

PRINTED: 07/18/2011  
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:  185342	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 07/02/2011
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  COLONIAL HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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)	(X6) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
F 241 SS=D	<p>A Recertification/Abbreviated Survey investigating ARO#KY00016483 was conducted on 06/28/11 through 07/02/11. Deficiencies were cited with the highest scope and severity of an "F". ARO#KY00016483 was substantiated with no deficient practice identified.</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's cleaning assignment sheet it was determined the facility failed to ensure each residents dignity was maintained for six (6) of twenty-one (21) sampled residents, Residents #1, #5, #7, #9, #10, #11 and one unsampled resident, Unsampled Resident B. Observations of skin assessments revealed window blinds were left open while Residents #7 and #9 were exposed. In addition Residents #1, #5, #10, #11 and Unsampled Resident B were noted to have soiled and/or cracked and peeling arm rests on their chairs/wheel chairs.</p> <p>The findings include:</p> <p>Review of the facility's State Registered Nursing Assistant (SRNA) cleaning assignments, not dated, revealed SRNA's must check to be sure their assigned resident's walkers/merry walkers,</p>	F 241	<p>F241 Colonial Health and Rehabilitation Center (CHRC) promotes care for residents in a manner and in an environment that maintains or enhances dignity and respect in full recognition of his or her individuality. Wheelchair, reclining chair, and positioning device repairs for resident 10, 11, and unsampled resident B will be completed by August 5, 2011, pending delivery of parts on order. If the needed parts do not arrive, temporary repairs using vinyl repair tape and sheepskin covers will be made. The facility Maintenance Director completed an inspection of all wheelchairs/reclining chairs on July 27, 2011. Any identified repair needs will be completed, pending parts delivery, by August 5, 2011.</p>	Aug. 6, 2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>New Feet</i>	TITLE Administrator	(X8) DATE 8-12-11
--	------------------------	----------------------

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 discloseable 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 discloseable 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.

PRINTED: 07/18/2011  
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:  185342	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 07/02/2011
---	---	--	--

NAME OF PROVIDER OR SUPPLIER  COLONIAL HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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 241	<p>Continued From page 1</p> <p>wheel chairs/Geri chairs and feeding tube poles are clean at the end of the third shift each night.</p> <p>1. Observation on 06/29/11 at 2:35 PM revealed Resident #11's high back wheel chair had cracks in the plastic covering, the back of the wheel chair in which the resident's back came in contact when seated in the chair. Further observation revealed the positioning device in the wheel chair also had a plastic covering which was cracked.</p> <p>Observation on 06/30/11 at 4:45 PM revealed Resident #11's reclining chair in his/her room had an area in the plastic which was cracked where the resident's head would make contact with the back of the recliner.</p> <p>Interview with Resident #11 on 06/29/11 at 2:35 PM revealed the cracks in the plastic did scratch his/her skin at times.</p> <p>2. Observation on 06/29/11 at 2:45 PM revealed Unsampled Resident B's wheel chair had cracked plastic on both arm rests of the wheel chair.</p> <p>3. Observation on 07/01/11 at 9:30 AM revealed Resident #10's wheel chair arm rest was cracked and peeling.</p> <p>Interview with the Maintenance Director on 07/01/11 at 10:00 AM revealed he relied on the Nursing staff to let them know when wheel chairs were broken or in need of repair. He further stated Nursing staff would fill out a form titled "Work Order Summary Log", which he reviewed every morning for new items which were in need of repair. He further stated all wheel chairs were checked each month on a schedule he described</p>	F 241	<p>F241 (continued)</p> <p>The facility restorative nurse completed an inspection of all other positioning devices on July 25, 2011. Repair or replacement of these will be completed, pending delivery, by August 5, 2011. On July 22, 2011, the DON provided a written reminder to the nursing staff of their responsibility to report items in need of repair to maintenance. The frequency for wheel-chair/reclining chair checks performed as part of the facility preventive maintenance program has been increased to twice a month to ensure timely repairs are made.</p> <p>The wheelchairs for residents 1 and 5 were cleaned on July 12th and weekly thereafter. On July 27, 2011, the facility ADON convened a group of CNAs to identify which residents had care needs that would result in their wheelchairs needing more frequent cleaning. The wheelchair cleaning schedule was amended to increase the frequency of cleaning for these residents. All resident wheelchairs have been cleaned according to the new schedule. The maintenance director will, following his twice monthly wheelchair/reclining chair checks, report to the ADON any instance where the cleaning schedule appears inadequate.</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 07/18/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186342	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 07/02/2011
---	---	--	--

