

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

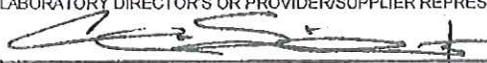
PRINTED: 07/13/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 06/28/2011
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NAME OF PROVIDER OR SUPPLIER COLONIAL MANOR CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2365 NASHVILLE ROAD BOWLING GREEN, KY 42101
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{F 000}	INITIAL COMMENTS An onsite revisit was conducted, on 06/27/11 and concluded on 06/28/11, which determined Immediate Jeopardy (IJ) had been removed at 483.13 (F224), 483.25 (F309), 483.75 (F490 & 520) on 06/08/11 as alleged. While the IJ was removed continued non-compliance remained at a S/S of "D" at F224, F309, F490, and F520 as the facilities Quality Assessment and Assurance Committee had not fully implemented a plan to ensure correction of the deficient practice to prevent non-compliance recurrence. The non Immediate Jeopardy deficiency, F282, cited during the abbreviated survey (06/07/11) was not reviewed for compliance as the facility had not submitted an acceptable Plan of Correction. Therefore, the deficiency detailed on this Statement of Deficiencies for the revisit, 06/28/11, includes the deficiency identified on the abbreviated survey, dated 06/07/11.	{F 000}	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Colonial Manor Care and Rehabilitation Center does not admit that the deficiency listed on this form exists, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency." F224 483.13 Prohibit Mistreatment/ Neglect/ Misappropriation	
{F 224} SS=D	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATION The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and Allegation of Compliance (AoC) review, it was determined the Immediate Jeopardy (IJ) identified	{F 224}	1. Resident #1 was sent to Western Kentucky Diagnostic Imaging for a CT scan on 05/11/2011. The scan results indicated anterior dislocated mandibular condyles bilaterally with arthritic sclerotic irregularity. The resident was discharged to the Medical Center of Bowling Green on 05/11/2011. Resident #1 did not return to the facility. 2. Current residents' medical charts were reviewed for therapy screens on 6/2/11 and 6/3/11 by the Director of Nursing and via communication with the Administrator and therapy staff for any potential outside referrals needed due to a change in condition. The Administrator reviewed all screens conducted since 4/28/2011 through 06/03/2011 on 6/3/2011. Therapy	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 7.22.11
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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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{F 224}	<p>Continued From page 1</p> <p>during the abbreviated survey, concluded on 06/02/11, had been removed. However, non-compliance continued to exist as the facility's Quality Assessment and Assurance Committee (QAAC) had not fully implemented a plan of correction to prevent recurrence of the deficient practice related pain management.</p> <p>The findings include:</p> <p>A review of the facility's acceptable Allegation of Compliance (AoC), received on 06/21/11, revealed the Director of Nurses (DON) or charge nurse would conduct daily reviews of pain documentation to identify the effectiveness of the pain intervention each day of the week. If issues were identified, corrective action would include re-education and/or disciplinary action, as determined by the DON or the Assistant Director of Nurses (ADON).</p> <p>An interview with the DON, on 06/28/11 at 8:05 AM & 10:44 AM, and review of the AoC, revealed the facility had begun implementing action per their AoC; however, the facility had not fully implemented a plan of correction for the deficient practice identified. The DON stated the weekend supervisor failed to conduct the audits the weekend of 06/18-19/11 and 06/25-26/11. The DON informed and educated the weekend supervisor, regarding the nurse's responsibility for completion of audits. The DON further revealed she discovered the weekend supervisor failed to identify lack of documentation for routine pain medication. The DON revealed she had not completed disciplinary action for the staff involved.</p>	{F 224}	<p>Screen logs were reviewed from 04/28/2011 through 06/03/2011 by the Administrator on 6/3/11. The Director of Nursing and the Assistant Director of Nursing reviewed physician orders from 5/30/11 to 6/3/11 and the 24 hour reports to identify any potential change in conditions in the past 72 hours on 6/3/2011. No other residents were identified in these audits to have a referral from a screen. The Director of Nursing and two charge nurses completed pain assessments on current residents on 6/2/11 and 6/3/11.</p> <p>3. The Administrator, Director of Nursing, Assistant Director of Nursing and Health Information Coordinator conducted re-education on abuse and neglect on 6/2/11 and 6/3/11 with staff; utilizing the abuse policy through verbal lecture and visual aids to include examples of neglect and the reporting process. The Regional Director of Clinical Operations conducted re-education on 6/3/11 with therapy staff, Administrator and the Director of Nursing. The education was conducted verbally and with visual aids to utilize the "Hey Therapy" cards for referral management and to review the therapy screening log in the clinical stand up meeting with the interdisciplinary team. The 24 hour report will be reviewed for any recommendations made for outside referrals with the interdisciplinary team in clinical stand up Monday through Friday. On Monday, the Director of Nursing, Assistant Director of Nursing or Charge Nurse will review the 24 hour reports from the weekend for any recommendations made for</p>		

