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	06/02/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on record review and interview, the facility failed to ensure the resident's physician was notified of medication being held for 1 of 5 residents reviewed for unnecessary medications. (Resident 183) Finding includes: Resident 183's record was reviewed on 5/29/25 at 11:10 a.m. Diagnoses included, but were not limited to, cellulitis of the right lower limb, type 2 diabetes mellitus, and pressure ulcer to the right heel. The Discharge Minimum Data Set (MDS) assessment, dated 5/10/25, indicated the resident was cognitively intact for daily decision making. She received diuretic, opioid, antiplatelet, and hypoglycemic medications in the 7-day look-back period. The current May 2025 Physician's Order Summary indicated the resident received Novolog FlexPen (insulin injection) subcutaneous solution pen-injector 100 unit/milliliter, inject 12 units subcutaneously three times a day with meals. The May 2025 Medication Administration Record indicated the Novolog medication was coded 11= blood sugar level below parameters on the following dates and times: - At 8:00 a.m.: 5/1/25 blood sugar 97, 5/4/25 blood sugar 123, 5/8/25 blood sugar 80, and 5/9/25 blood sugar 75 - At 12:00 p.m.: 5/6/25 blood sugar 111, 5/8/25 blood sugar 106, and 5/9/25 blood sugar not applicable - At 5:00 p.m.: 5/6/25 blood sugar 107 and 5/8/25 blood sugar 89 There was a lack of any physician's orders for parameters for holding the medication, corresponding progress notes related to the medication being held, or documentation that the physician was notified when the medication was held. During an interview on 5/29/25 at 2:09 p.m., the Director of Nursing indicated the resident often refused her insulin dose based on what the blood sugar levels were and the nurse should have documented refusals instead of holding the medications. 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-5(a)(2)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, record review, and interview, the facility failed to ensure a comprehensive care plan was implemented for a resident with a diabetic foot ulcer for 1 of 12 resident care plans reviewed. (Resident 13) Finding includes: During an observation of wound care on 5/29/25 at 10:00 a.m., Resident 13's left foot diabetic foot ulcer treatment was observed with RN 1. The area was located on the lateral foot and was open, light red in color, and had minimal drainage. RN 1 performed the wound care per the physician's order and then adjusted the resident in bed for comfort with a round cushion noted to the right leg. Resident 13's record was reviewed on 5/28/25 at 3:08 p.m. Diagnoses included, but were not limited to, hemiplegia and hemiparesis (weakness and paralysis) affecting the right dominant side, cognitive communication deficit, and type 2 diabetes mellitus. The Quarterly Minimum Data Set (MDS) assessment, dated 4/4/25, indicated the resident was severely cognitively impaired. The resident had impairments in range of motion to one side of the upper extremities and both sides of the lower extremities. She was dependent on staff for all activities of daily living including, but not limited to, bed mobility and transfers. She had diabetic foot ulcer(s) and skin tear(s). A Physician's Order, dated 5/29/25, indicated cleanse with normal saline, apply calcium alginate, and cover with dry dressing to left foot (dorsal) every day shift. A Care Plan, revised on 10/2/23, indicated the resident was at risk for alterations in skin integrity. Interventions included, but were not limited to, adjust tubing to avoid skin breakdown, administer treatments as ordered, and turn and reposition as indicated. A Skin and Wound Note, dated 5/28/25 at 4:17 p.m., indicated the resident had a diabetic ulcer to the left lateral distal foot which measured smaller today. The resident had the wound on 9/11/24 and was receiving treatments at the time. The wound healed on 1/22/25, reopened on 3/5/25, healed on 4/16/25, and reopened on 5/28/25. The diabetic foot ulcer was a full thickness wound, measuring 1 centimeter (cm) long by 0.1 cm wide with 100% epithelial tissue, and had a scant amount of drainage. The recommendations were to continue ongoing pressure reduction and turning/repositioning precautions per protocol, including pressure reduction to the heels and all bony prominences. The record lacked a comprehensive care plan related to the diabetic foot ulcer. During an interview on 5/29/25 at 1:56 p.m., the Director of Nursing indicated there was no care plan at the time for the diabetic foot ulcer, as it was a wound that would heal out and then reopen again. The wound was currently open and being treated, so the care plan should have been initiated. 