NAME OF PROVIDER OR SUPPLIER  COLONIAL HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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 241	<p>Continued From page 2</p> <p>as during the first week of each month wheel chairs and any other items in resident rooms one (1) through eleven (11) were checked for any repairs which might be needed and the next week rooms twelve (12) through twenty-four (24) would be checked. Interview further revealed this cycle continued until all rooms were checked for the month. He indicated the wheel chairs needed to be repaired.</p> <p>4. Observation on 07/01/11 at 9:30 AM revealed Resident #1 had substances which were yellow and brown in color, and dried and crumbs in his/her wheel chair seat.</p> <p>5. Observation on 07/01/11 at 9:45 AM revealed Resident #5 had substances which were white and yellow in color and crumbs in his/her wheel chair seat.</p> <p>Interview with the Director of Nursing (DON) on 07/01/11 at 9:50 AM revealed wheel chairs were cleaned on night shift by the SRNAS.</p> <p>Interview with the Maintenance Director on 07/01/11 at 10:00 AM revealed the wheel chairs were dirty. He further stated the SRNAs cleaned the wheel chairs at nights and he believed there was a schedule for the nights when particular chairs were cleaned. He further indicated if he was working on a chair and noticed it was dirty he would clean the chair.</p> <p>6. Clinical Record review revealed Resident #9 was admitted on 04/22/11 with diagnoses which included Chronic Obstructive Pulmonary Disease and Renal Failure.</p>	F 241	<p>F241 (continued)</p> <p>The nurse who failed to close the window blinds prior to performing skin assessments for resident 7 and 9 is now aware of the need to do so. On July 22, 2011, the Director of Nursing instructed all the nursing staff, via written communication, that to ensure visual privacy the window blinds needed to be closed during personal care. In addition, this need will be discussed during a review of resident rights that is part of new hire orientation to ensure new employees are aware of this requirement.</p> <p>The facility's Director of Social Services will monitor facility compliance with this requirement through resident interviews, random observation of staff/resident interactions, environmental inspection, reviews of resident council minutes and resident/family grievances. This will be done twice a month for the next two quarters. A report of these findings will be presented to the QA committee so that compliance or need for additional system modification may be determined.</p>	

PRINTED: 07/18/2011  
FORM APPROVED  
OMB NO. 0938-0391DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185342	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 07/02/2011
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  COLONIAL HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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 241	Continued From page 3 During an observed skin assessment by RN #4 on 06/29/11 at 3:05 PM, the nurse assisted Resident #9 to remove his/her pants while standing in front of an uncovered window. The nurse closed the blinds only after surveyor intervention.  7. Review of the Clinical Record revealed Resident #7 was admitted on 02/19/09 with diagnoses which included Alzheimer's Disease.  On 06/29/11 at 3:30 PM, Registered Nurse (RN) #4 was observed to perform a head-to-toe skin assessment on Resident #7. The nurse assisted the resident, who was standing at the bedside next to the window, to remove his/her pants. The nurse failed to close the window blinds prior to surveyor intervention.  Interview with RN #4 on 06/29/11 at 3:45 PM revealed she had not worked at the facility more than a few days and was not used to the routines yet. She acknowledged the windows should be covered during personal care to protect the residents' privacy.	F 241		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending	F 280	F280 CHRC utilizes an interdisciplinary team, including the attending physician, resident and resident's family or legal representative to develop comprehensive care plans within 7 days after completion of the comprehensive assessment. The care plan is periodically reviewed and revised by a team of qualified persons after each assessment. On July 22, 2011, the care plans for residents 1, 3, and 12 were reviewed and revised as needed.	August 13, 2011

PRINTED: 07/18/2011  
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:  185342	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 07/02/2011
---	---	--	--

NAME OF PROVIDER OR SUPPLIER  COLONIAL HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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 280	<p>Continued From page 4</p> <p>physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy it was determined the facility failed to ensure Care Plans were revised as indicated by the assessment for four (4) of nineteen (19) sampled residents. (Residents #1, #3, #9, and #12). The facility failed to ensure written Physician's Orders were updated on each of the identified sampled residents' Comprehensive Care Plans.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Nursing Care Plan Policy and Procedure", (no date), revealed changes in physical or mental condition should be added to the Care Plan in order to keep it current and up to date and procedures directly ordered by the physician will be recorded and the Care Plan will be kept current. Continued review revealed "the nursing care plan acts as a communication instrument to all caregivers".</p> <p>1. Review of Resident #9's medical record revealed the facility admitted the resident on</p>	F 280	<p>F280 (continued)</p> <p>Resident 9 has been discharged to home. By August 5, 2011, the Director of Nursing will review, and revise if necessary, the care plans for all residents who have used alarms in the past 6 months. On July 26, 2011 the Dietary manager completed a review of each resident's diet order and care plan to ensure they matched. By August 12, 2011, the DON, ADON, MDS Coordinators, and Charge nurse will complete a review of all resident care plans to ensure they have been revised as indicated by the assessment and that physician order changes have been updated on the plans.</p> <p>The ADON will review the facility's "Nursing Care Plan Policy and Procedure" with the nursing staff on August 5, 2011. This training will clarify who has responsibility for daily review of orders and updating of care plans. The Director of Nursing will audit 10 care plans a month, for the next two quarters, to ensure care plan revisions are being made timely. A report of these audits will be presented to the QA committee so that compliance or need for additional systemic change may be determined.</p>	