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{F 224}	Continued From page 2 An interview with the Administrator, on 06/28/11 at 4:13 PM, revealed he was to ensure the facility staff completed the actions as detailed in their AoC (daily audits of pain documentation). He stated he was responsible for the audits he conducted and discussed them in their Quality Improvement meetings weekly. The Administrator stated the DON made him aware of the issues found related to follow-up for pain and the weekend supervisor's failure to complete the daily review of the pain documentation, for the weekend of 06/18-19/11 and 06/25-26/11. He stated the DON informed him, on 06/27/11, of the results of her audit. He stated, "Each case we followed the steps and completed re-education as we alleged. If we have problem with the audits, then we may have to adjust who completes the weekend audits".	{F 224}	outside referrals. The Director of Nursing or Assistant Director of nursing verbally and with visual aids re-educated the licensed nursing staff on any staff or family member's ability to make a referral to therapy using the "Hey Therapy" cards on 6/2/11-6/3/11. Therapy will place all screens on the 24 hour report with the result of the therapy screen. Screens will be recorded on the screening log by the therapist. Staff identified as being on leave of absence or prn that were unable to receive education will be required to attend abuse and neglect education and the "Hey Therapy" cards prior to working. Their next scheduled shift has been identified and re-education will be provided by the Administrator, Assistant Director of Nursing or Health Information Coordinator before staff return to work.		
{F 282} SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, it was determined the facility failed to ensure interventions were implemented in accordance with each resident's written care plan for three residents (Residents #4, #5 and #7), in a selected sample of seven, who received pain medication on an as needed (PRN) basis and were not provided pain assessments to evaluate for effective pain relief.	{F 282}	The Director of Nursing, Assistant Director of Nursing or charge nurses will review the 24 hour shift reports in morning meeting process for any change in conditions and/or outside referrals from therapy to ensure physician notification. This was initiated immediately as of 6/2/11 and will continue. The Administrator, Director of Nursing or Assistant Director of Nursing will conduct daily reviews of pain documentation to identify effectiveness of pain interventions each day of the week for the next four weeks. They will continue these audits weekly for the next three months and report to the Performance Improvement		

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{F 282}	Continued From page 3 The findings include: 1. A record review revealed Resident # 4 was admitted to the facility on 5/16/11 with diagnosis to include Healing Traumatic Fracture (Fx.) of other Bone. A review of the physician's order, dated 05/16/11, revealed Hydrocodone-APAP 7.5/500 milligrams (mg) by mouth (po) every four hours PRN, for moderate to severe pain, as well as Tylenol 650 mg po every four hours PRN for mild to moderate pain. A review of the the Comprehensive Care Plan for "Pain/Potential for pain related to Fracture of Bilateral Pubic Ramus and Osteoarthritis," revised 05/30/11, revealed an intervention to administer pain medication as per the physician's orders and note the effectiveness. Notify the physician if the pain was not reduced. A review of the Medication Administration Record (MAR), "PRN Pain Management Flow Sheet," dated 05/01-31/11, revealed Resident #4 was administered thirteen doses of Hydrocodone-APAP 7.5/500 mg po PRN for pain on 05/17/11 at 12:40 PM, on 05/23/11 at 2:00 PM, on 05/23/11 at 11:25 PM, on 05/24/11 at 3:30 AM, on 05/24/11 at 11:50 PM, on 05/25/11 at 3:30 AM, on 05/26/11 at 1:00 PM, on 05/26/11 at 11:30 PM, on 5/27/11 at 12:00 AM, on 5/27/11 at 4:00 AM, on 05/30/11 at 1:00 PM, on 05/31/11 at 12:00 AM, and on 05/31/11 at 4:25 AM. However, there were no assessments on the type of pain the resident experienced, the extent of the pain or whether the administration of the	{F 282}	Committee. Any identified issues will be corrected and re-education/disciplinary action as indicated by the Director of Nursing or Assistant Director of Nursing will be completed. Re-education was conducted on 06/20/11 with Licensed Nurses by the Director of Nursing regarding documentation of effectiveness of pain medication. Re-education was conducted regarding the audit of effectiveness of pain documentation with weekend charge nurse on 06/20/2011 by the Director of Nursing. The Director of Nursing provided re-education on 06/30/2011 to Licensed Nurses regarding initiating pain questions for evaluation of effectiveness. 4. A Performance Improvement Meeting consisting of the Administrator as chair, the Director of Nursing, the Medical Director, Assistant Director of Nursing and Health Information Coordinator was held on 6/2/11 to review the Immediate Jeopardy notification and to assess, develop and implement corrective action that is in accordance with internal policies and procedures as it relates to neglect and quality of care. The Administrator will audit the therapy screens and compare them to the therapy screen log weekly for three months and then monthly for three months. The Director of Nursing will compare the therapy screens with the 24 hour report weekly for three months and then monthly for three months. The results of the audits will be presented to the Performance Improvement Committee by the Administrator or Director of Nursing.		

