PRINTED: 02/17/2014
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185342		02/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL HEALTH AND REHABILITATION CENTER	708 BARTLEY AVENUE 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 A standard health survey was conducted on February 11-13, 2014 and Life Safety Code survey on February 11, 2013. The Health survey found the facility met all regulatory requirements with no deficiencies cited. The Life Safety Code survey found the facility did not meet all regulatory requirements with deficiencies cited at highest scope and severity of a "D".	F 000		

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FEB 24 2014
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Northern Enforcement Branch

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 2/21/14

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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED
	185342		02/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL HEALTH AND REHABILITATION CENTER	708 BARTLEY AVENUE BARDSTOWN, KY 40004

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K 000	INITIAL COMMENTS	K 000		
	CFR: 42 CFR 483.70(a) BUILDING: 01 PLAN APPROVAL: 1986 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One (1) story, Type III Protected Construction SMOKE COMPARTMENTS: Six (6) smoke compartments. FIRE ALARM: Complete fire alarm system with heat and smoke detectors. SPRINKLER SYSTEM: Complete automatic dry sprinkler system. GENERATOR: Type II generator. Fuel source is Diesel. A standard Life Safety Code survey was conducted on 02/11/14. Colonial Health and Rehabilitation Center was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)			

FEB 24 2014
Office of Inspector General
Northern Enforcement

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE X TITLE X Administrator (X6) DATE X 2/21/14

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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K 000	Continued From page 1 Deficiencies were cited with the highest deficiency identified at an "D" level.	K 000		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements for Protection of Hazards, in accordance with NFPA standards. The deficiency had the potential to affect two (2) of six (6) smoke compartments, approximately twenty-five (25) residents, staff and visitors. The facility has sixty-five (65) certified beds and the census was sixty-two (62) on the day of the survey. The findings include: Observation, on 02/11/14 at 9:23 AM, with the Maintenance Director revealed the door to the Oxygen Storage Room for full cylinders, did not have a self-closing device installed on the door.	K 029	K29 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. 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. 3. The facility will initiate the following measure to ensure the deficient practice will not recur. • Door closures were installed 02/14/14 on both the O_2 door and the Medical Records door by the Maintenance Director. • Placement and functionality of all door closures will be checked monthly by the maintenance director or maintenance assistant through the facility TELS system, which is a work order computer system, which will be set to prompt the maintenance department to check the door closures monthly for two quarters. • The Safety Committee Calendar will also be revised to include an audit of fire safety/life safety audits including door closures by the Maintenance Director to be completed monthly for two quarters. • The Performance Improvement QA Calendar will be revised to address fire safety/life safety audits including door closures to be performed monthly by the Director of Education for two quarters. • Complete implementation of #3 by 03/03/14. 4. The facility plans to monitor the performance of the solutions for sustainability by the following. • The Administrator will access TELS monthly to ensure this work order is being completed for two quarters.	3/5/14

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	185342		02/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL HEALTH AND REHABILITATION CENTER	708 BARTLEY AVENUE BARDSTOWN, KY 40004

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K 029	Continued From page 2 Interview, on 02/11/14 at 9:23 AM, with the Maintenance Director revealed he was not aware the door to the Oxygen Storage Room for full cylinders, was not equipped with a self-closing device. Observation, on 02/11/14 at 10:28 AM, with the Maintenance Director revealed the door to the Medical Records Room, did not have a self-closing device installed on the door. Interview, on 02/11/14 at 10:28 AM, with the Maintenance Director revealed he was not aware the door to the Medical Records Room was not equipped with a self-closing device. Interview, on 02/11/14 at 2:51 PM, with the Administrator revealed he was not aware the door to the Oxygen Storage Room for full cylinders, was not equipped with a self-closing device and the door to the Medical Records Room was not equipped with a self-closing device. Reference: NFPA 101 (2000 Edition). 19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall	K 029	K29 Continued • The Safety Committee will review the fire safety/life safety audit monthly for two quarters and make recommendations to the Quality Assurance Committee as needed. • The Performance Improvement (PI) Committee will review the PI fire safety/life safety audit performed and make recommendations to QA committee monthly for two quarters as needed. The Quality Assurance Committee will review the submitted reports/audits monthly for two quarters to ensure compliance. Recommendations will be made based on the outcomes of these reports/audits as to needed revisions. 5. Corrective action and regulatory compliance will be achieved by 03/5/14.	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER: COLONIAL HEALTH AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 708 BARTLEY AVENUE, BARDSTOWN, KY 40004

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K 029	Continued From page 3 include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect one (1) of six (6) smoke compartments, approximately twenty (20) residents, staff, and	K 147	K147 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. 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. 3. The facility will initiate the following measure to ensure the deficient practice will not recur.	3/5/14

FEB 21 2014
Office of Inspector General
Northern Enforcement Branch

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

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K 147	Continued From page 4 visitors. The facility has sixty-five (65) certified beds and the census was sixty-two (62) on the day of the survey. The findings include: Observation, on 02/11/14 at 10:31 AM, with the Maintenance Director revealed the hydrocollator (therapy equipment containing hot water) located within the Physical Therapy Room, was plugged into a standard electrical wall outlet instead of a ground fault circuit interrupter (GFCI) outlet as required in wet areas. Interview, on 02/11/14 at 10:31 AM, with the Maintenance Director revealed he was not aware of the hydrocollator being plugged into a standard electrical wall outlet and stated the requirement of medical equipment containing water was to be plugged into a GFCI outlet. The hydrocollator used within the Physical Therapy Room had recently been relocated to accommodate new equipment within the room. Reference: NFPA 99 (1999 edition) 3-3.2.1.2 D Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.	K 147	K147 Continued • The hydroculator was returned to the GFI plug on 02/12/14 by the Rehab Manager. • Placement of the hydroculator will be checked monthly for two quarters by the maintenance director or maintenance assistant through the facility TELS system, which is a work order computer system, which will be set to prompt the maintenance department to ensure that the hydroculator is plugged into a GFI plug. • The Safety Committee Calendar will also be revised to include an audit of fire safety/life safety audits including the hydroculator by the Maintenance Director to be completed monthly for two quarters. • The Performance Improvement QA Calendar will be revised to address fire safety/life safety audits including the hydroculator to be performed monthly for two quarters by the Director of Education. • Complete implementation of #3 by 03/03/14. 4. The facility plans to monitor the performance of the solutions for sustainability by the following. • The Administrator will access TELS monthly for two quarters to ensure this work order is being completed. • The Safety Committee will review the fire safety/life safety audit monthly for two quarters and make recommendations to the Quality Assurance Committee as needed. • The Performance Improvement (PI) Committee will review the PI fire safety/life safety audit performed and make recommendations to QA committee monthly for two quarters as needed. The Quality Assurance Committee will review the submitted reports/audits monthly for two quarters to ensure compliance. Recommendations will be made based on the outcomes of these reports/audits as to needed revisions. 5. Corrective action and regulatory compliance will be achieved by 03/5/14.	

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