PRINTED: 07/18/2011  
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:  185342	(X2) MULTIPLE CONSTRUCTION, A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 07/02/2011
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  COLONIAL HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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 280	<p>Continued From page 5</p> <p>04/22/11 with diagnosis which included Pneumonia, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease (COPD), and Renal Failure.</p> <p>Record review of Resident #9 Physician's Orders revealed an order to discontinue the bed alarm and Aloe Vesta barrier ointment on 06/10/11. Record review of Resident #9 Care Plan dated 04/22/11 revealed no evidence the Care Plan was revised to discontinue the bed alarm and Aloe Vesta barrier ointment.</p> <p>Interview with Licensed Practical Nurse (LPN) #7 on 06/29/11 at 10:45 AM revealed it was the nurses job to update the care plans every Friday with all new orders. LPN #7 stated when a new order was written, the unit nurse was to take the order off and then update the Care Plan. Also every Friday the nurse was to review and update all residents' Care Plans on the unit they were working.</p> <p>Interview with the Director of Nursing (DON) on 06/29/11 at 11:00 AM revealed the order written 06/10/11 for Resident #9 for the bed alarm and Aloe Vesta to be discontinued should have been updated on the Care Plan at the time the order was taken off and noted by the nurse.</p> <p>2. Review of the Clinical record revealed the facility admitted Resident #3 on 02/20/07 with diagnoses which included Dementia, Anxiety and Depression.</p> <p>Review of the Physician's Orders, signed 08/02/11, revealed no order for a bed or wheelchair alarm.</p>	F 280		

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

PRINTED: 07/18/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186342	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 07/02/2011
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  COLONIAL HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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 280	<p>Continued From page 6</p> <p>Review of the Comprehensive Care Plan revealed it was initiated on 08/02/09, updated on 08/17/10, and was reviewed quarterly. Continued review revealed the resident was considered to be at risk for falls. Current interventions, active until 08/25/11, included instructions for alarms to the bed and wheelchair.</p> <p>Observation during the initial facility tour on 08/28/11 at 10:25 AM revealed Resident #3 was lying in bed. No bed alarm was noted. Further observation revealed the resident's wheelchair did not have an alarm. On 08/28/11 at 3:05 PM the resident was observed in the wheelchair in the dayroom. Continued observation revealed no alarm present on the wheelchair.</p> <p>Interview with the DON on 07/01/11 at 4:45 PM revealed the resident was reassessed by nursing on 05/08/11 regarding urinary continence and the need for assistance. Continued interview and review of the Clinical Record revealed Resident #3 was also evaluated by Physical Therapy and an order was received to discontinue the alarms. The DON stated she personally removed the alarms and was responsible for updating the Care Plan but failed to do so.</p> <p>3. Review of Resident #1's medical record revealed the resident was admitted to the facility on 04/01/07 with diagnoses which included CVA, Dementia, and Reflux. Review of the Annual Minimum Data Set (MDS) Assessment dated 10/15/10 revealed the resident required a Mechanical Altered Diet. Review of the resident Care Plan dated 10/14/10 included interventions for a mechanically altered diet due to chewing</p>	F 280		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 07/18/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185342	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 07/02/2011
NAME OF PROVIDER OR SUPPLIER  COLONIAL HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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)	(X6) COMPLETION DATE	
F 280	<p>Continued From page 7</p> <p>problems. One of the interventions under this specific plan of care was for the resident to have a "Regular/Mechanical soft with ground meats".</p> <p>Review of the Physician's Orders revealed on 05/29/11 an order was written for Speech Therapy to evaluate and treat for diagnosis of Dysphagia. A Physician's Order on 05/31/11 called for a dietary change to Puree Diet (foods pureed to be smooth in consistency) with Nectar Thickened Liquids.</p> <p>Observation of Resident #1 in the dining room on 06/29/11 at 5:45 PM revealed their meal ticket identified the diet as Puree and the food appeared to be of puree consistency.</p> <p>Further review of the Comprehensive Care Plan revealed no evidence the facility had revised the plan of care to include the Pureed Diet with nectar Thickened Liquids.</p> <p>Interview with the DON on 07/01/11 at 10:40 AM regarding Care Plans revealed the facility should update the Care Plan when a new Physician's Order was written.</p> <p>4. Review of Resident #12's medical record revealed the resident was admitted to the facility on 01/03/04 with diagnoses which included Alzheimer's, Depression, and Weakness. The Care Plan dated 11/19/10 identified as a problem: the resident leaves 25% or more of food uneaten at most meals. One intervention was for the resident to get 60 cc Med Pass (nutritional supplement) twice daily. Review of the current Physician's Orders for the 60 day period of May 2011 thru June 2011 revealed no Physician's</p>	F 280			