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{F 282}	<p>Continued From page 4</p> <p>medication relieved the resident's pain. There was no documented evidence the facility assessed and evaluated the resident's pain or the effectiveness of the medication after administration and the staff did not document the assessment findings. Record review revealed Registered Nurse (RN) #1 administered nine of the twelve doses and LPN #1 administered four of the doses.</p> <p>An interview with Registered Nurse (RN) #1, on 06/02/11 at 8:45 AM, revealed she realized she was responsible for the assessment of the resident's pain and to complete the "Pain Management PRN Flow Sheet." She revealed she did not complete the assessment and could provide no explanation as to why this was not completed. She stated she was aware of the "Pain Management" policy and was inserviced on assessments by the facility.</p> <p>An interview with Licensed Practical Nurse (LPN) #1, on 06/07/11 at 11:05 AM, revealed she was aware of the "Pain Management Program" and the "PRN Pain Management Flow Sheet." She stated she was inserviced on pain assessments by the the facility and was unaware of the missed assessments.</p> <p>2. A record review revealed Resident # 5 was admitted to the facility on 02/03/11 with diagnosis to include Healing Fx. Vertebrae.</p> <p>A review of the Comprehensive Care Plan for "Pain/Potential for pain related to amputation of right above the knee (fathom pain) and left leg pain," revised 02/16/11, revealed interventions to give PRN medication for breakthrough pain per</p>	{F 282}	<p>Performance Improvement Meetings were conducted on 06/02/11, 06/09/2011, 06/16/2011, 06/20/2011, 06/21/2011, 06/30/2011, 07/07/2011, 07/15/2011 and 07/20/2011 to identify trends, ensure findings are addressed and systems are in place to prevent recurrence of event. The Administrator, Director of Nursing or the Assistant Director of Nursing will conduct daily reviews of pain documentation to identify effectiveness of pain interventions each day of the week for the next four weeks. The audits will continue weekly for the next three months and findings will be reported to the Performance Improvement Committee for further recommendations beginning 6/28/2011. We will continue to have Performance Improvement meetings weekly for the next 2 weeks and monthly thereafter.</p> <p>5. Compliance date:</p> <p>F282 483.20 Services by qualified persons / per care plan</p> <p>1. The Director of Nursing and two charge nurses completed pain assessments on Residents #4, #5 and #7 on 6/2/11 and 6/3/11 and each resident's plan of care was update to reflect current status.</p> <p>2. The Director of Nursing and two charge nurses completed pain assessments on current residents on 6/2/11 and 6/3/11. Plans of care were updated as indicated to reflect current resident status as of 6/3/11.</p>	07/01/11	

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{F 282}	<p>Continued From page 5</p> <p>the physician's order and note the effectiveness of the medication. Review of the physician's order dated 02/03/11, revealed Hydrocodone-APAP 10/500 mg po every six hours PRN pain. Notify the physician if the pain is not reduced. A revision was added on 03/03/11 for Lortab as ordered.</p> <p>A review of the MAR, "PRN Pain Management Flow Sheet," dated 05/01-31/11, revealed Resident #5 was administered twenty-two doses of Hydrocodone-APAP 10/500 mg po PRN for pain and three of the doses were administered on 05/05/11 at 12:30 PM, on 05/13/11 at 9:15 AM, and on 05/30/11 at 12:30 PM. There were no assessments on the type of pain the resident experienced, the extent of the pain or whether the administration of the medication relieved the resident's pain and the staff failed to document the assessment findings. LPN #7 administered all three doses.</p> <p>An interview with LPN# 7, on 06/07/11 at 10: 20 AM, revealed she was aware of the "Pain Management" policy and was inserviced by the facility. She stated she usually assessed the residents' pain; however, she could not recall why she did not document the assessments on Resident #5.</p> <p>3. A record review revealed Resident # 7 was admitted to the facility on 07/19/10 with diagnoses to include Altered Mental State, Lack of Coordination, Muscle weakness and abnormal Gait.</p> <p>A review of the Comprehensive Care Plan for "Pain/Potential for pain related to Arthritis," dated</p>	{F 282}	<p>3. The Director of nursing verbally conducted re-education on the pain management program and following the plan of care. Nurses were re-educated on assessing pain using 0-10 pain scale on the pain evaluation form, on assessing pain before and after administration of pain medications and documenting the effectiveness of the pain medication on the pain management flow sheet. All licensed nursing staff were re-educated on 6/2/11 and 6/3/11.</p> <p>The Director of Nursing, Assistant Director of Nursing or charge nurses will review the 24 hour shift reports in the morning meeting process for any change in conditions and/or outside referrals from therapy to ensure physician notification. This meeting is held Monday through Friday and all 24 hour reports from Saturday and Sunday are reviewed on Monday</p> <p>The Administrator, Director of Nursing or Assistant Director of Nursing will conduct daily reviews of pain documentation to identify effectiveness of pain interventions each day of the week for the next four weeks. They will continue these audits weekly for the next three months and report to the Performance Improvement Committee for further recommendations. Any identified issues will be corrected and re-education/disciplinary action as indicated by the Director of Nursing or Assistant Director of Nursing will be completed. Re-education was conducted on 06/20/11 with Licensed Nurses by the Director of Nursing regarding</p>		

