

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/04/2013  
FORM APPROVED  
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                              |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>185342 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____  | (X3) DATE SURVEY COMPLETED<br><br>05/23/2013 |
| NAME OF PROVIDER OR SUPPLIER<br><br>COLONIAL HEALTH AND REHABILITATION CENTER |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>708 BARTLEY AVENUE<br>BARDSTOWN, KY 40004  |  |
| (X4) ID PREFIX TAG  | SUMMARY STATEMENT OF DEFICIENCIES (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                         |
| F 000   | INITIAL COMMENTS<br><br>A Standard Health Survey was conducted 05/21/13 through 05/23/13 and a Life Safety Code survey was conducted on 05/21/13. Deficiencies were cited with the highest scope and severity of a "F" with the facility having the opportunity to correct the deficiencies before remedies would be recommended for imposition.  | F 000  | <b>Disclaimer:</b> Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.  |  |
| F 164<br>SS=D   | 483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS<br><br>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.<br><br>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.<br><br>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.<br><br>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.<br><br>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. | F 164  | F 164<br><br>1. Resident #2 was provided privacy by closing the privacy curtain to the resident's room therefore not allowing her to be seen by those passing in the hallway.<br><br>2. All residents have the potential to be affected by the deficient practice. The Administrator will develop an assessment tool to assess 100% of current residents related to resident privacy and residents at high risk of privacy/dignity compromise. This assessment will be performed by the Administrator and/or Director of Nursing (DON) to identify residents who have the greatest potential to be affected by the deficient practice. Complete implementation of #2 by 6/13/13.<br><br>3. The facility will initiate the following measure to ensure the deficient practice will not recur.<br><ul style="list-style-type: none"><li>Privacy of residents will be added to the Quality Assurance (QA) Observation Rounds to be completed two days each week; directors expected to perform these rounds include the Director of Social Services, Dietary Director, Housekeeping Director, Maintenance Director, Business Office Director, Director of Education, MDS Director, Director of Nursing, and Administrator.</li></ul> | 6/28/13                                      |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

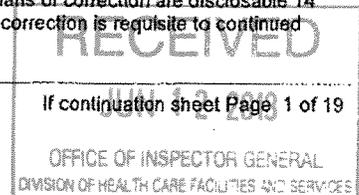
TITLE

(X6) DATE

*[Signature]*

*X Administrator X 6/12/13*

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.

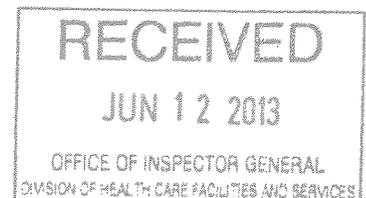


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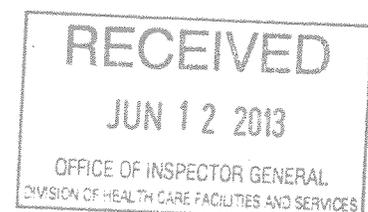
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| F 164   | <p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on observation, interview, and review of the facility's policy, it was determined the facility failed to provide privacy for one (1) of fifteen (15) sampled residents. The facility staff left the door to the hallway open and the privacy curtain pushed back exposing Resident #2's brief and legs to anyone passing by the door.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Residents' Rights (no date), revealed the residents had the right to privacy and confidentiality to include during treatment and in the care of their personal needs, and be treated with the fullest measure of consideration, respect, and dignity.</p> <p>Observation, on 05/21/13 at 9:00 AM, revealed Resident #2 was lying on the bed, the door was open to the room and the privacy curtain had been pushed back. The residents' blue brief and bare legs were exposed to anyone who passed by the doorway. Additional observation at 11:15 AM revealed the resident had kicked off the top sheet exposing the blue brief, abdomen, and bare legs. The door and curtain to Resident #2's room remained opened.</p> <p>Interview with LPN #2, on 05/21/13 at 11:15 AM, revealed the resident had a diagnosis of Huntington's Disease, causing involuntary movement. She stated the resident would frequently kick off everything and had recently been refusing care. She stated they could not</p> | F 164  | <p>Directors are assigned specific areas of the facility to complete these rounds.</p> <ul style="list-style-type: none"> <li>The Performance Improvement QA Calendar will be revised to include Privacy and Dignity audits to be performed monthly by Social Services Director.</li> <li>Education/Inservicing will be given to all facility departments by the Director of Education on providing resident privacy and maintaining dignity. This education will be performed no later than 6/13/13 and quarterly thereafter.</li> <li>Complete Implementation of # 3 by 6/13/13.</li> </ul> <p>4. The facility plans to monitor the performance of the solutions for sustainability by the following.</p> <ul style="list-style-type: none"> <li>The Administrator will review the QA Observation Rounds on a weekly basis to identify any issues related to the deficient practice and make recommendation to the QA Committee monthly as needed.</li> <li>The Performance Improvement Committee will review the Privacy and Dignity audit performed and make needed recommendations to the QA Committee monthly.</li> <li>The Administrator will perform an additional bi-weekly round of all resident rooms and common areas to ensure compliance and make needed recommendations to the QA Committee monthly.</li> </ul> <p>The Quality Assurance committee will review the submitted reports/audits monthly to ensure compliance. Recommendation will be made based on the outcomes of these reports/audits as to needed revisions.</p> <p>5. Corrective action and regulatory compliance will be achieved by: 6/28/13</p> |                      |  |