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

PRINTED: 07/18/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185342	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 07/02/2011
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  COLONIAL HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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 280	Continued From page 8 Order for the Med Pass. Review of the resident's June 2011 Medication Administration Record (MAR) revealed no evidence of Med Pass being administered to Resident #12.  Interview with the Director of Nursing (DON) on 07/01/11 at 10:40 AM regarding the discrepancy between the Care Plan Intervention for Med Pass and the current Physician's Orders not showing an order for the Med Pass revealed she thought the Med Pass supplement had been discontinued by the Physician. The DON provided a copy of a physician order dated 11/18/10, for Resident #12, to discontinue the Med pass due to weight gain and good nutritional intake. The DON said the Care Plan should have been updated to indicate the Med Pass had been discontinued on 11/18/10. She further stated the Care Plan needed to be updated when a Physician's Order changed the plan of care for a resident.	F 280		
F 311 SS=E	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS  A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.  This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure residents received restorative services per the Restorative Program based on the residents assessment. Record review revealed the facility failed to provided Restorative Services as ordered for twelve (12) of nineteen (19) sampled residents, Residents #1, 2, 4, 5, 7, 8, 10, 11, 12, 13, 14, and	F 311	F311 CHRC provides its residents with appropriate treatment and services to maintain or improve his or her abilities in activities of daily living. On July 21, 2011, the MDS Coordinator, restorative nurse and restorative aides, with consultation from the therapy department, reevaluated, and updated as appropriate, the restorative plans for residents 1,2,4,5,7,8,10,11,12,13,14, and 17. No decline in functions was identified for these residents. Restorative plan reviews for all other residents receiving restorative services were completed on August 5, 2011. No decline in function was identified for these residents. The remaining residents not receiving restorative services have no limits in their functional ability and they are currently able to maintain this ability independently. Functional status for all residents will continue to be assessed in accordance with the RAI requirements.	Aug 6, 2011

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

PRINTED: 07/18/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  165342	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 07/02/2011
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  COLONIAL HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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)	(X6) COMPLETION DATE
F 311	<p>Continued From page 9 17.</p> <p>The findings include:</p> <p>1. Medical record review revealed the facility admitted Resident #1 on 04/01/07 with diagnoses which included Dementia Alzheimer's, Cerebrovascular Accident (CVA), Osteoarthritis, and Osteoporosis. Review of the resident's medical record revealed the resident had a restorative plan of care for splinting devices, date 03/15/11, and for Passive Range of Motion (PROM), date 12/12/07. Review of the restorative care plan revealed the splinting devices were to be applied bilaterally to the ankles/feet, between knees, and left hand for four (4) hours twice daily. Further review of the restorative care plan revealed the resident was also to receive passive range of motion bilaterally to their upper and lower extremities for fifteen (15) minutes a day seven days a week.</p> <p>Review of Resident #1's Restorative Treatment Grid for April 2011 revealed the splinting devices were not applied and PROM not done for five (5) of the thirty (30) days in April. There was no documentation showing why the resident did not get treatment on those days.</p> <p>Review of Resident #1's Restorative Treatment Grid for May 2011 revealed the splinting devices were not applied for five (5) of the thirty-one (31) days in May and PROM was not done for four (4) of the thirty-one (31) days in May. There was no documentation showing why the resident did not get treatment on those days.</p> <p>Review of Resident #1's Restorative Treatment</p>	F 311	<p>F 311 (continued)</p> <p>To ensure restorative services are being provided as planned, 5 additional CNAs have been hired to reduce the need to divert a restorative aide to direct care duties. By August 5, 2011, the floor staff CNAs will be trained by the restorative nurse to provide the functional maintenance components of the restorative program. This will build reserve capacity for the provision of restorative services to ensure they are offered as planned. For each of the next 4 weeks, the DON or ADON will audit the restorative treatment grids to verify restorative plans are being followed. These audits will continue monthly for the following 5 months to ensure these systematic changes will be effective. A report of these audits will be presented to the QA committee so that compliance or need for additional systemic change may be determined.</p>	