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{F 282}	Continued From page 6 10/14/10, revealed interventions to administer medication as ordered by the physician and give PRN medication for breakthrough pain per the physician's order and note the effectiveness. Notify the physician if pain is not reduced. A review of the MAR, "PRN Pain Management Flow Sheet," dated 05/01-31/11, revealed Resident #7 was administered seventy-eight Hydrocodone-APAP for pain PRN and twenty-six of those times on 05/02/11 at 7:30 PM, on 05/03/11 at 12:20 AM, on 05/03/11 at 11:50 PM, on 05/05/11 at 12:10 AM, on 05/05/11 at 11:50 PM, on 05/06/11 at 10:00 PM, on 05/09/11 at 7:30 PM, on 05/10/11 at 7:25 PM, on 05/11/11 at 12:15 AM, on 05/11/11 at 11:40 PM, on 05/13/11 at 7:30 PM, on 05/13/11 at 11:30 PM, on 05/15/11 at 10:15 PM, on 05/16/11 at 5:00 PM, on 05/18/11 at 12:30 AM, on 05/19/11 at 6:30 PM, on 05/19/11 at 10:45 PM, on 05/20/11 at 1:00 PM, on 05/20/11 at 5:00 PM, on 05/23/11 at 7:15 PM, on 05/24/11 at 12:AM, on 05/24/11 at 10:10 PM, on 05/25/11 at 11:30 PM, on 05/27/11 at 12:00 AM, on 05/30/11 at 7:15 PM, and on 05/30/11 at 11:55 PM. There were no assessments on the type of pain the resident experienced, the extent of the pain or whether the administration of the medication relieved the resident's pain and the staff failed to document the assessment findings. The medication was administered twelve times by the Certified Medication Technician (CMT) #1, nine times by RN#1, three times by RN# 4, one time by RN #2, and one time by LPN# 3. An interview with CMT #1, on 06/06/11 at 7:20 PM, revealed she was aware of the "Pain Management" policy; however, as a CMT she did	{F 282}	documentation of effectiveness of pain medication. Re-education was conducted regarding the audit of effectiveness of pain documentation with weekend charge nurse on 06/20/2011 by the Director of Nursing. The Director of Nursing provided re-education on 06/30/2011 to Licensed Nurses regarding initiating pain questions for evaluation of effectiveness. 4. A Performance Improvement Meeting consisting of the Administrator as chair, the Director of Nursing, the Medical Director, Assistant Director of Nursing and Health Information Coordinator was held on 6/2/11 to review the event and to assess, develop and implement corrective action that is in accordance with internal policies and procedures as it relates to neglect and quality of care. The daily reviews of pain documentation and services provided as written in the plan of care will be brought to the Performance Improvement Committee by the Director of Nursing. Performance Improvement Meetings were conducted on 06/02/11, 06/09/2011, 06/16/2011, 06/20/2011, 06/21/2011, 06/30/2011, 07/07/2011, 07/15/2011 and 07/20/2011 to identify trends, ensure findings are addressed and systems are in place to prevent recurrence of event. The Administrator, Director of Nursing or the Assistant Director of Nursing will conduct daily reviews of pain documentation to identify effectiveness of pain interventions each day of the week for the next four weeks. The audits will continue weekly for the next three months and findings reported		

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{F 282}	<p>Continued From page 7</p> <p>not assess the residents. She stated she alerted the unit nurse when a resident complained of pain and waited to be told by the nurse if the resident needed medication.</p> <p>An interview with Registered Nurse (RN) #1, on 06/02/11 at 8:45 AM, revealed she realized she was responsible for the assessment of the resident's pain and to complete the "Pain Management PRN Flow Sheet." She revealed she did not complete the assessment and could provide no explanation as to why this was not completed. She stated she was aware of the "Pain Management" policy and was inserviced on assessments by the facility.</p> <p>An interview with RN #4, on 06/07/11 at 8:35 AM, revealed she was familiar with the "Pain Management" policy and usually assessed the residents per policy. She stated at times she did not document the assessments and could provide no explanation as to why it was not completed.</p> <p>An interview with LPN #3, on 06/06/11 at 7:15 PM, revealed that she was sure she was inserviced on pain assessments by the facility and was aware of the "Pain Management" policy. She stated she usually assessed and documented the assessments per policy.</p> <p>An interview with RN# 2, on 06/07/11 at 10:15 AM, revealed she was inserviced on pain assessments by the facility and was aware of the "Pain Management" policy. She stated if she missed completion of an assessment, it was due to human error.</p> <p>A review of the facility's policy and procedures</p>	{F 282}	<p>to the Performance Improvement Committee for further recommendations beginning 6/28/2011. We will continue to have Performance Improvement meetings weekly for the next 2 weeks and monthly thereafter.</p> <p>5. Compliance date:</p> <p>F309 483.25 Provide care / Services for highest well being</p> <p>1. Resident #1 was sent to Western Kentucky Diagnostic Imaging for a CT scan on 5/11/11. The scan showed anteriorly dislocated mandibular condyles bilaterally with arthritic sclerotic irregularity. The resident was discharged to the Medical Center of Bowling Green on 05/11/2011 for treatment. Resident #1 did not return to the facility. The Director of Nursing and two charge nurses completed pain assessments on Residents #4, #5 and #7 on 6/2/11 and 6/3/11.</p> <p>2. Current residents' medical charts were reviewed for therapy screens on 6/2/11 and 6/3/11 by Director of Nursing and via communication with the Administrator and therapy staff for any potential outside referrals needed due to a change in condition. The Administrator reviewed all screens conducted since 4/28/2011 through 06/03/2011 on 06/03/11. Therapy screen logs were reviewed from 04/28/2011 through 06/03/2011 by the Administrator on 06/03/11. The Director of Nursing and Assistant Director of Nursing reviewed</p>	07/01/11	

