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Form Approved OMB
No. 0938-0391

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Nursing Home	119 N Indiana Ave Crown Point, IN 46307

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45666 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 [DATE] and discharged on [DATE]. 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. 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. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 3.1-50(a)(1)