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

PRINTED: 07/18/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185342	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 07/02/2011
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  COLONIAL HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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)	(X6) COMPLETION DATE
F 311	<p>Continued From page 10</p> <p>Grid for June 2011 revealed the splinting devices were not applied for three (3) of the thirty (30) days in June and PROM was not done for three (3) of the thirty (30) days in June. There was no documentation showing why the resident did not get treatment on those days.</p> <p>2. Record review revealed the facility admitted Resident #4 on 05/24/07 with diagnoses which included Muscle Disorders, Senile Dementia, Failure to Thrive, Bilateral Above the Knee Amputation, and Diabetes Mellitus. Review of the resident's medical record revealed the resident had a restorative plan of care (updated 03/15/11) for PROM to both the lower and upper extremities for fifteen (15) minutes a day, seven (7) days a week.</p> <p>Review of Resident #4's Restorative Treatment Grid for April 2011 revealed the resident did not get PROM done for eight (8) of the thirty (30) days in April. There was no documentation showing why the resident did not get treatment on those days.</p> <p>Review of Resident #4's Restorative Treatment Grid for May 2011 revealed the resident did not get PROM done for seven (7) of the thrifty-one (31) days in May. There was no documentation showing why the resident did not get treatment on those days. In addition; on two (2) of the days the resident did get PROM it was not for the full fifteen (15) minutes as care planned but the PROM was for only seven (7) minutes. There was no documentation as to why the resident did not receive the full fifteen (15) minutes.</p>	F 311		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  165342	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 07/02/2011
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  COLONIAL HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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 311	<p>Continued From page 11</p> <p>Review of Resident #4's Restorative Treatment Grid for June 2011 showed that the resident did not get PROM done for eight (8) of the thirty (30) days in June. There was no documentation showing why the resident did not get treatment on those days.</p> <p>3. Record review revealed Resident #7 was admitted to the facility on 02/19/09 with diagnoses which included Muscle Weakness, Difficulty Walking, and Alzheimer's. Review of the resident's medical record revealed the resident had a restorative plan of care (04/08/11) that included a restorative program for Active Range of Motion (AROM) to the upper extremities six (6) days a week and a restorative program to ambulate the resident six (6) days a week for one-hundred (100) to four-hundred (400) feet with a rolling walker and gait belt.</p> <p>Review of Resident #7's Restorative Treatment Grid for April 2011 revealed the week of April 24 th through April 30th the resident did not receive AROM and ambulation for two (2) days as per the restorative plan of care. There was no documentation showing why the resident did not get treatment on those days.</p> <p>4. Record review revealed the facility admitted Resident #12 on 01/13/04 with diagnoses of Alzheimer's, Osteoporosis, and Weakness. Review of Resident #12's medical record revealed the resident had a restorative plan of care that included a restorative program for Assisted Active Range of Motion (AAROM) to the upper and lower extremities for fifteen (15) minutes a day, seven (7) days a week.</p>	F 311		

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

PRINTED: 07/18/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185342	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 07/02/2011
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  COLONIAL HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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 311	<p>Continued From page 12</p> <p>Review of Resident #12's Restorative Treatment Grid for April 2011 revealed the resident did not get AAROM for seven (7) of the thirty (30) days in April. There was no documentation showing why the resident did not get treatment on those days. In addition, on 04/05/11 the resident only received five (5) minutes of AAROM and on 04/17/11 the resident only received eight (8) minutes of AAROM and not the full fifteen (15) minutes that was care planned. Record review revealed no documentation showing why the resident did not get the full fifteen (15) minutes of treatment on this day.</p> <p>Review of Resident #12's Restorative Treatment Grid for May 2011 revealed the resident did not get AAROM for seven (7) of the thirty-one (31) days in May. Record revealed no documentation why the resident did not get treatment on those days.</p> <p>Review of Resident #12's Restorative Treatment Grid for June 2011 revealed the resident did not get AAROM for nine (9) of the thirty (30) days in June. There was no documentation showing why the resident did not get treatment on those days.</p> <p>5. Review of Resident #14 closed medical record revealed the facility admitted the resident on 06/09/08 with diagnoses which included Cardiovascular Heart Disease, Cerebrovascular Accident (CVA), and Progressive Dementia. Review of Resident #14's medical record revealed a restorative plan of care that included Passive Range of Motion to extremities seven (7) days a week for fifteen (15) minutes each day.</p>	F 311		
-------	--	-------	--	--

