

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155733	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/23/2024
NAME OF PROVIDER OR SUPPLIER  Colonial Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide activities to meet all resident's needs.</p> <p>32664</p> <p>Based on observation, record review, and interview, the facility failed to ensure activities were implemented for a cognitively impaired dependent resident for 1 of 1 resident reviewed for activities. (Resident 14)</p> <p>Finding includes:</p> <p>On 8/19/24 at 11:16 a.m., Resident 14 was observed lying in bed with her eyes open and looking up at the ceiling. The room was dark, the television was off, and there was no music playing.</p> <p>On 8/20/24 at 1:07 p.m., Resident 14 was was observed lying in bed with her eyes open and looking up at the ceiling. The room was dark, the television was off, and there was no music playing.</p> <p>On 8/20/24 at 2:25 p.m., Resident 14 was was observed lying in bed with her eyes open and looking up at the ceiling. The room was dark and the television was not on. A bingo activity was being played in the dining area and in some resident rooms.</p> <p>Record review for Resident 14 was completed on 8/20/24 at 1:27 p.m. Diagnoses included, but were not limited to, stroke, aphasia (loss of ability to understand or express speech) and depression.</p> <p>The Annual Minimum Data Set (MDS) assessment, dated 7/22/24, indicated the resident was severely cognitively impaired. The resident had an impairment of both upper and lower extremities for a functional limitation in range of motion. The resident was dependent on staff for all ADLs (activities of daily living). The Preferences for Routines and Activities, completed by staff, indicated listening to music, keeping up with the news, doing things with groups of people, participating in favorite activities, and participating in religious activities were important to the resident.</p> <p>A Care Plan, revised 4/20/22, indicated the resident would passively observe in group activities when available. The resident was seen for one on one visits with staff three times a week for social and cognitive stimulations. The resident had a customary preference to love a specific singer and a specific actor. The resident would passively observe the roommate's television and music at times. Her roommate would play music and put on movies for them to watch together. When the resident was not participating in group activities, she would enjoy watching television in the common area and or passively observing the happenings around her. Interventions included to assist the resident to and from activities, and to the invite resident to daily activities.</p> <p>(continued on next page)</p>