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{F 282}	<p>Continued From page 8</p> <p>entitled, " Pain Management Program," dated January 2008 and revised July 2010, revealed the pain management program was an interdisciplinary program that utilized the "APIE" (assess, plan, implement, and evaluate) approach to care giving. The program's components were as follows: identifying residents with pain, developing an individual pain management program, implementing the program and monitoring and evaluating the effectiveness of the program.</p> <p>An interview with the Assistant Director of Nursing (ADON), on 06/02/11 at 12:45 PM, revealed she conducted inservicing and training on "Pain Management and Assessment" for staff in the facility; however, the DON does most of the training of the new hires and much of the inservicing/training was completed on the computer.</p> <p>A review of "In-Service Training Reports", dated 01/18/11, revealed an inservice was conducted by the ADON. The topic, "PRN MEDS" revealed, "All prn medications (except pain medications documented on the PRN pain log) must be put in the nurse's notes. Documentation must include: 1.) why the medication was administered, and 2.) if the medication was effective or not. This will be closely monitored for compliance." There were nine staff signatures on the document. Review of an inservice, dated 03/07/11, for Licensed Nurses and CMTs, and conducted by the DON revealed a document titled "Medication Administration Competency-General Overview." It included nine staff signatures. Review of an inservice, dated 02/17/11, was an "all" staff inservice conducted by the DON and the ADON which included a</p>	{F 282}	<p>physician orders from 5/30/11 to 6/3/11 and the 24 hour reports to identify any potential change in conditions in the past 72 hours on 06/03/11. No other residents were identified in these audits to have a referral from a screen. The Director of Nursing and two charge nurses completed pain assessments on current residents on 6/2/11 and 6/3/11. Plans of care were updated as indicated to reflect current resident status as of 6/3/11.</p> <p>3. The Director of Nursing verbally conducted re-education on pain management program. Nurses were re-educated on assessing pain using 0-10 pain scale on the pain evaluation form, on assessing pain before and after administration of pain medications and documenting the effectiveness of the pain medication on the pain management flow sheet. All licensed nursing staff were re-educated on 6/2/11 and 6/3/11.</p> <p>The Director of Nursing, Assistant Director of Nursing or charge nurses will review the 24 hour shift reports in the morning meeting process for any change in conditions and/or outside referrals from therapy to ensure physician notification. This meeting is held Monday through Friday and all 24 hour reports from Saturday and Sunday are reviewed on Monday.</p> <p>The Administrator, Director of Nursing or Assistant Director of Nursing will conduct daily reviews of pain documentation to identify effectiveness of pain interventions each day of the week for the next four</p>	

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{F 282}	Continued From page 9 statement to complete pain assessments. There were twenty staff signatures and seven of those were licensed staff.	{F 282}	weeks. They will continue these audits weekly for the next three months and report to the Performance Improvement Committee for further recommendations. Any identified issues will be corrected and re-education/disciplinary action as indicated by the Director of Nursing or Assistant Director of Nursing will be completed. Re-education was conducted on 06/20/11 with Licensed Nurses by the Director of Nursing regarding documentation of effectiveness of pain medication. Re-education was conducted regarding the audit of effectiveness of pain documentation with weekend charge nurse on 06/20/2011 by the Director of Nursing. The Director of Nursing provided re-education on 06/30/2011 to Licensed Nurses regarding initiating pain questions for evaluation of effectiveness.		
{F 309} SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and Allegation of Compliance (AoC) review, it was determined the Immediate Jeopardy (IJ) identified during the abbreviated survey, concluded on 06/02/11, had been removed. However, non-compliance continued to exist as the facility's Quality Assessment and Assurance Committee (QAAC) had not fully implemented a plan of correction to prevent recurrence of the deficient practice related pain management. The findings include: Review of the facilities acceptable Allegation of Compliance (AoC), received on 06/21/11, revealed the Director of Nurses (DON) verbally conducted re-education on the facility's pain management program. Nurses were re-educated on assessing pain using 0-10 pain scale on the pain evaluation form, on assessing pain before and after administration of pain medications, and	{F 309}	4. A Performance Improvement Meeting consisting of the Administrator as chair, the Director of Nursing, the Medical Director, Assistant Director of Nursing and Health Information Coordinator was held on 6/2/11 to review the event and to assess, develop and implement corrective action that is in accordance with internal policies and procedures as it relates to neglect and quality of care. The daily reviews of pain documentation will be brought to the Performance Improvement Committee by the Director of Nursing. The Administrator will audit the therapy screens and compare them to the therapy screen log weekly for three months and then monthly for three months. The Director of Nursing will compare the therapy screens with the 24		