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| F 164   | Continued From page 2<br>shut the door or pull the curtains because it was a fire hazard. Additional interview at 4:45 PM revealed LPN #2 had a discussion with the Administrator who told her it was okay to close the door for the resident's dignity. She stated she had been there a year and was told the door had to be open for fire safety. She stated she did understand the resident's right to privacy to preserve their dignity by not exposing them to the hallway traffic.<br><br>Interview with LPN #1, on 05/22/13 at 2:35 PM, revealed she did not like leaving the privacy curtain open because Resident #2 exposed his/her self. She stated she had heard they could not pull the privacy curtain closed due to the Fire Marshall or something. She stated she was told this morning in report to keep the privacy curtain pulled for the resident's privacy, that it was a dignity issue. | F 164  |   |  |
| F 221<br>SS=E   | 483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS<br><br>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to ensure each resident was not restrained unless necessary to treat a medical symptom for three (3) of fifteen (15) sampled residents. Residents #8, #11, and  | F 221  | F 221<br><br>1. Resident #8 had reduction attempted from 5/24/13 thru 5/27/13. Reduction attempts failed due to residents decreased safety awareness and cognitive status related to dementia. A care plan was scheduled for 6/5/13 with Resident #11's family to discuss reduction attempts, family was agreeable and evaluation was started. Reduction evaluation was completed 6/10/13. Recommendations to reduce the resident from full lap tray to half lap tray were made to the family based on nursing observations during the reduction period. The family refused to allow the reduction and signed a refusal of care after discussion of risks and benefits of the reduction. Physician was notified and risks and benefits were discussed physician stated to continue full lap tray. Resident #14 is no longer a resident of the facility. | 6/28/13                                      |



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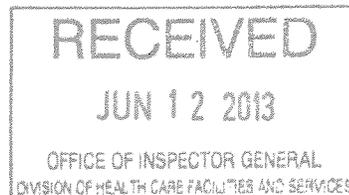
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| F 221   | <p>Continued From page 3</p> <p>#14. In addition, the facility failed to routinely attempt reduction of the physical restraint.</p> <p>The findings include:</p> <p>Review of the facility's Physical Restraint policy, revised January 1, 2009, revealed the facility would establish a systematic process for assessment, implementation, and evaluation of the use of a physical restraint. The policy stated a physical restraint would only be used for medical symptoms. The facility would periodically re-evaluate the use of a restraint to determine if reduction in use was appropriate. The facility would utilize the Device Decision Tree, Restraint Assessment, and Restraint Review Assessment forms.</p> <p>1. Observation of Resident #8, on 05/21/13 at 11:15 AM and 4:00 PM, revealed the resident was sitting up in a wheelchair with an alarming seat belt restraint applied around the resident's waist. On 05/22/13 at 8:20 AM, the resident was observed to be in the back dining room eating breakfast. The seat belt restraint was applied. At 10:50 AM, the resident was observed sitting in the wheelchair with the seat belt restraint applied. Observation, on 05/23/13 at 9:30 AM and 11:20 AM, revealed the resident sitting in the wheelchair with the alarming Velcro seat belt applied. Throughout the survey of 05/21/13 to 05/23/13 when the resident was up in the wheelchair, the seat belt restraint was applied.</p> <p>Review of Resident #8's clinical record revealed the facility admitted the resident on 09/25/13 with diagnoses of Dementia, Difficulty in Walking, Pneumonia, and Metabolic Encephalopathy.</p> | F 221  | <p>2. All residents with restraints have to potential to be affected by the deficient practice. An audit of current residents with restraints was completed by the Director of Nursing, the Director of Staff Development and the MDS Director on 5/24/13. Residents found to be out of compliance were assessed by the IDT (Interdisciplinary Team) consisting of the Director of Nursing, Staff Development, the MDS Director, Social Services Director, Activities Director and the Therapy Manager on 6/10/13 assessment reduction attempts will be completed by 6/13/13. Complete implementation of #2 by 6/13/13.</p> <p>3. The facility will initiate the following measure to ensure the deficient practice will not recur.</p> <ul style="list-style-type: none"> <li>• The nursing department was educated/inserviced on restraint reduction during meals and activities as well as ADL care by the director of Staff Development on 6/5/13. This education/inservicing will be repeated quarterly.</li> <li>• The Interdisciplinary Team will review each resident to determine appropriate reduction attempts before started and at the completion of attempt period.</li> <li>• The Interdisciplinary Team was educated/inserviced on the Restraint Policy by the Director of Staff Development and the Director of Nursing on 6/7/13.</li> <li>• All residents with physical restraints will be reviewed by the Interdisciplinary Team quarterly for reduction attempts. A restraint review calendar will be utilized for when review is due and the schedule will follow the MDS schedule for quarterly and annual reviews.</li> </ul> |  |

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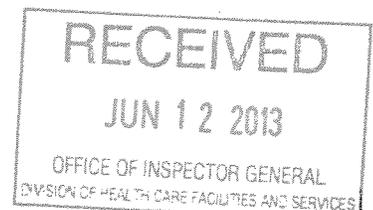
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| F 221   | <p>Continued From page 4</p> <p>Review of the Admission assessment, dated 10/02/12, revealed the facility assessed the resident to have a cognition deficit with a Brief Interview Mental Status (BIMS) score of four (4) out of fifteen (15). The facility assessed the resident to be at risk for falls. A care plan was developed to address the risk. The record revealed an alarming Velcro release seat belt was ordered and applied on 12/07/12.</p> <p>Review of the Device Decision Tree form, completed on 12/07/12, revealed the device was considered a physical restraint and instructed staff to complete a restraint assessment. However, there was no evidence in the clinical record that a restraint assessment had been completed. In addition, there was no evidence in the record what the medical symptom was that required the physical restraint and no evidence the facility had attempted a reduction.</p> <p>Interview with the Director of Nursing (DON), on 05/23/13 at 3:40 PM, revealed she could not find evidence a restraint assessment had been completed. She stated she was looking at all devices and had started to reassess all residents who utilized a restraint. She continued to state the Corporate Consultant had conducted an audit of devices/restraints a few weeks ago and found the required assessments and documentation were missing. The DON stated she identified there was a lack of documentation and failure to re-evaluate the restraints.</p> <p>2. Review of the closed clinical record for Resident #14 revealed an alarming seat belt restraint was applied on 07/28/11. Review of the restraint assessment for that date revealed the</p> | F 221  | <ul style="list-style-type: none"> <li>• Restraint reductions during meals will be monitored on Quality Assurance (QA) Observation Rounds to be completed two days each week.</li> <li>• Complete implementation of # 3 by 6/13/13.</li> </ul> <p>4. The facility plans to monitor the performance of the solutions for sustainability by the following.</p> <ul style="list-style-type: none"> <li>• The Administrator will review the QA Observation Rounds on a weekly basis to identify any issues related to the deficient practice and make recommendation to the QA Committee monthly as needed.</li> <li>• The results of the reduction attempts will be reported by the Director of Nursing to the Performance Improvement Committee monthly and recommendations will be made as needed to the QA Committee monthly.</li> </ul> <p>The Quality Assurance committee will review the submitted reports/audits monthly to ensure compliance. Recommendation will be made based on the outcomes of these reports/audits as to needed revisions.</p> <p>5. Corrective action and regulatory compliance will be achieved by: 6/28/13</p> |  |