3.1-35(b)(1)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on observation, record review, and interview, the facility failed to ensure a resident with a reddened sclera (white part of eyeball) of the eye was assessed and monitored for 1 of 2 residents reviewed for vision/hearing services. (Resident 20). Finding includes: On 5/28/25 at 11:02 a.m., Resident 20 was sitting in a recliner in her room. She indicated her right eye had been red for some time, but could not say exactly when it began. The nursing staff had pointed it out to her the other day as she was not even aware of the redness noted to her eye. The right eyeball was observed to be solid red in color on the bottom portion of the sclera. On 5/30/25 at 1:20 p.m., Resident 20 was observed in the common area. Her right eye was still red in color. Resident 20's record was reviewed on 5/30/25 at 2:45 p.m. Diagnoses included, but were not limited to, schizophrenia and neuromuscular dysfunction of the bladder. The Quarterly Minimum Data Set (MDS) assessment, dated 4/8/25, indicated the resident was cognitively intact for daily decision making. The record lacked documentation of assessment or monitoring of the right eye discoloration. During an interview on 6/2/25 at 11:42 a.m., the Director of Nursing indicated she had no further information related to the resident's red eye. 3.1-37(a)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure a resident with pressure ulcers received the necessary treatment and services related to not obtaining treatment orders for a wound vac for 1 of 4 residents reviewed for pressure ulcers. (Resident 183) Finding includes: During an observation of wound care on 5/29/25 at 9:53 a.m. with RN 1, a dressing change was observed to Resident 183's proximal and distal left thigh. RN 1 indicated at the time that Resident 183 had a wound vac placed to her right heel the day before (5/28/25) and there was no treatment change due at the time. Resident 183's record was reviewed on 5/29/25 at 11:10 a.m. Diagnoses included, but were not limited to, cellulitis of the right lower limb, type 2 diabetes mellitus, and pressure ulcer to the right heel. The Discharge Minimum Data Set (MDS) assessment, dated 5/10/25, indicated the resident was cognitively intact for daily decision making. The resident had two unstageable pressure ulcers. A Skin and Wound Note, dated 5/28/25 at 6:23 p.m., indicated the resident had readmitted to the facility on [DATE]. The right heel pressure injury was surgically debrided during the recent hospital admission due to purulent drainage and evidence of infection. The wound vac was to continue to the heel wound at 100 mmHg (millimeters mercury) per the surgeon's request and a rescue dressing of calcium alginate with silver. The plan was discussed with the wound nurse. The right heel wound was an open surgical full thickness wound measuring 9.8 centimeters (cm) long by 5.5 cm wide by 1.7 cm deep. Treatment recommendations for the right heel open surgical wound were to clean with wound cleanser, apply a wound vac at 100 mmHg, rescue dressing of calcium alginate with silver with abdominal pad and rolled gauze to the base of the wound, secure with transparent film, change three times per week and as needed. There were no treatment orders for the right heel wound vac or rescue dressing in the May 2025 Physician's Order Summary. During an interview on 5/29/25 at 2:09 p.m., the Director of Nursing (DON) indicated there should have been physician's orders entered for the wound vac. A policy titled, Skin and Wound Management System, received on 6/2/25 at 1:05 p.m., 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 record system] on the Wound Evaluation Flow Sheet form . 3.1-40

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation, record review, and interview, the facility failed to ensure there were orders and/or monitoring completed for a resident on a fluid restriction. (Resident 183) Finding includes: During an observation and interview on 5/28/25 at 9:47 a.m., Resident 183 indicated she had returned to the facility the day before and had an infection, so she was now on antibiotic therapy. She had to have surgery on her leg. The resident indicated she has had to have fluid removed at the hospital before and was on a fluid restriction at the hospital; however, since being back in the facility, she was not required to be on a fluid restriction any longer. There was a large foam cup on her bedside table full of water. Resident 183's record was reviewed on 5/29/25 at 11:10 a.m. Diagnoses included, but were not limited to, chronic kidney disease, type 2 diabetes mellitus, and pressure ulcer to the right heel. The Discharge Minimum Data Set (MDS) assessment, dated 5/10/25, indicated the resident was cognitively