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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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A Care Plan, dated 12/19/22, indicated the resident had a personal preference that she preferred 1 on 1 activities. Interventions included to allow the resident 1 on 1 activities, and to provide the opportunity to listen to music she preferred.</p> <p>A Care Plan, dated 6/28/23, indicated the resident was at risk for a decline in activity status due to health condition deficits. An intervention included the staff would invite and encourage the resident to participate in scheduled group activities.</p> <p>A Care Plan, revised 4/23/24, indicated the resident chose to remain in room related to her preference. An intervention included to provide activities of interest for resident to do in room.</p> <p>During an interview on 8/21/24 at 8:51 a.m., CNA 1 indicated the resident did not get out of bed to attend activities. The staff would talk with the resident when providing care but had not seen any activities being completed with her in her room. The resident's roommate did not like when they turned on the television or any lights being on in the room. She was unsure if the resident had a radio in her room.</p> <p>During an interview on 8/21/24 at 8:58 a.m., the Activity Director indicated she did not have any set curriculum for residents who received 1 on 1 activities. The residents who received 1 on 1 visits preferred conversations with her. She would do a daily visit with the resident and talk to her. She had not documented any 1 on 1 visits for activities when she completed them. She did not have a computer, so she would document the Activity Assessments on paper and she would provide a copy of the most recent assessment she had completed for the resident.</p> <p>A copy of the most current Activity Assessment completed was not provided by the Activity Director.</p> <p>3.1-33(a)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>32582</p> <p>Based on observation, record review and interview, the facility failed to ensure a resident's wounds were assessed and monitored for 1 of 3 residents reviewed for non-pressure skin conditions. (Resident 10)</p> <p>Finding includes:</p> <p>On 8/19/24 at 3:10 p.m. and on 8/20/24 at 2:15 p.m., Resident 10 was observed lying in bed. She had two open areas, approximately 3 centimeters round each, on her right shin. She indicated they had been fluid filled blisters that had opened.</p> <p>The resident's record was reviewed on 8/20/24 at 11:33 a.m. Diagnoses included, but were not limited to, hemiparesis (one sided weakness) and hemiplegia (one sided paralysis) following a cerebral vascular accident, Diabetes Mellitus and heart failure.</p> <p>The Annual Minimum Data Set assessment, dated 6/30/24, indicated the resident was cognitively intact and was dependent on assistance for bed mobility and transfers.</p> <p>A Nursing Note, dated 8/14/24, indicated the resident had been up in a chair for five hours and fluid filled blisters developed to her right leg. The Nurse Practitioner was notified and orders were received to apply skin prep to the blisters.</p> <p>A Physician's Order, dated 8/19/24, indicated to apply Betadine external solution 19% to open blisters twice daily and monitor until resolved.</p> <p>There were no additional progress notes related to assessment or monitoring of the wounds.</p> <p>A Weekly Skin Assessment, dated 8/14/24, indicated the resident's skin was dry and intact. A Weekly Skin Assessment, dated 8/21/24, indicated the skin was dry and there was a treatment in progress to the right lower leg.</p> <p>During an interview on 8/21/24 at 11:20 a.m., the Wound Nurse indicated the Wound Nurse Practitioner had seen the resident that morning to assess the wounds and provided new treatment orders. There had not been an assessment completed before today.</p> <p>The policy, Skin and Wound Management System, dated September 2022, indicated, .5. Residents identified with skin impairments will have appropriate interventions, treatment and services implemented to promote healing and impede infection. Wound location, characteristics and a physician's order for treatment are documented in the medical record. Wound status will be evaluated and documented in PCC [electronic medical record system] on the Wound Evaluation Flow Sheet form</p> <p>3.1-37(a)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>32582</p> <p>Based on observation, record review, and interview, the facility failed to follow up on an Occupational Therapy recommendation for a resting hand splint for 1 of 2 residents reviewed for position/mobility. (Resident 8)</p> <p>Finding includes:</p> <p>On 8/19/24 at 10:59 a.m., Resident 8 was observed seated in her wheelchair. Her right hand was contracted (tightening of muscle, tendons and skin that causes joints to shorten and become very stiff)and there was not a splint in place.</p> <p>The resident's record was reviewed on 8/20/24 at 2:40 p.m. Diagnoses included, but were not limited to, hemiplegia (one sided weakness) and hemiparesis (one sided paralysis) and unspecified dementia.</p> <p>The Quarterly Minimum Data Set assessment, dated 6/11/24, indicated the resident had severe cognitive impairment and was dependent for bed mobility and transfers. The resident received Occupational Therapy from 1/30/24 to 3/29/24.</p> <p>An Occupational Therapy Discharge Summary, dated 3/29/24, indicated the resident was to tolerate a resting hand splint for 5 hours a day to ensure joint protection and contracture management.</p> <p>There were no order Physician's Orders for a resting hand splint.</p> <p>During an interview on 8/20/24 at 3:11 p.m., the Director of Rehab indicated she had worked with the resident and she did well with the resting hand splint. She did not know why the splint had not been carried over after discharge from therapy.</p> <p>During an interview on 8/21/24 at 10:00 a.m., the Director of Nursing indicated the resident's mother had been trained on how to use the splint, but she did not want the resident to use it, so the order had never been completed. The record should have some documentation related to the refusal of the splint recommendation.</p> <p>3.1-42(a)(2)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32788</b></p> <p>Based on record review and interview, the facility failed to ensure catheter care was completed and urinary output was recorded for 1 of 3 residents reviewed for urinary catheters. (Resident D)</p> <p>Finding includes:</p> <p>The closed record for Resident D was reviewed on 8/22/24 at 10:20 a.m. Diagnoses included, but were not limited to, cerebral infarction, type 2 diabetes mellitus, and malignant neoplasm of the prostate. The resident was admitted to the facility on [DATE] and discharged to the hospital on 4/12/24.</p> <p>The Admission Minimum Data Set (MDS) assessment, dated 3/11/24, indicated the resident was cognitively impaired and had an indwelling urinary catheter.</p> <p>A Care Plan, updated 3/26/24, indicated the resident had an indwelling urinary catheter. An intervention indicated to monitor and document intake and output.</p> <p>A Physician's Order, dated 3/8/24, indicated 10 cc (cubic centimeters) 18 fr (french, catheter size) Foley catheter with drainage bag to gravity, monitor every shift.</p> <p>The Medication Administration Records (MAR) and Treatment Administration Records (TAR), dated 3/2024 and 4/2024, lacked any documentation of catheter care or urine output.</p> <p>The Task documentation lacked any documentation of catheter care or urine output.</p> <p>During an interview on 8/23/24 at 10:43 a.m., the Infection Preventionist (IP) indicated the catheter order included monitoring every shift, but she was unable to provide any further documentation that catheter care was completed or urinary output was recorded.</p> <p>A facility policy, titled Urinary Catheter Care, received from the IP as current, indicated, .Input/Output .2. Maintain an accurate record of the resident's daily output, per facility policy and procedure .Infection Control . 2. Maintain clean technique when handling or manipulating the catheter, tubing, or drainage bag. a. Do not clean the periurethral area with antiseptics to prevent catheter associated UTIs while the catheter is in place. Routine hygiene [e.g. cleansing of the meatal surface during daily bathing or showering] is appropriate . Documentation. The following information should be recorded in the resident's medical record: 1. The date and time that catheter care was given. 2. The name and title of the individual[s] giving the catheter care. 3. All assessment data obtained when giving catheter care</p> <p>This citation relates to Complaints IN00433696 and IN00440056.</p> <p>3.1-41(a)(2)</p>		