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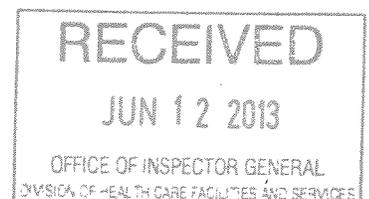
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| F 221   | <p>Continued From page 5</p> <p>medical symptoms being treated was Confusion and Dementia. Although the seat belt restraint was reviewed quarterly, there was no attempt to reduce or remove the seat belt restraint. The record revealed the resident became palliative care on 04/05/13 and expired at the facility.</p> <p>Interview with the DON, on 05/23/13 at 3:40 PM, revealed there was no evidence found in the closed record that Resident #14's physical restraint had been reduced.</p> <p>3. Review of the clinical record for Resident #11 revealed the facility re-admitted the resident with diagnoses of Senile Dementia and Anxiety, on 01/13/12. The resident had been assessed on readmission for a Lap Tray with physician's orders to apply to the wheelchair, to check and release every 2 hrs, check ROM, skin and toilet every shift. Review of the current plan of care revealed the resident had wandering behaviors and seemed unaware of safety needs; and was at risk for elopement. The care plan also showed the resident required the use of a lap tray to be up in the wheelchair safely. The facility assessed the resident as at risk for falls.</p> <p>Observation of Resident #11, on 05/23/13 at 9:30 AM, 10:30 AM, and 2:00 PM, revealed the resident sitting up in the wheelchair with the lap tray in place.</p> <p>Review of the clinical record revealed no evidence that attempts had been made to reduce use of the lap tray since re-admission.</p> <p>Interview with the Director of Nursing (DON), on 05/23/13 at 2:45 PM, revealed Resident #11 had</p> | F 221  |   |                      |  |



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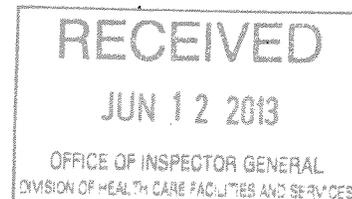
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| F 221   | Continued From page 6<br>been recently assessed to not need the lap tray or restraint. The DON stated the resident could not remove the lap tray, therefore it was a restraint. The DON stated the resident's lap tray was discontinued, and she had called the family to inform them; however, the family called the physician and requested the physician give orders to reapply the restraint. The physician gave orders to reapply the lap restraint.<br><br>Review of the initial admission assessment, dated 01/13/12 revealed the family had signed an initial notice of risk/benefits education; however, refused to allow attempts at a trial reduction or discontinuing the restraint.<br><br>Interview with the Administrator, on 05/23/13 at 3:00 PM, revealed the facility Corporate Compliance Nurse had identified issues with restraints regarding if reductions were appropriate. The Administrator revealed all residents that have been reviewed have been referred to therapy for safety evaluations; however, therapy evaluations were not provided during the survey. | F 221  |   |                      |  |
| F 275<br>SS=D   | 483.20(b)(2)(iii) COMPREHENSIVE ASSESS AT LEAST EVERY 12 MONTHS<br><br>A facility must conduct a comprehensive assessment of a resident not less than once every 12 months.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, it was determined the facility failed to ensure the Annual Minimum Data Set (MDS) Comprehensive  | F 275  | F 275<br><br>1. An Annual Comprehensive Assessment was completed on Resident #10 on 5/28/13.<br>2. All residents have the potential to be affected by the deficient practice. A complete audit was performed by the Director of Nursing and MDS Director for every resident to determine when the last Annual Comprehensive Assessment was done. This audit was completed 5/24/13.<br>3. The facility will initiate the following measure to ensure the deficient practice will not recur.<br>• A new MDS Director was put in place on 5/20/13. | 6/28/13              |  |



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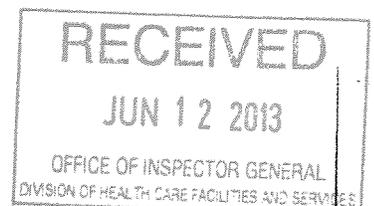
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| F 275   | <p>Continued From page 7</p> <p>Assessment was completed within the regulatory time frames for one of fifteen (15) residents. (Resident #10)</p> <p>The findings include:</p> <p>The facility did not provide a policy regarding assessments; however the facility stated they followed the MDS 3.0 RAI Manual as a reference when completing the annual assessments.</p> <p>Review of the MDS 3.0 RAI Manual, Chapter 2, page 2-19, Section 03 Annual Assessment, dated 09/2010, revealed the Annual assessment is a comprehensive assessment for a resident that must be completed on an annual basis (at least every 366 days). Its completion dates depend on the most recent comprehensive and past assessments' Assessment Reference Dates (ARDs) and completion dates. The ARD must be set within 366 days after the ARD of the previous comprehensive assessment and within 92 days since the ARD of the previous Quarterly assessment.</p> <p>Record review for Resident #10 on 05/23/13, revealed the Annual Comprehensive assessment due 02/14/13 was not located.</p> <p>Interview with the MDS Coordinator, on 05/23/13 at 1:10 PM, revealed she was new to the position and could not explain why the Annual Comprehensive Assessment was not done. She stated the records were a mess and she could not tell who updated the records or when they were done. She stated the Annual Comprehensive Assessment should have been done 02/14/13.</p> | F 275  | <ul style="list-style-type: none"> <li>The new MDS Director was educated by the Corporate Nurse Consultant on setting dates for Assessments. This education was completed on 5/28/13.</li> <li>The new MDS Director will be sent to the next scheduled MDS Basic and Advanced Training which is being conducted by KAHCF. The Director of Nursing will oversee the calendar for scheduled assessments weekly until the MDS Director receives training, thereafter the Director of Nursing will review calendar monthly.</li> <li>The Performance Improvement QA Calendar will be revised to include a RAI process audit to be completed by the Director of Nursing.             <ul style="list-style-type: none"> <li>Director of Nursing will complete the audit of the RAI Process to include MDS documentation completed timely on 5 residents monthly and report findings to the Performance Improvement Committee monthly.</li> <li>Director of Nursing will complete audit of the RAI Process to include MDS documentation completed timely on 25% of residents quarterly, these findings will be reported to the Performance Improvement Committee quarterly.</li> </ul> </li> <li>A monthly assessment review calendar will be utilized by the MDS Director to record when assessments are due and what type of assessment is due.</li> <li>Complete implementation of # 3 by 6/13/13.</li> </ul> |                      |  |



