELS Preventative Maintenance Log. Any concerns noted will receive immediate follow-up. Monitoring will continue until substantial compliance is achieved as determined by the Quality Assurance committee. After consecutive compliance is achieved, the Maintenance Supervisor/designee will randomly complete the observation to ascertain continued compliance at lease biannually. The Maintenance Supervisor report of monitoring will be forwarded to the Administrator for monthly QA review and the plan of action will be adjusted accordingly. | |
| K 0920 SS=E Bldg. 01 | NFPA 101<br>Electrical Equipment - Power Cords and Extens<br>Electrical Equipment - Power Cords and Extension Cords<br>Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips | | | |

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| | for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5<br>1. Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords were installed properly and used in a safe manor. NFPA 99, Section 10.2.4.2 states adapters and extension cords meeting the requirements of 10.2.4.2.1 through 10.2.4.2.3 shall be permitted. Section 10.2.4.2.3 states the cabling shall comply with 10.2.3. Section 10.2.3.5.1 states cord strain relief shall be provided at the attachment of the power cord to the appliance so that mechanical stress, either pull, twist, or bend, is not transmitted to internal connections. This deficient practice could affect 4 staff in the copy machine area.<br><br>Findings include:<br><br>Based on observations and interview during a tour of the facility with the Maintenance Supervisor and Administrator on 07/27/22 between 12:20 p.m. and 3:30 p.m., in the copy machine/storage area a power strip used to power equipment was not secured and dangling from the wall. This condition could put stress on the power cord causing damage to the power cord.<br>Based on interview at the time of observations, the Maintenance Supervisor agreed the power strip was dangling, not secured, and stated the power strip will need to be mounted or set on the | K 0920 | Extension cord was removed from resident's room immediately upon finding. No residents experienced adverse reactions related to this deficient practice. All residents residing in the facility have the potential to be affected by this deficient practice. The facility staff was reeducated on the facility policy for Use of Electrical Power Strips or Surge Protectors. The facility policy and procedure for Guidelines for Use of Electrical Power Strips or Surge Protectors was reviewed with no changes indicated. The Maintenance Supervisor/designee will complete random room observations weekly. The observations will be documented on the TELS Preventative Maintenance Log. Any concerns noted will receive immediate follow-up. Monitoring will continue until substantial compliance is achieved as determined by the Quality Assurance committee. After consecutive compliance is | 08/11/2022 |

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| (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 |
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| | floor.<br><br>This finding was acknowledged by the Maintenance Supervisor at the time of observation and again at the exit conference with the Maintenance Supervisor and Administrator present.<br><br>2. Based on observation and interview, the facility failed to ensure power strips in all resident rooms were of UL rating of 1363A or 60601-1. Patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 6 feet beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment. A patient care vicinity extends vertically to 7 feet 6 inches above the floor. This deficient practice affects 2 staff and 2 residents.<br><br>Findings include:<br><br>Based on observations and interview during a tour of the facility with the Maintenance Supervisor and Administrator on 07/27/22 between 12:20 p.m. and 3:30 p.m., the power strip being used in resident room 329 lacked a UL rating of 1363A or 60601-1 label.<br><br>This finding was acknowledged by the Maintenance Supervisor at the time of observation and again at the exit conference with the Maintenance Supervisor and Administrator present.<br><br>3.1-19(b) | | achieved, the Maintenance Supervisor/designee will randomly complete the observation to ascertain continued compliance at lease biannually. The Maintenance Supervisor report of monitoring will be forwarded to the Administrator for monthly QA review and the plan of action will be adjusted accordingly. | |