intact for daily decision making. She received diuretic, opioid, antiplatelet, and hypoglycemic medications in the 7-day look-back period. The current May 2025 Physician's Order Summary indicated the resident received a carbohydrate controlled no added salt diet, received furosemide (diuretic medication) 40 milligrams (mg) daily, and spironolactone (diuretic medication) 100 mg daily. The Nursing Evaluation, dated 5/27/25 at 10:33 p.m., indicated the resident had readmitted to the facility. She had skin conditions noted to the right buttock, coccyx, groin redness, right elbow pressure, right hand bruising, right wrist bruising, left lower extremity healed surgical wound, left lower arm generalized bruising, left heel deep tissue injury, left thigh surgical wound, right heel surgical incision, left lower leg surgical wound, left lower leg lateral healed surgical wound, and was to receive a regular no added salt thin liquid diet with 1800 milliliter fluid restriction. There were no orders or documentation of fluid intake/restriction in the record. During an interview on 5/29/25 at 2:09 p.m., the Director of Nursing indicated she was going to add the order for the fluid restriction and monitoring now. A policy titled, Encouraging and Restricting Fluids, indicated .General Guidelines .1. Follow specific instructions concerning fluid intake and restrictions .Restricting Fluids: 1. Remove the resident's water pitcher and cup from the room. Store in designated area 6. Record the amount of fluid consumed on the intake side of the intake an output record. Record fluid intake in mLs . 3.1-46(b)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure a resident received the necessary care and treatment related to oxygen administration for 1 of 1 resident reviewed for respiratory care. (Resident 9) Finding includes: On 5/27/25 at 11:09 a.m., Resident 9 was observed in her room lying in bed. A nasal cannula was in place and oxygen was flowing. The oxygen concentrator was set at 2 liters. On 5/28/25 at 3:05 p.m., Resident 9 was observed in her room lying in bed. A nasal cannula was in place and oxygen was flowing. The oxygen concentrator was set at 2 liters. Resident 9's record was reviewed on 5/29/25 at 10:38 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, heart failure, and hypertension. A Physician's Order, dated 4/3/25, indicated oxygen 2 L (liters) via nasal cannula as needed (PRN) for shortness of breath, maintain oxygen saturation above 90. The Quarterly Minimum Data Set assessment (MDS), dated [DATE], indicated the resident was cognitively impaired, dependent on staff for all activities of daily living (ADLs), and had not received oxygen. A Care Plan, updated 5/14/25, indicated the resident was at risk for alterations in oxygen levels due to heart failure. The interventions included to administer oxygen as ordered. The Medication Administration Record (MAR) and Treatment Administration Record (TAR), dated 5/2025, lacked any documentation the PRN oxygen had been signed out as administered or that the resident's oxygen saturation had been monitored. During an interview on 5/29/25 at 1:50 p.m., the Director of Nursing indicated the resident would get short of breath when staff was doing wound care or repositioning, so they would just keep the oxygen on at all times. She would update the oxygen orders. No further information was provided. A facility policy, titled, Oxygen Administration, received from the Administrator as current, indicated .Steps in the Procedure .10. Adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being administered .Documentation: After completing the oxygen setup or adjustment, the following information should be recorded in the resident's medical record: .3. The rate of oxygen flow, route, and rationale. 4. The frequency and duration of the treatment. 5. The reason for p.r.n. administration . 3.1-47(a)(6)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to ensure a sanitary kitchen related to testing the dishwasher sanitation level with faulty test strips in 1 of 1 kitchens observed (Main Kitchen). This had the potential to affect the 26 of 29 residents in the facility who received food from the kitchen. Finding includes: During the initial kitchen tour on 5/27/25 at 9:10 a.m. with the Dietary Food Manager (DFM), the dishwasher was observed and noted to be a low temperature, chemical system. The DFM obtained a testing strip, dipped it into the dishwasher water and compared it to the results on the side of the testing strip container. The strip did not have a readily discernable color change. He indicated they always used those strips and was unsure why they were not changing. He opened a new package of test strips and attempted to get another reading, however the strips still did not have a