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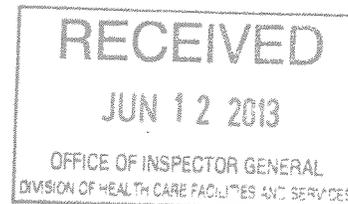
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| F 275   | Continued From page 8<br><br>Interview with the Director of Nursing, on 05/23/13 at 1:30 PM, revealed she was new to the facility and had not been made aware of the late comprehensive assessment for Resident #10. She stated the resident had several discharges and staff had completed the quarterly assessment when it should have been an annual comprehensive assessment.  | F 275  | 4. The facility plans to monitor the performance of the solutions for sustainability by the following.<br><ul style="list-style-type: none"><li>The Performance Improvement Committee will review the RAI Process audit performed and make needed recommendations to the QA Committee monthly.</li></ul> The Quality Assurance committee will review the submitted reports/audits monthly to ensure compliance. Recommendation will be made based on the outcomes of these reports/audits as to needed revisions.   |  |
| F 323<br>SS=D   | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to provide an environment free from accidents for three (3) of fifteen (15) sampled residents. (Residents #3, #5 and #8) The facility failed to assess Resident #3 for falls risk after the resident had a change in status. Resident #3 was noted to be very restless after a hospitalization, and rolled out of the bed, on 05/22/13. Although no injury was incurred, the facility failed to appropriately assess the resident for preventive interventions. In addition, the facility failed to provide assistive devices to | F 323  | 5. Corrective action and regulatory compliance will be achieved by: 6/28/13<br>F 323<br><br>1. Resident #3 had bolsters placed on the bed on 5/22/13, care plan and CNA care plan were update to reflect placed bolsters. Resident #5 had the alarm checked and functioning properly on 5/23/13. Resident # 8 had the fall mat placed for use on 5/22/13 and the care plan was updated to reflect the fall mat at that time as well the CNA care plan was updated 5/23/13 to reflect the fall mat.<br><br>2. All residents with a change in condition and all residents with assistive devices have the potential to be affected by the deficient practice. An audit of all assistive devices in use was completed by the Director of Nursing and the Director of Staff Development on 5/24/13 to ensure that all were in place and on the care plan and CNA care plan.<br><br>3. The facility will initiate the following measure to ensure the deficient practice will not recur.<br><ul style="list-style-type: none"><li>The Interdisciplinary Team morning meeting report form will be updated to address all falls which have occurred between morning meeting reporting times in an effort to address root cause of the fall and immediate action taken to prevent further falls.</li><li>Residents with a change in condition will be reviewed in</li></ul> | 6/28/13                                      |



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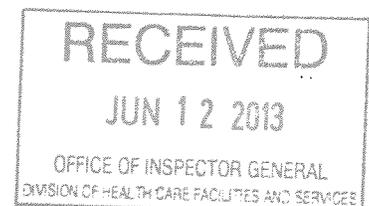
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| F 323   | <p>Continued From page 9<br/>prevent accidents for Residents #5 and #8.</p> <p>The findings revealed:</p> <p>Review of the facility's policy regarding Falls Management, dated January 1, 2010, revealed it was the policy of this facility to screen all residents: to identify possible risk factors that may place residents at risk for falls; to evaluate those risks; implement interventions to reduce those risks; and monitor those interventions and modify when necessary. The facility would complete a Falls Risk Screen upon admission/readmission, with a significant change, review the current plan of care and if necessary revise the interventions.</p> <p>1. Observation of Resident #3, on 05/21/13 at 1:30 PM, and 4:30 PM, and again, on 05/22/13 at 8:30 AM and 9:30 AM, revealed the resident was restless, moving about in the bed and trying to move his/her legs. The resident was observed lying on a bariatric mattress.</p> <p>Review of the clinical record for Resident #3 revealed the facility readmitted the resident on 05/20/13 at 4:15 PM, with diagnoses of Congestive Heart Failure, Urinary Tract Infection, and Respiratory Failure. Review of the readmission Falls Risk Screen, dated 05/20/13, revealed the resident's bed would be positioned against the wall for safety, with increased staff supervision. Review of the readmission Pain Assessment, dated 05/20/13, indicated the resident was restless, with constant or intermittent shifting of position, and pain medication would be provided for comfort measures.</p> | F 323  | <p>Interdisciplinary Team morning meeting in an effort to address root cause of the change in condition and action taken.</p> <ul style="list-style-type: none"> <li>• Education/inservicing for the Nursing Department on applying alarms and ensuring proper function done by the Director of Staff Development on 6/5/13.</li> <li>• Education/inservicing for Nurses on putting interventions in place and updating the CNA care plans done by the Director of Staff Development on 6/7/13).</li> <li>• Interdisciplinary Team was educated/inserviced on the Falls Policy by the Director of Staff Development and the Director of Nursing on 6/7/13.</li> <li>• The Interdisciplinary Team will review newly admitted residents and residents with a change in condition 5 days a week to ensure that proper preventative measures are in place and are documented on the care plan and on CNA care plan.</li> <li>• Safety devices will be checked on Quality Assurance (QA) Observation Rounds, rounds will occur no less than twice a week and when a new device is put in place.</li> <li>• Complete implementation of # 3 by 6/13/13.</li> </ul> <p>4. The facility plans to monitor the performance of the solutions for sustainability by the following.</p> <ul style="list-style-type: none"> <li>• The Administrator will review the QA Observation Rounds on a weekly basis to identify any issues related to the deficient practice and make recommendation to the QA Committee monthly as needed.</li> </ul> |