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

PRINTED: 07/18/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185342	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 07/02/2011
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  COLONIAL HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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 311	<p>Continued From page 13</p> <p>Review of Resident #14's Restorative Treatment Grid for May 2011 revealed the resident did not get PROM done on two (2) of the thirty-one (31) days in May.</p> <p>6. Record review revealed the facility admitted Resident #11 on 04/24/04 with diagnoses which included Cerebral Palsy, Joint Contractures, Muscular Atrophy, Quadriplegia and Diaphragmatic Hernia.</p> <p>Review of Resident #11's Restorative Treatment Grid for the month of April 2011 revealed the resident was to receive PROM to the bilateral extremities for at least fifteen (15) minutes a day for seven (7) days a week. Further review revealed the resident missed a total of four (4) days of PROM.</p> <p>Review of Resident #11's Restorative Treatment Grid for the month of June 2011 revealed the resident missed two (2) days of PROM. Further review revealed the resident only received eight (8) minutes of PROM on 06/11/11 and seven (7) minutes on 06/18/11. There was no documentation to explain why the resident missed the PROM.</p> <p>7. Record review revealed the facility admitted Resident #8 on 09/02/03 with diagnoses which included impaired renal function, Hypothyroidism, Hypercalcemia, Metabolic Cardiomyopathy and Alzheimer's Dementia.</p> <p>Review of Resident #8's Restorative Treatment Grid for the month of May revealed the resident was to receive PROM to the bilateral extremities for at least fifteen (15) minutes a day for seven</p>	F 311		
-------	---	-------	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185342	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 07/02/2011
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  COLONIAL HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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 311	<p>Continued From page 14</p> <p>(7) days a week. Further review revealed the resident missed four (4) days of PROM in the month of May.</p> <p>Review of Resident #8's Restorative Treatment Grid for the month of June revealed the resident missed four (4) days of PROM. Continued review revealed the resident only received seven (7) minutes of PROM on 06/20/11.</p> <p>8. Record review revealed the facility admitted Resident #17 on 12/19/07 with diagnoses which included Type two (2) Diabetes Mellitus, Fracture of the neck of the femur, Senile Dementia and Degenerative Joint Disease.</p> <p>Review of Resident #17's Restorative Treatment Grid for the month of June revealed the resident was to receive PROM to the bilateral extremities for at least fifteen (15) minutes a day for six (6) days a week. Further review revealed the resident missed three (3) days of PROM. Continued review revealed the resident received only seven (7) minutes on 06/03/11, 06/19/11 and 06/24/11. Continued review revealed the resident received only eight (8) minutes on 06/01/11, 06/22/11, and received only ten (10) minutes on 06/02/11.</p> <p>9. Review of the Clinical Record revealed the facility admitted Resident #10 on 01/06/11 with diagnoses which included Dementia, Hypertension, Asthma and Depression.</p> <p>Review of the Restorative Plan of Care updated on 03/11/11 revealed Resident #10 was to receive restorative services to include passive range of motion to the bilateral upper and lower</p>	F 311		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185342	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 07/02/2011
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  COLONIAL HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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 311	<p>Continued From page 15 extremities, fifteen (15) minutes per day, seven (7) days per week.</p> <p>Review of the Restorative Treatment Grid for April 2011 revealed Resident #10 did not receive restorative services five (5) days. Continued review the resident received only seven (7) minutes of therapy on two (2) days.</p> <p>Review of the Restorative Treatment grid for May 2011 revealed Resident #10 missed six (6) days of treatment during the month.</p> <p>10. Clinical Record review revealed Resident #5 was admitted to the facility on 06/21/04 with diagnoses which included Multiple Sclerosis and multiple Contractures.</p> <p>Review of the Restorative Plan of Care updated on 03/11/11 revealed Resident #5 was to receive passive range of motion to the bilateral upper and lower extremities fifteen (15) minutes per day, seven (7) days per week.</p> <p>Review of the Restorative Treatment Grids for the months of April, May and June 2011 revealed Resident #5 did not receive restorative services on nine (9) days during April. Continued review revealed the resident missed six (6) days in May and three (3) days in June. There was no documentation as to why the restorative services were not completed on the missed days.</p> <p>11. Record Review of Resident #13 Medical Chart revealed the facility admitted the resident on 07/12/04 with a diagnosis which included dDspasia, Closed Head Injury, Pain, Anxiety, and Depression. Record review of the resident's</p>	F 311		
-------	--	-------	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186342	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 07/02/2011
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  COLONIAL HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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 311	<p>Continued From page 16</p> <p>medical record revealed the resident had a restorative plan of care for bilateral (both sides of the body), upper and lower active range of motion seven (7) days a week for at least fifteen (15) minutes.</p> <p>Review of Resident #13 Restorative Treatment Grid for the month of April 2011 revealed the resident did not receive Restorative Therapy for eight (8) of the thirty (30) days for the month of April per resident's restorative plan of care. Further review of the resident's Restorative Grid revealed no documentation showing why the resident did not receive treatment on those days.</p> <p>Review of Resident #13 Restorative Treatment Grid for the month of May 2011 revealed the resident did not receive Restorative Therapy for eight (8) of the thirty one (31) days for the month of May per resident's restorative plan of care. Further review of the resident's Restorative Grid revealed no documentation showing why the resident did not receive treatment on those days.</p> <p>Review of Resident #13 Restorative Treatment Grid for the month of June 2011 revealed Resident #13 did not receive Restorative Therapy eleven (11) of the thirty (30) days restorative treatment should have been done for the month of June per resident's restorative plan of care. Further review of the resident's Restorative Grid revealed no documentation showing why the resident did not receive treatment on those days.</p> <p>12. Record Review revealed the facility admitted Resident #2 on 01/18/2000 with diagnosis which included Anemia, Hypertension (high blood pressure), Diabetes type two (2), Alzheimer's,</p>	F 311		