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{F 309}	<p>Continued From page 10</p> <p>documenting the effectiveness of the pain medication on the pain management flow sheet. The DON or charge nurse would conduct daily reviews of pain documentation to identify the effectiveness of the pain intervention each day of the week. Any identified issues were to be corrected and re-education/disciplinary action, as indicated by the DON or the Assistant Director of Nurses (ADON), would be completed.</p> <p>A review of the policy entitled, "Pain Management Program" dated January 2008 and revised July of 2010, revealed for regularly scheduled or routine doses of pain medication ordered by the physician, the nurse dispensing the medication would document the following on the Medication Administration Record (MAR); pain intensity (using the 0-10 scale); signs of sedation; and side effects. Soon after the medication was administered, the licensed nurse would return to the resident and question them about their pain and how they would rate it. The response would be documented on the MAR and any comments or concerns would be documented on the back of the MAR. If, for some reason, the medication was not effective in controlling pain, the licensed nurse would address the specifics with the physician immediately.</p> <p>Interviews with the DON, on 06/27/11 at 10:50 AM and 06/28/11 at 10:44 AM, and review of the AOC, revealed the facility had begun implementing action per their AOC; however, the facility had not completely implemented a plan of correction for the deficient practice identified. The DON revealed during her daily audits, she identified two incidents when staff failed to</p>	{F 309}	<p>hour report weekly for three months and then monthly for three months. The results of the audits will be presented to the Performance Improvement Committee by the Administrator or Director of Nursing. Performance Improvement Meetings were conducted on 06/02/11, 06/09/2011, 06/16/2011, 06/20/2011, 06/21/2011, 06/30/2011, 07/07/2011, 07/15/2011 and 07/20/2011 to identify trends, ensure findings are addressed and systems are in place to prevent recurrence of event. The Administrator, Director of Nursing or the Assistant Director of Nursing will conduct daily reviews of pain documentation to identify effectiveness of pain interventions each day of the week for the next four weeks. The audits will continue weekly for the next three months and findings reported to the Performance Improvement Committee for further recommendations beginning 6/28/2011. We will continue to have Performance Improvement meetings weekly for the next 2 weeks and monthly thereafter.</p> <p>5. Compliance Date</p> <p>F490 Effective administration/resident well being</p> <p>1. Resident #1 was sent to Western Kentucky Diagnostic Imaging for a CT scan on 5/11/11. The scan showed anteriorly dislocated mandibular condyles bilaterally with arthritic sclerotic irregularity. The resident was discharged to the Medical Center of Bowling Green on 05/11/2011 for</p>	7/01/11	

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{F 309}	<p>Continued From page 11</p> <p>document a follow-up assessment for "as needed (prn)" pain medication. She stated she provided in-services for the staff involved regarding the pain management program. During the inservices, she discussed the need to assess the resident before and after administration of the medication. If the medication was not effective in controlling the resident's pain, the nurse should notify the physician. If a resident had a PRN medication for pain, then the nurse should document on the PRN Pain Flow Sheet. If a resident had a routine pain medication, the nurse was responsible for answering the three pain criteria questions. She stated she identified through the audits problems had occurred, on 06/13/11, on 06/20/11, and on 06/27/11. Per interview she had also identified the audits were not completed for the weekend of 06/18-19/11 and 06/25-26/11. At the time of the interviews, she had completed education and disciplinary action with staff involved, with the exception of the weekend supervisor.</p> <p>An interview with the Administrator, on 06/28/11 at 4:13 PM, revealed he was to ensure the facility staff completed the actions as detailed in their AoC (daily audits of pain documentation). He stated he was responsible for the audits he conducted and discussed them in their Quality Improvement meetings weekly. The Administrator stated the DON made him aware of the issues found related to pain documentation not being followed up on and the weekend supervisor's failure to complete the daily review of the pain documentation for the weekend of 06/18-19/11 and 06/25-26/11. He stated the DON informed him, on 06/27/11, of the results of her audit. He stated, "Each case we followed the</p>	{F 309}	<p>treatment. Resident #1 did not return to the faculty. The Director of Nursing and two charge nurses completed pain assessments on Residents #4, #5 and #7 on 6/2/11 and 6/3/11. Plans of care were updated to reflect current status of these residents.</p> <p>2. Current residents' medical charts were reviewed for therapy screens on 6/2/11 and 6/3/11 by Director of Nursing and via communication with the Administrator and therapy staff for any potential outside referrals needed due to a change in condition. The Administrator reviewed all screens conducted since 4/28/2011 through 06/03/2011 on 06/03/2011. Therapy screen logs were reviewed from 04/28/2011 through 06/03/2011 by the Administrator on 06/03/2011. The Director of Nursing and Assistant Director of Nursing reviewed physician orders from 5/30/11 to 6/3/11 and the 24 hour reports to identify any potential change in conditions in the past 72 hours on 06/03/2011. No other residents were identified in these audits to have a referral from a screen. The Director of Nursing and two charge nurses completed pain assessments on current residents on 6/2/11 and 6/3/11. Plans of care were updated as indicated to reflect current resident status as of 6/3/11.</p> <p>3. The Regional Vice President re-educated the Administrator and Director of Nursing on a facility being administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and</p>		