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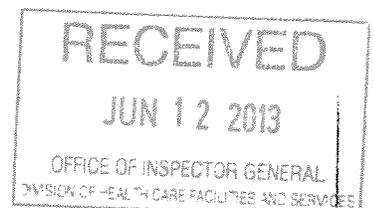
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| F 323   | <p>Continued From page 10</p> <p>Review of the Nurse's notes, dated 05/21/13 at 2:00 AM, revealed the resident was restless with disorientation, and continued to remove the nasal cannula. At 11:10 AM, the resident had tossed and turned most of morning, taking off the oxygen tubing, his/her gown, and throwing the covers off. The Nurse's notes at 1:00 PM, 9:30 PM, and 10:45 PM, on 5/21/13, revealed the resident continued to be restless and tried to get out of the bed. The record also revealed a family member was with the resident at all times.</p> <p>Continued review of the Nurse's notes, on 05/22/13, at 3:00 AM and 3:45 AM, revealed the resident was lying half off the bed, swatting into the air, restless, and was moaning. Pain medication was given at 3:45 AM.</p> <p>Review of the Nurse's notes, dated 05/22/13 at 8:25 AM, revealed the resident was found on the floor beside the bed. The Nurse's notes stated the resident had slid out off the bed, and an assessment of the resident revealed no injury. After assessment by the Director of Nursing (DON), a decision was made to provide bed bolsters for the resident to define bed parameters related to decreased safety awareness. Physician orders were obtained, on 05/22/13, for the bed bolsters.</p> <p>Interview with Certified Nursing Assistant (CNA) #3, on 05/23/13 at 2:20 PM, revealed she had observed Resident #3 as very restless the morning of the fall, on 05/22/13. CNA #3 stated the resident had not been restless prior to the hospitalization, but since returning had been tossing and rolling about in the bed. The CNA stated the resident's bed was against the wall,</p> | F 323  | <ul style="list-style-type: none"> <li>The Administrator will make random visits (at least twice per week) to ensure the Interdisciplinary Team morning meeting is being conducted per #3.</li> </ul> <p>5. Corrective action and regulatory compliance will be achieved by: 6/28/13</p> |  |



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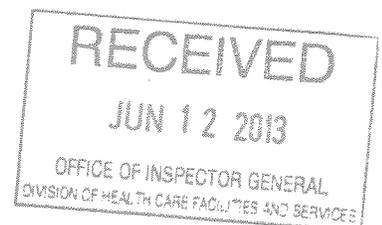
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| F 323   | <p>Continued From page 11 and in the lowest position.</p> <p>Interview with LPN #5, on 05/23/13 at 2:20 PM, revealed the resident had been sedated when first returned from the hospital, on 05/20/13, but had become more restless after the first day. The LPN revealed she received report from the night shift prior to the fall, on the morning of 5/22/13, around 6:30 AM, and then checked all the residents. LPN #3 revealed Resident #3 was asleep at that time; however, was still moving his/her arms. She stated the fall occurred around 8:30 AM. The LPN revealed the niece stayed with the resident at all times, and had fallen asleep at the time the resident slid out of the bed.</p> <p>Interview with the Niece who was the Power of Attorney (POA) for Resident #3, on 05/23/13 at 2:30 PM, revealed the resident needed something to protect him/her from falling out of bed, and revealed the Director of Nursing had ordered bed bolsters be placed on the bed after the fall, to alert the resident when tossing and turning. The Niece stated the resident had been restless, off and on, since return from the hospital on 05/20/13, and was getting worse. Interview with the Niece, also revealed that she had placed a chair against the bed to prevent the resident from falling, until the bed bolsters arrived, which would be any time. Observation revealed the bed bolsters were placed on the bed at 3:00 PM on 05/22/13, six and half hours after the fall.</p> <p>Interview with the Director of Nursing, on 05/23/13 at 2:45 PM, revealed Resident #3 had not tried to get out of the bed since admission, and revealed this was a new change. Further interview with the DON revealed the resident was</p> | F 323  |   |



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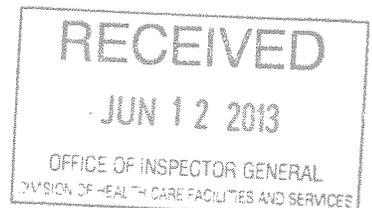
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| F 323   | <p>Continued From page 12</p> <p>restless, on 02/21/13, but was only picking in the air, picking at the sheets, and also trying to remove his/her gown. The DON revealed the resident rolled out of the bariatric bed in the lowest position, on 05/22/13, without injury. The DON stated she was not aware of the restless behavior documented in the nurse's notes, between 02/21/13 and 05/22/13.</p> <p>Further Interview with the DON, on 05/23/13 at 2:45 PM, revealed they had identified problems with falls and had incorporated this into their quality assurance. She stated that falls are reviewed each day in the Interdisciplinary Team (IDT) morning meeting.</p> <p>2. Observation of Resident #8, on 05/21/13 at 9:10 AM revealed the resident was sitting up in a recliner with their eyes closed. A small dark bruise (blue-purple color) was noted under the right eye. On 05/22/13 at 2:27 PM, the resident was observed to be laying in bed asleep. The bruise had enlarged under the right eye and extended down the right cheek. An alarming sensor pad had been placed under the resident. One side of the resident's bed had been position against the wall with the other opened to the room. Observation revealed no floor mat had been placed beside the bed. Continued observation at 3:30 PM revealed the resident remained in bed asleep without a floor mat beside the bed.</p> <p>Review of Resident #8's clinical record revealed the facility admitted the resident on 09/25/13 with diagnoses of Metabolic Encephalopathy,</p> | F 323  |   |  |