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

PRINTED: 07/18/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185342	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 07/02/2011
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  COLONIAL HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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 311	<p>Continued From page 17</p> <p>Depression, and COPD (Chronic Obstructive Pulmonary Disorder). Record review revealed the resident had a restorative plan of care for bilateral (both sides of the body), upper and lower active range of motion (AROM) six (6) days a week for at least fifteen (15) minutes. Further record review of the resident's medical record revealed the resident had a restorative plan of care for bilateral (both sides of the body), upper and lower active range of motion (AROM) Restorative Therapy six (6) days a week for at least fifteen (15) minutes.</p> <p>Review of Resident #2 Restorative Treatment Grid for the month of April 2011 revealed the resident did not receive Restorative Therapy for three (3) of the twenty two (22) days for the month of April per resident's restorative plan of care. Further review of the resident's Restorative Grid revealed no documentation showing why the resident did not receive treatment on those days.</p> <p>Review of Resident #2 Restorative Treatment Grid for the month of May 2011 revealed the resident did not receive Restorative Therapy for four (4) of the fourteen (14) days for the month of May per the resident's restorative plan of care. Further review of the resident's Restorative Grid revealed no documentation showing why the resident did not receive treatment on those days.</p> <p>Review of Resident #2 Restorative Treatment Grid for the month of June 2011 revealed Resident #2 did not receive Restorative Therapy seven (7) of the twenty six (26) days restorative treatment should have been done for the month of June per resident's restorative plan of care. Further review of the resident's Restorative Grid</p>	F 311		

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

PRINTED: 07/18/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186342	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 07/02/2011
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  COLONIAL HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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 311	<p>Continued From page 18</p> <p>revealed no documentation showing why the resident did not receive treatment on those days.</p> <p>Interview with Restorative Aid/State Registered Nursing Assistant(RA/SRNA) #4 on 06/29/11 at 3:55 PM revealed when the floor SRNA's were short, they would pull a RA/SRNA to work the floor leaving the RA/SRNA's working with only two (2) and they were unable to get to all of the resident's on the Restorative Program. Further interview with RA/SRNA #4 revealed that when they were working with only two (2) RA/SRNA's they were to make the residents that missed Restorative Therapy the day before a priority.</p> <p>Interview with Restorative Aide (RA)/State Registered Nursing Assistant (SRNA)# 5 on 07/01/11 at 10:00 AM revealed when there are only two (2) RA/SRNA's they can't get to all the residents scheduled for Restorative Therapy and have to focus on the priority resident's and the Restorative Nurse instructed the RA/SRNA's to at least try to get some time in with those residents since they were not able to get the full fifteen (15) minutes in.</p> <p>Interview with Assistant Director of Nursing (ADON) on 01/01/11 at 3:20 PM revealed when the floor SRNA's are short they pull from the RA/SRNA's when they have three (3) to cover the floor. Interview with ADON further revealed that she knew this left the RA/SRNA's short but the floor has to be covered.</p> <p>Interview with Restorative Nurse on 07/01/11 at 3:30 PM revealed she was aware that there were times when there were only two (2) RA/SRNA's and residents on the Restorative Program were</p>	F 311		
-------	---	-------	--	--