discernable color change. He indicated he would call the service company to address the dishwasher and go get another new package of strips. During a follow up interview on 6/2/25 at 11:45 a.m., the DFM provided a test strip that was the appropriate sanitation level for the dishwasher (50 parts per million). He indicated the other test strips were not working and was not sure the reason why. He had called the service company and they recalibrated the dishwasher on 5/27/25 and it had been working appropriately since that time. 3.1-21(i)(3)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure infection control practices were in place and implemented related to the disposal of used lancets into the garbage can for 1 of 1 glucometer (machine used to test blood sugar levels) testing observed. (Resident 183, RN 1) Finding includes: On 5/30/25 at 11:02 a.m., RN 1 indicated he was going to check Resident 183's blood sugar. The nurse washed his hands, applied gloves, and wiped the resident's left first finger with an alcohol wipe. He then poked the resident's finger with the lancet. Blood was observed on the resident's finger and he then proceeded to check the blood sugar with the glucometer. He discarded the lancet into the garbage can next to the resident's bed. He then proceeded back to the medication cart. During an interview at that time with RN 1, he indicated he should not have discarded the lancet into the garbage can, but instead into the sharps container. He was unsure what the blood sugar reading was and he would have to re-check the resident's blood sugar. The nurse then proceeded to wash his hands again, applied gloves, and wiped the resident's second finger with an alcohol wipe. He then poked the resident's finger with a lancet. Blood was observed on the resident's finger and then he proceeded to check the blood sugar again with the glucometer. He then discarded the lancet into the garbage can next to the resident's bed again. During an interview after the second observation with RN 1, he indicated he had thrown the lancet away again into the garbage can and he was aware it needed to be discarded into the sharps container. He also wrote down the blood sugar at that time so he would remember what it was. During an interview on 5/30/25 at 2:00 p.m., the Director of Nursing indicated the nurse should have discarded the lancets into the sharps container and not into the garbage can. A facility policy titled, Obtaining a Fingerstick Glucose Level and received as current from the Administrator, indicated, .Steps in the Procedure .16. Dispose of the lancet in the sharps disposal containers . 3.1-18(b)

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F 0912 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to provide at 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) Findings include: 1. The floor area of the following single resident room measured: a. room [ROOM NUMBER] - 1 resident, 96.2 SQ FT. NF. 2. The floor areas of the following multiple resident rooms measured: a. room [ROOM NUMBER] - 0 residents, 150.3 SQ FT, 75.2 SQ FT per bed. NF. b. room [ROOM NUMBER] - 1 resident, 145.0 SQ FT, 72.5 SQ FT per bed. NF. c. room [ROOM NUMBER] - 1 resident, 149.0 SQ FT, 74.5 SQ FT per bed. NF. d. room [ROOM NUMBER] - 1 resident, 144.0 SQ FT, 72.0 SQ FT per bed. NF. e. room [ROOM NUMBER] - 1 resident, 144.0 SQ FT, 72.0 SQ FT per bed. NF. f. room [ROOM NUMBER] - 0 residents, 140.0 SQ FT, 70.0 SQ FT per bed. NF. g. room [ROOM NUMBER] - 0 residents, 146.9 SQ FT, 73.4 SQ FT per bed. NF. The facility rooms with room variances were observed on 5/28/25 at 2:50 p.m. The rooms were observed with the following number of beds: 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 room [ROOM NUMBER] - 1 bed (continued on next page)

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F 0912 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/27/25 8:53 a.m., the Administrator indicated these were the rooms which had the room variance waivers and did not have the required square footage. 3.1-19(l)(2)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation and interview, the facility failed to maintain a sanitary, safe, and homelike environment related to dirty kitchen walls and floors in the kitchen. (Main Kitchen) Findings include: During the initial kitchen tour on 5/27/25 at 9:10 a.m. with the Dietary Food Manager (DFM), the following was observed: a. The wall next to stove top was covered in splashed food and debris. b. The floor and baseboard underneath the dishwasher was dirty and covered in a build up of debris. During an interview at the time, the DFM indicated the above areas were in need of a deep clean. He was not supposed to be the main cook today, so he had not had time to get to those areas yet. 3.1-19(f)