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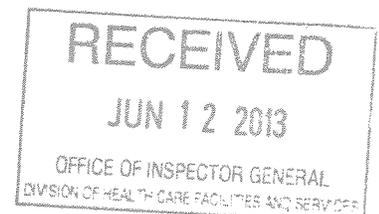
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| F 323   | <p>Continued From page 13</p> <p>Pneumonia, Dementia, and Difficulty in Walking. Review of the admission assessment, dated 10/02/12, revealed the facility assessed the resident as requiring extensive assistance with ambulation, transfers, bed mobility, and toileting needs. The facility assessed the resident with a Brief Interview Mental Status (BIMS) and determined a score of four (4) out of fifteen (15) indicating a cognitive deficit. The facility assessed the resident to be at risk for falls with a care plan developed to address the risk. The physician orders revealed an alarming Velcro release seat belt was ordered and applied on 12/07/13.</p> <p>Continued review of the clinical record revealed, on 05/20/13 at 12:25 AM, the resident was found face down on the floor beside the bed. The resident required emergency treatment at the local hospital and returned with bruising under the right eye and bump to the right side of the head. Review of the post fall investigation tool (provided by the facility) revealed the sensor alarm was in place prior to the fall. The report indicated the facility implemented an immediate falls prevention approach of a floor mat beside the bed. Review of the CNA care plan, on 05/21/13, revealed the fall prevention floor mat was not listed on the care plan.</p> <p>Observation, on 05/23/13 at 2:30 PM, revealed a floor mat had been folded and placed at the end of Resident #8's bed.</p> <p>Interview with CNA #4, on 05/23/13 at 2:30 PM, revealed the floor mat was provided by the facility today. Interview with the DON, on 05/23/13 at 3:30 PM, revealed the floor mat was not available until yesterday afternoon. She stated the CNA</p> | F 323  |   |                      |  |



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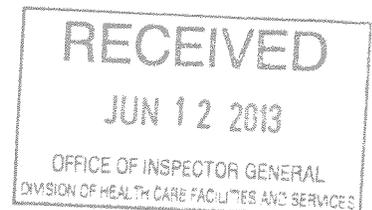
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| F 323   | <p>Continued From page 14</p> <p>care plan had been updated today, 05/23/13, three days after the order was obtained.</p> <p>2. Observation of Resident #5, on 05/21/13 at 9:00 AM, revealed the resident sitting up in a wheelchair with an alarming Velcro seat belt around the resident's waist. On 05/23/13 at 1:25 PM, the resident was sitting in the wheelchair with the seat belt applied. Upon instructions from CNA #4, the resident removed the alarming Velcro seat belt. However, the alarm did not sound.</p> <p>Interview with CNA #4, on 05/23/13 at 1:25 PM, revealed the alarm had been turned off while the resident was toileted earlier and the she had forgotten to turn the alarm back on. She stated the resident was at risk for falling and had a history of falls.</p> <p>Record review revealed Resident #5 had resided at the facility since March 2007. The most current MDS assessment, dated 04/16/13, revealed the resident required extensive assist with mobility tasks and had a history of falls. The facility assessed the resident to have a severe cognition loss with a BIMS score of three (3) out of fifteen (15).</p> <p>Interview with the Administrator, on 05/23/13 at 3:00 PM, revealed their Corporate Nurse did a compliance audit, and identified problems with falls during the last visit a couple of weeks ago. The Administrator revealed the facility was in the process of assessing all residents, and some have been referred to therapy. However, copies of therapy referrals were not produced at the time of the survey, or evidence that all residents had been assessed as indicated by the Quality</p> | F 323  |   |  |



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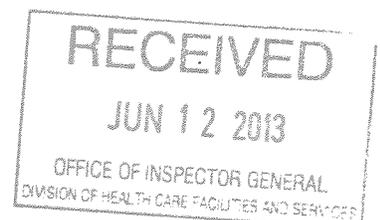
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| F 323   | Continued From page 15 Improvement Plan.   | F 323  |  |                      |  |
| F 371<br>SS=F   | 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br><br>The facility must -<br>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and<br>(2) Store, prepare, distribute and serve food under sanitary conditions<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and review of the facility's policy, it was determined the facility failed to ensure dietary staff washed their hands between glove changes and when going from dirty areas to clean areas. Facility staff returned a tray of clean glasses that was to be utilized on the units to the dirty side of the wash room. The glasses were left on the delivery cart and returned to the kitchen storage area without being washed or sanitized. The facility staff left a soiled washcloth lying on a tray of clean glasses. In addition, the staff failed to ensure a window air-conditioner (AC) unit was free of a black substance on the AC vent as well as dirt, debris, and dust in the window near the stove.<br><br>The findings include:<br><br>Review of the facility's policy regarding Environmental Sanitation /Infection Control Policy 8.21 and 9.3, revealed hands were to be properly | F 371  | F 371<br><br>1. No resident was identified as being affected by the deficient practice. However the facility has implemented corrective action to address the identified deficient practice, which is outlined in #3 and #4.<br>2. No other resident was identified as being affected by the deficient practice, however all residents have the potential to be affected by the deficient practice and the facility has implemented corrective action to address the identified deficient practice, which is outlined in #3 and #4.<br>3. The facility will initiate the following measure to ensure the deficient practice will not recur.<br><ul style="list-style-type: none"> <li>Dietary staff was inserviced on proper hand washing, appropriate times to sanitize hands, and proper handling of dishes in the clean and soiled sides of the dish room on 5/28/13 and 6/3/13 by the facility dietician.</li> <li>The Director of Dietary and/or dietician will inservice dietary staff on a quarterly basis related to proper hand washing, appropriate times to sanitize hands, and proper handling of dishes and equipment in the clean and soiled sides of the dish room.</li> <li>The air-conditioner (AC) unit was removed from service permanently.</li> </ul> | 6/28/13              |  |