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{F 309}	Continued From page 12 steps and completed re-education as we alleged. If we have problem with the audits, then we may have to adjust who completes the weekend audits".	{F 309}	psychosocial well-being of each resident on 06/03/2011.		
{F 490} SS=D	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview, record review and Allegation of Compliance (AoC) review, it was determined the Immediate Jeopardy (IJ) identified during the abbreviated survey, concluded on 06/02/11, had been removed. However, non-compliance continued to exist as the facility's Quality Assessment and Assurance Committee (QAAC) had not fully implemented a plan of correction to prevent recurrence of the deficient practice related pain management. The findings include: Review of the facility's acceptable Allegation of Compliance (AoC), received on 06/21/11 revealed, the Director of Nurses (DON) or charge nurse would conduct daily reviews of pain documentation to identify the effectiveness of the pain intervention each day of the week. Any identified issues were to be corrected and re-education/disciplinary action, as indicated by the DON or the Assistant Director of Nurses	{F 490}	The Regional Director of Clinical Operations conducted re-education on 6/3/11 with therapy staff, Administrator and the Director of Nursing. The education was conducted verbally to utilize the "Hey therapy" cards for referral management and to review the therapy screening log in the clinical stand up meeting with the interdisciplinary team. The 24 hour report will be reviewed for any recommendations made for outside referrals with the interdisciplinary team in clinical stand up. The Director of Nursing, Assistant Director of Nursing or charge nurses will review the 24 hour shift reports in the morning meeting process for any change in conditions and/or outside referrals from therapy to ensure physician notification. This meeting is held Monday through Friday and all 24 hour reports from Saturday and Sunday are reviewed on Monday. The Administrator, Director of Nursing or Assistant Director of Nursing will review the therapy screens and the therapy screen log in clinical stand up meeting. 4. A Performance Improvement Meeting consisting of the Administrator as chair, the Director of Nursing, the Medical Director, Assistant Director of Nursing and Health Information Coordinator was held on 6/2/11 to review the event and to assess, develop and implement corrective action		

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{F 490}	<p>Continued From page 13 (ADON) would be completed.</p> <p>An interview, on 06/27/11 at 10:50 AM, with the DON revealed she discovered two incidents of staff failing to document a follow-up to an as needed (prn) pain medication on a resident. On the morning of 06/20/11 (a Monday) following the weekend (06/18/11 & 06/19/11) she discovered the weekend supervisor had not completed the daily pain audit. The DON stated she informed and educated the weekend supervisor that she was responsible for conducting the daily audits of pain documentation, from 3:00 PM on Friday until the end of her shift on Sunday night at 9:00 PM. The DON revealed she discovered the issues regarding the failure to complete the daily audits, on 06/27/10. The DON revealed she had not completed disciplinary action for the staff involved.</p> <p>An interview with the weekend supervisor, on 06/28/11 at 11:06 AM, revealed she received counseling earlier that morning. She stated the DON talked with her about the daily audits not conducted on 06/17/11. She stated, "The DON said it was just a miscommunication about the daily pain audits".</p> <p>An interview, on 06/28/11 at 4:13 PM, with the facility's Administrator revealed he was responsible to ensure the facility staff carried out activities per the AoC (daily audits of pain documentation). The DON made him aware of the issues found regarding follow-up pain assessment documentation, for dates 06/13/11 and 06/17/11) and the weekend supervisor not completing the daily review of the pain documentation for the weekend of 06/18-19/11</p>	{F 490}	<p>that is in accordance with internal policies and procedures as it relates to neglect and quality of care. The Administrator will audit the therapy screens and compare them to the therapy screen log weekly for three months and then monthly for three months. The Director of Nursing will compare the therapy screens with the 24 hour report weekly for three months and then monthly for three months. The results of the audits will be presented to the Performance Improvement Committee by the Administrator or Director of Nursing. Performance Improvement Meetings were conducted on 06/02/11, 06/09/2011, 06/16/2011, 06/20/2011, 06/21/2011, 06/30/2011, 07/07/2011, 07/15/2011 and 07/20/2011, to identify trends, ensure findings are addressed and systems are in place to prevent recurrence of the event. The Administrator, Director of Nursing or the Assistant Director of Nursing will conduct daily reviews of pain documentation to identify effectiveness of pain interventions each day of the week for the next four weeks. The audits will continue weekly for the next three months and findings reported to the Performance Improvement Committee for further recommendations beginning 6/28/2011 We will continue to have Performance Improvement meetings weekly for the next 2 weeks and monthly thereafter</p> <p>5. Compliance date</p>	7/01/11	

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{F 490}	Continued From page 14 and 06/25-26/11. The Administrator stated, "Each case we followed the steps and completed re-education as we alleged. If we have problem with the audits, then we may have to adjust who completes the weekend audits".	{F 490}	F 520 483.75 Committee-members / meet quarterly / Plans		
{F 520} SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview, record review and Allegation of Compliance (AoC) review, it was determined	{F 520}	1. Resident #1 was sent to Western Kentucky Diagnostic Imaging for a CT scan on 5/11/11. The scan showed anteriorly dislocated mandibular condyles bilaterally with arthritic sclerotic irregularity. The resident was discharged to the Medical Center of Bowling Green on 05/11/2011 for treatment. Resident #1 did not return to the faculty. The Director of Nursing and two charge nurses completed pain assessments on Residents #4, #5 and #7 on 6/2/11 and 6/3/11. Plans of care were updated to reflect current status of these residents. 2. Current residents' medical charts were reviewed for therapy screens on 6/2/11 and 6/3/11 by Director of Nursing and via communication with the Administrator and therapy staff for any potential outside referrals needed due to a change in condition. The Administrator reviewed all screens conducted since 4/28/2011 through 06/03/2011 on 06/03/2011. Therapy screen logs were reviewed from 04/28/2011 through 06/03/2011 by the Administrator on 06/03/2011. The Director of Nursing and Assistant Director of Nursing reviewed physician orders from 5/30/11 to 6/3/11 and the 24 hour reports to identify any potential change in conditions in the past 72 hours on 06/03/2011. No other residents were identified in these audits to have a referral from a screen. The Director of Nursing and two charge nurses completed pain		