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide for the safe, appropriate administration of IV fluids for a resident when needed.</p> <p>32788</p> <p>Based on observation, record review and interview, the facility failed to care for a PICC line (peripherally inserted central catheter, intravenous catheter placed into the peripheral veins of the upper arm) in accordance with professional standards of practice, related to flushing the PICC line for 1 of 1 resident reviewed for intravenous care. (Resident 25)</p> <p>Finding includes:</p> <p>On 8/19/24 at 2:00 p.m., Resident 25 was observed lying in bed in her room. There was a PICC line in place to her right upper arm. She indicated she had surgery last week and was now getting antibiotics through the line.</p> <p>Resident 25's record was reviewed on 8/20/24 at 3:03 p.m. Diagnoses included, but were not limited to, hypertension, abdominal aortic aneurysm, major depressive disorder.</p> <p>The Admission Minimum Data Set (MDS) assessment, dated 7/18/24, indicated the resident was cognitively impaired.</p> <p>A Care Plan, updated 8/17/24, indicated the resident was receiving IV (intravenous) antibiotics for a urinary tract infection.</p> <p>A Care Plan, updated 8/19/24, indicated the resident had a PICC line. An intervention indicated to flush line as needed/per policy.</p> <p>A Physician's Order, dated 8/17/24, indicated meropenem (an antibiotic) 1 g (gram) IV every 8 hours at 12:00 a.m., 8:00 a.m., and 4:00 p.m. A Physician's Order, dated 8/17/24, indicated normal saline flush, 10 ml (milliliters) every shift for IV patency. There were no Physician's Orders to indicate the PICC was to be flushed with saline before and after the administration of the antibiotic medication</p> <p>The Medication Administration Record (MAR), dated 8/2024, indicated the meropenem had been administered as ordered. The normal saline flushes were documented as given once each on the day, evening, and night shifts. There was lack of documentation to indicate the PICC was flushed with saline before and after the administration of the antibiotic medication.</p> <p>During an interview on 8/20/24 at 4:00 p.m., the Director of Nursing (DON) indicated the PICC line should have been flushed before and after the antibiotic administration. She would clarify the orders.</p> <p>A facility policy, titled Medication Infusion, received from the DON as current, indicated, .7. Intermittent medication administration with no continuous infusion .c. Flush IV access catheter with preservative-free 0.9% sodium chloride .g. Infuse medication as prescribed and per label instructions .j. Disinfect IV access port with alcohol swab and let air dry, flush with preservative-free 0.9% sodium chloride .</p> <p>(continued on next page)</p>		