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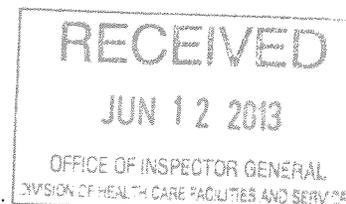
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                              |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>185342 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____   |                      | (X3) DATE SURVEY COMPLETED<br><br>05/23/2013 |
| NAME OF PROVIDER OR SUPPLIER<br><br>COLONIAL HEALTH AND REHABILITATION CENTER |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>708 BARTLEY AVENUE<br>BARDSTOWN, KY 40004   |                      |  |
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| F 371   | <p>Continued From page 16</p> <p>washed before and /or after putting on clean, single use gloves and between glove changes to include handling clean equipment and serving utensils. Additionally, gloves were to be discarded when they were contaminated in any way such as touching unclean surfaces. Review of the HVAC Clean air filters revealed the filters were to be replaced or thoroughly cleaned depending on type of filter every three (3) months.</p> <p>Observation, on 05/23/13 at 8:45 AM, revealed Dietary Staff #3 rinsed left over breakfast food from the dirty dishes and stacked them on trays to be cleaned. She left the dirty side of the dishroom, with her soiled gloves on, and pulled out the cleaned/sanitized tray of dishes from the dishwasher. She did not change her gloves and wash her hands between dirty to clean tasks. Staff #3 pushed the transport cart containing a tray of clean glasses, that were utilized on the units during the breakfast meal on 05/23/13, through the dirty side of the wash room. The glasses were left on the delivery cart and returned to the kitchen storage area for clean dishes without being washed or sanitized. A tray of ten (10) clean glasses sitting on a small table in the dishwashing area had a used soiled washcloth lying on the tray. Dietary Staff #4 failed to change gloves or wash her hands when she took clean dried dishes from the wash room into the kitchen storage area and was observed to touch various counter tops and drawers as she moved from one area to the next.</p> <p>Interview with Dietary Staff #3, on 05/23/13 at 8:55 AM, revealed she was wearing gloves, but did not know she had to change them prior to moving the clean dish trays. She stated she did</p> | F 371  | <ul style="list-style-type: none"> <li>The Performance Improvement QA Calendar will be revised to include a comprehensive Food Safety Sanitation audits to be performed monthly by the business office manager.</li> <li>The Safety Committee calendar will also be revised to include audit of proper sanitation procedures/food safety and audit of vents and fans for cleanliness by the Director of Housekeeping to be completed monthly.</li> <li>Complete implementation of # 3 by 6/13/13.</li> </ul> <p>4. The facility plans to monitor the performance of the solutions for sustainability by the following.</p> <ul style="list-style-type: none"> <li>The Performance Improvement Committee will review the Food Safety Sanitation audit performed and make needed recommendations to the QA Committee monthly.</li> <li>The Safety Committee will review sanitation procedure/food safety and vent/fans audits monthly and make recommendations to the Quality Assurance committee monthly as needed.</li> </ul> <p>The Quality Assurance committee will review the submitted reports/audits monthly to ensure compliance. Recommendation will be made based on the outcomes of these reports/audits as to needed revisions.</p> <p>5. Corrective action and regulatory compliance will be achieved by: 6/28/13</p> |                      |  |



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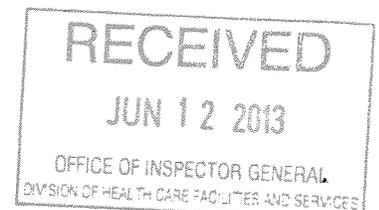
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| F 371   | Continued From page 17<br>not know about the dirty rag on the clean tray with the glasses and guessed it should not have been there.<br><br>Interview with Dietary Staff #4, on 05/23/13 at 9:00 AM, revealed staff were to wash their hands and change gloves when going between each task, clean to dirty. She stated staff could cross contaminate the clean dishes and areas. She stated she did not see the glasses's left on the transport cart and she should not have taken them out of the dish room prior to cleaning them. She identified the tray of glasses on the small table as clean and stated the used washcloth should not be on the tray of clean glasses.<br><br>Interview with the Dietary Manager, on 05/23/13 at 9:20 AM, revealed staff were to wash their hands with every glove change and between dirty to clean tasks. She stated all dishes, utensils, and glasses were to be cleaned before being stored. She stated there should not have been washcloths lying on any trays with clean dishes. She stated Dietary Staff #3 was new and still in training.<br><br>Observation, on 05/21/13 at 8:40 AM, during the initial tour of the kitchen, revealed a window AC above the sink, with a black substance, dust, and debris on the vents. Observation on 05/23/13 at 9:15 AM, revealed the Dietary Cook opened the front of the AC and removed the dust coated filter. The interior of the AC unit was covered with dust, debris, and the black substance was also on the interior of the door to the vents.<br><br>Interview with the Dietary Cook, on 05/23/13 at 9:15 AM, revealed the black substance looked | F 371  |   |                      |  |



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| F 371   | Continued From page 18<br>like mold and the AC was filthy dirty; however, she had not noticed it. She stated the maintenance man usually serviced the AC and he was out on medical leave.<br><br>Interview with the Dietary Manager, on 05/23/13 at 9:20 AM, revealed she had not noticed the air-conditioner being dirty. She stated the maintenance man usually serviced the AC and he was out on medical leave. She stated the AC should have been cleaned. | F 371  |   |                      |  |



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| NAME OF PROVIDER OR SUPPLIER<br><br>COLONIAL HEALTH AND REHABILITATION CENTER |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>708 BARTLEY AVENUE<br>BARDSTOWN, KY 40004                              |                      |  |
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| K 000   | <p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1966</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type III Protected Construction</p> <p>SMOKE COMPARTMENTS: Six (6) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is Diesel.</p> <p>A standard Life Safety Code survey was conducted on 05/21/13. Colonial Health and Rehabilitation Center was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid. The facility has sixty-five (65) certified beds and the census was fifty-eight (58) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from</p> | K 000  |   |                      |  |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