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{F 520}	<p>Continued From page 15</p> <p>the Immediate Jeopardy (IJ) identified during the abbreviated survey, concluded on 06/02/11, had been removed. However, non-compliance continued to exist as the facility's Quality Assessment and Assurance Committee (QAAC) had not fully implemented a plan of correction to prevent recurrence of the deficient practice related pain management.</p> <p>The findings include:</p> <p>A review of the facility's acceptable Allegation of Compliance (AoC), received on 06/21/11, revealed the Director of Nurses (DON) or charge nurse would conduct daily reviews of pain documentation to identify the effectiveness of the pain intervention each day of the week. Any identified issues would be corrected and re-education/disciplinary action would be provided, as indicated by the DON or the Assistant Director of Nurses (ADON).</p> <p>Interviews with the DON, on 06/27/11 at 10:50 AM and 06/28/11 at 10:44 AM, and review of the AoC, revealed the facility had begun implementing action per their AoC; however, the facility had not completely implemented a plan of correction for the deficient practice identified. The DON revealed that during her daily audits, she identified two incidents when staff failed to document a follow-up assessment for "as needed (prn)" pain medication. She stated she provided in-services for the staff involved regarding the pain management program. During the inservices, she discussed the need to assess the resident before and after administration of the medication. If the medication was not effective in controlling the resident's pain, the nurse should</p>	{F 520}	<p>assessments on current residents on 6/2/11 and 6/3/11. Plans of care were updated as indicated to reflect current resident status as of 6/3/11.</p> <p>3. The Regional Vice President re-educated the Administrator and Director of Nursing on a facility being administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident on 06/03/2011.</p> <p>The Regional Vice President re-educated the Administrator and Director of Nursing on Performance Improvement process and the functions of the committee to include identifying quality deficiencies and developing and implementing plans of action to correct these quality deficiencies, including monitoring the effect of implemented changes and making needed revisions to the action plans on 06/03/2011.</p> <p>4. A Performance Improvement Meeting consisting of the Administrator as chair, the Director of Nursing, the Medical Director, Assistant Director of Nursing and Health Information Coordinator was held on 6/2/11 to review the event and to assess, develop and implement corrective action that is in accordance with internal policies and procedures as it relates to neglect and quality of care. The Administrator will audit the therapy screens and compare them to the therapy screen log weekly for three months and then monthly for three months.</p>		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 06/28/2011
NAME OF PROVIDER OR SUPPLIER COLONIAL MANOR CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2365 NASHVILLE ROAD BOWLING GREEN, KY 42101		
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{F 520}	Continued From page 16 notify the physician. If a resident had a PRN medication for pain, then the nurse should document on the PRN Pain Flow Sheet. If a resident had a routine pain medication, the nurse was responsible for answering the three pain criteria questions. She stated she identified through the audits problems had occurred, on 06/13/11, 06/20/11 and 06/27/11. At the time of the interviews, she had completed education and disciplinary action with staff involved, with the exception of the weekend supervisor. An interview with the Administrator, on 06/28/11 at 4:13 PM, revealed he was to ensure the facility staff carried out quality assurance activities per the AoC (daily audits of pain documentation). He was responsible for audits he conducted and he reviewed the DON's audits. He discussed them in their Quality Improvement (QI) meetings on a weekly basis. The Administrator stated the DON made him aware of the issues regarding documentation of follow-up pain assessments and the weekend supervisor failure to complete daily reviews of the pain documentation for the weekend of 06/18-19/11 and 06/25-26/11. The administrator stated, "Each case we followed the steps and completed re-education as we alleged. If we have problem with the audits, then we would come back to the Performance Improvement (PI) team to track and trend. We would have to make adjustments and we may have to adjust who completes the weekend audits".	{F 520}	The Director of Nursing will compare the therapy screens with the 24 hour report weekly for three months and then monthly for three months. The results of the audits will be presented to the Performance Improvement Committee by the Administrator or Director of Nursing. Performance Improvement Meetings were conducted on 06/02/11, 06/09/2011, 06/16/2011, 06/20/2011, 06/21/2011, 06/30/2011, 07/07/2011, 07/15/2011 and 07/20/2011 to identify trends, ensure findings are addressed and systems are in place to prevent recurrence of the event. The Administrator, Director of Nursing or the Assistant Director of Nursing will conduct daily reviews of pain documentation to identify effectiveness of pain interventions each day of the week for the next four weeks. The audits will continue weekly for the next three months and findings reported to the Performance Improvement Committee for further recommendations beginning 6/28/2011. We will continue to have Performance Improvement meetings weekly for the next 2 weeks and monthly thereafter 5. Compliance date	7/01/11	