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F 0694  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	3.1-47(a)(2)

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>32582</p> <p>Based on observation, record review and interview, the facility failed to ensure a resident received the necessary care and treatment related to incorrect oxygen flow rate for 1 of 2 residents reviewed for respiratory care. (Resident 22)</p> <p>Finding includes:</p> <p>On 8/19/24 at 10:06 a.m., Resident 22 was observed seated in his room. He had a nasal cannula in place that was attached to an oxygen concentrator and the flow rate was set on 2 liters per minute (lpm).</p> <p>On 8/20/24 at 2:25 p.m., the resident was observed seated in his room. His oxygen was on and flowing at 2.5 lpm.</p> <p>The resident's record was reviewed on 8/21/24 at 10:50 a.m. Diagnoses included, but were not limited to, chronic respiratory failure and chronic obstructive pulmonary disease.</p> <p>The Quarterly Minimum Data Set assessment, dated 6/4/24, indicated the resident was cognitively intact and was on oxygen.</p> <p>A Physician's Order, dated 7/16/23, indicated the resident was to receive oxygen at 3 lpm continuously.</p> <p>On 8/21/24 at 1:27 p.m., the oxygen concentrator was observed with the Director of Nursing. She indicated it was set on 2.5 lpm. She then adjusted the flow rate from 2.5 lpm to 3 lpm.</p> <p>3.1-47(a)(6)</p>

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<p>F 0912</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32788</b></p> <p>Based on observation, record review, and interview, the facility failed to provide a least 80 square feet (SQ FT) per resident in multiple resident rooms and 100 SQ FT in single occupancy rooms. This was evidenced in 8 of 30 resident rooms in the facility. (Rooms 101, 104, 111, 201, 202, 204, 206, and 208)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. The floor area of the following single resident room measured:               <ol style="list-style-type: none"> <li>a. room [ROOM NUMBER] - 1 resident, 96.2 SQ FT. NF.</li> </ol> </li> <li>2. The floor areas of the following multiple resident rooms measured:               <ol style="list-style-type: none"> <li>a. room [ROOM NUMBER] - 1 resident, 150.3 SQ FT, 75.2 SQ FT per bed. NF.</li> <li>b. room [ROOM NUMBER] - 0 resident, 145.0 SQ FT, 72.5 SQ FT per bed. NF.</li> <li>c. room [ROOM NUMBER] - 1 resident, 149.0 SQ FT, 74.5 SQ FT per bed. NF.</li> <li>d. room [ROOM NUMBER] - 1 resident, 144.0 SQ FT, 72.0 SQ FT per bed. NF.</li> <li>e. room [ROOM NUMBER] - 1 resident, 144.0 SQ FT, 72.0 SQ FT per bed. NF.</li> <li>f. room [ROOM NUMBER] - 1 resident, 140.0 SQ FT, 70.0 SQ FT per bed. NF.</li> <li>g. room [ROOM NUMBER] - 1 resident, 146.9 SQ FT, 73.4 SQ FT per bed. NF.</li> </ol> </li> </ol> <p>The facility rooms with room variances were observed on 8/20/24 at 9:45 a.m. The rooms were observed with the following number of beds:</p> <p>room [ROOM NUMBER] - 1 bed            room [ROOM NUMBER] - 1 bed            room [ROOM NUMBER] - 1 bed            room [ROOM NUMBER] - 1 bed            room [ROOM NUMBER] - 1 bed            room [ROOM NUMBER] - 1 bed            room [ROOM NUMBER] - 1 bed</p> <p>(continued on next page)</p>

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<p>F 0912</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>room [ROOM NUMBER] - 1 bed</p> <p>During an interview on 8/19/24 at 8:50 a.m., the Administrator indicated these were the rooms which had the variance waivers and did not have the required square footage.</p> <p>3.1-19(l)(2)</p>