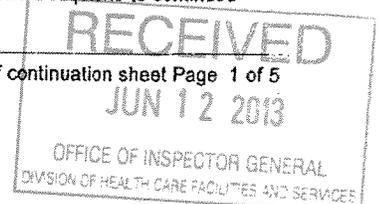
TITLE

(X6) DATE

*[Signature]*

*X Administrator X 6/13/13*

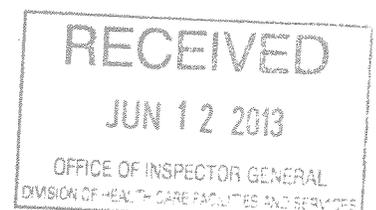
Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable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



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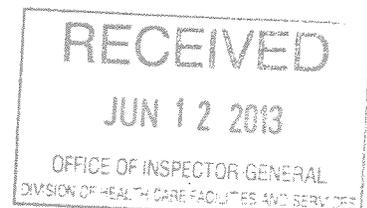
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| NAME OF PROVIDER OR SUPPLIER<br><br>COLONIAL HEALTH AND REHABILITATION CENTER |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>708 BARTLEY AVENUE<br>BARDSTOWN, KY 40004  |  |
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| K 000   | Continued From page 1<br>Fire)   | K 000  |   |  |
| K 038<br>SS=E   | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and interview, it was determined the facility failed to ensure delayed egress doors and exits were maintained in accordance with NFPA standards. The deficiency had the potential to affect two (2) of six (6) smoke compartments, approximately twenty (20) residents, staff and visitors. The facility has sixty-five (65) certified beds and the census was fifty-eight (58) on the day of the survey. The facility failed to ensure doors equipped with delayed egress had proper signage.<br><br>The findings include:<br><br>Observations, on 05/21/13 between 9:15 AM and 9:35 AM, with the Maintenance Assistant revealed the two (2) exit doors located at the Laundry Room (West) and the Lounge (East) within the Back Hall were equipped with delayed egress | K 038  | K 38<br><br>1. No resident was identified as being affected by the deficient practice. However the facility has implemented corrective action to address the identified deficient practice, which is outlined in #3 and #4.<br><br>2. No other resident was identified as being affected by the deficient practice, however all residents have the potential to be affected by the deficient practice and the facility has implemented corrective action to address the identified deficient practice, which is outlined in #3 and #4.<br><br>3. The facility will initiate the following measure to ensure the deficient practice will not recur.<br><ul style="list-style-type: none"> <li>• Delay egress signs were installed on 5/21/13 and extra signs were ordered as backups when signs are found to be removed.</li> <li>• A weekly check will be performed by the maintenance director or maintenance assistant through the facility TELS system, which is the work order computer system, which will be set to prompt the maintenance department to check egress signage weekly.</li> <li>• The Safety Committee calendar will also be revised to include an audit of fire safety/life safety audits including delay egress by</li> </ul> | 6/28/13                                      |



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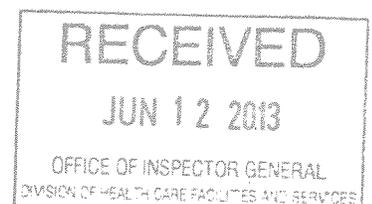
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| NAME OF PROVIDER OR SUPPLIER<br><br>COLONIAL HEALTH AND REHABILITATION CENTER |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>708 BARTLEY AVENUE<br>BARDSTOWN, KY 40004   |  |                      |
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| K 038   | <p>Continued From page 2</p> <p>locks, but did not display the proper signage on the door.</p> <p>Interviews, on 05/21/13 between 9:15 AM and 9:35 AM, with the Maintenance Assistant revealed he was aware of the requirement for delayed egress doors to display the proper signage for exiting, and indicated the signs were once displayed and could have been removed by a resident.</p> <p>Reference:<br/>NFPA 101 (2000 edition)</p> <p>7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met.</p> <p>(a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke</p> | K 038  | <p>the Maintenance Director to be completed monthly.</p> <ul style="list-style-type: none"> <li>The Performance improvement QA Calendar will be revised to address fire safety/life safety audits including delay egress to be performed monthly by the Director of Education.</li> <li>Complete implementation of # 3 by 6/13/13.</li> </ul> <p>4. The facility plans to monitor the performance of the solutions for sustainability by the following.</p> <ul style="list-style-type: none"> <li>The Administrator will access TELS weekly to ensure this work order has been completed.</li> <li>The Safety Committee will review the fire safety/ life safety audit monthly and make recommendations to the Quality Assurance committee as needed.</li> <li>The Performance Improvement (PI) Committee will review the PI fire safety/life safety audit performed and make needed recommendations to the QA Committee monthly.</li> </ul> <p>The Quality Assurance committee will review the submitted reports/audits monthly to ensure compliance. Recommendation will be made based on the outcomes of these reports/audits as to needed revisions.</p> <p>5. Corrective action and regulatory compliance will be achieved by: 6/28/13</p> |                      |



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| NAME OF PROVIDER OR SUPPLIER<br><br>COLONIAL HEALTH AND REHABILITATION CENTER |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>708 BARTLEY AVENUE<br>BARDSTOWN, KY 40004   |   |
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| K 038   | <p>Continued From page 3</p> <p>detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6.</p> <p>(b) The doors shall unlock upon loss of power controlling the lock or locking mechanism.</p> <p>(c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted.</p> <p>(d) *On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows:<br/>PUSH UNTIL ALARM SOUNDS<br/>DOOR CAN BE OPENED IN 15 SECONDS</p> | K 038  |   |



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| K 038   | Continued From page 4<br>7.10.8.1* No Exit. Any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows:<br>NO<br>EXIT<br>Such sign shall have the word NO in letters 2 in. (5 cm) high with a stroke width of 3/8 in. (1 cm) and the word EXIT in letters 1 in. (2.5 cm) high, with the word EXIT below the word NO. | K 038  |   |                      |  |