PRINTED: 07/18/2011  
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:  185342	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 07/02/2011
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  COLONIAL HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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 311	Continued From page 19 not getting their Restorative therapy. Interview with Restorative Nurse further revealed she had instructed the RA/SRNA's to try to get some Restorative Therapy in with the residents if unable to get the full fifteen minutes (15) and if the resident was missed the day before to make them a priority the next day and try to get them the next day.	F 311		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  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.  This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure the residents' environment was as free from accident hazards as is possible related to an unlocked door to a room directly across the hall from the dish room which contained two hot water heaters with exposed pipes which were too hot to hold onto.  The findings include:  Observations on 06/29/11 at 11:08 AM, 06/29/11 at 12:30 PM, 06/29/11 at 3:30 PM, 06/29/11 at 4:30 PM, 06/30/11 at 8:40 AM, 06/30/11 at 11:00 AM, 06/30/11 at 3:00 PM, 06/30/11 at 5:15 PM and 07/01/11 at 10:05 AM, revealed the room	F 323	F323 CHRC ensures that the resident environment remains as free of accident hazards as is possible. On July 21, 2011, a new lockset was installed on the door to the room containing the water heaters. On July 14, 2011, the facility's Regional Maintenance Director assisted the facility Maintenance Director and Administrator in identifying any other potentially hazardous areas requiring new locksets. Installation of the new locks was completed August 4, 2011. During his visit on July 14, 2011, the Regional Maintenance Director toured the building and reviewed the facility's preventive maintenance logs and documentation to ensure the resident environment is being adequately maintained to keep the resident environment as free from accident hazards as is possible. No additional issues were identified. On July 26, 2011, the facility Administrator provided written communication to all staff regarding the purpose of the new locksets and need to restrict resident access to hazardous areas.	Aug 5, 2011

PRINTED: 07/18/2011

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

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185342	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 07/02/2011
---	---	--	--

NAME OF PROVIDER OR SUPPLIER  COLONIAL HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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 323	Continued From page 20 across the hall from the dish washer room, which contained two (2) hot water heaters with hot pipes exposed, was open and pipes were too hot to hold onto.  Interview with the Maintenance Director on 07/01/11 at 10:05 AM revealed the doors had been locked using a sliding bolt lock. He further stated per Life Safety Code these were inappropriate to use and the facility was going to have to replace the locks with a different type of lock. He further indicated the pipes did get really hot.	F 323	F323 (continued)  To verify the locksets remain functional, monthly checks will be added to preventive maintenance program. In addition to its monthly review of facility environmental audits, the facility safety committee will review the effectiveness of the locks in preventing unauthorized access to hazardous areas. Identified problems will be referred to the QA committee for resolution.	
F 366 88=D	483.35(d)(4) SUBSTITUTES OF SIMILAR NUTRITIVE VALUE  Each resident receives and the facility provides substitutes offered of similar nutritive value to residents who refuse food served.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure food substitutes of similar nutritive value were offered to residents who refused food served. In addition, residents' food preferences were not honored consistently.  The findings include:  Review of the policy titled Meal Service-Individualized Substitutions (no date) revealed the following: "The Food Service department strives to meet the preferences of residents"; and "Residents are offered substitutions from alternates listed on the menu	F 366	F366 CHRC honors resident food preferences. For those resident who refuse the food served, substitutes of similar nutritive value are provided. On July 25, 2011, the dietary manager confirmed the food preferences and accuracy of tray card instructions for unsampled residents G, C, D, E, and F. By August 10, 2011, the Dietary Manager will confirm the food preferences and tray card accuracy for all other residents. On July 27, 2011, the Dietary Manager met with all dietary staff to review the procedure for reading tray cards and tray service procedures. The facility policies for meal service related to individualized substitutions and substitutions of equal nutritional value were also reviewed.	August 13, 2011

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 07/18/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185342	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 07/02/2011
NAME OF PROVIDER OR SUPPLIER  COLONIAL HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 366	<p>Continued From page 21 or through special request." Continued review revealed vegetables could be substituted with any other vegetable.</p> <p>Observation of the noon meal on 06/28/11 at 11:40 AM revealed the following: Unsampied Resident G was not served yogurt, although the tray ticket instructed "yogurt at lunch and supper"; Unsampied Resident C was not served Magic Cup, although the tray ticket indicated it should have been served; Unsampied Resident D was served beans, while the tray ticket indicated the resident disliked all beans; and Unsampied Resident E did not receive coffee although the tray ticket included instructions for coffee at all meals.</p> <p>Observation of the evening meal on 06/29/11 at 6:15 PM revealed Unsampied Resident E again did not receive coffee, in spite of tray ticket instructions for "coffee at all meals". In addition, Unsampied Resident F was served carrots. Review of the tray ticket revealed carrots were listed as a "dislike".</p> <p>Interview with State Registered Nursing Assistant (SRNA) #11 on 06/29/11 at 6:15 PM revealed she overlooked the instructions. She stated Unsampied Resident F did not eat any of the carrots, but the aide did not call for a substitute vegetable. Interview with SRNA #2 on 06/29/11 at 6:20 PM revealed kitchen staff should check the tray tickets before the food was sent out. She further stated staff in the dining room should double-check the trays for accuracy and request substitutes as indicated.</p> <p>Interview with the Dietary Manager on 07/01/11 at</p>	F 366	<p>F366(continued)</p> <p>With the exception of tray service procedures, the dietary manager will provide the same information for the nurses and CNAs who assist with meal service on July 29, 2011. ON August 12, 2011, the inservice modules used at this meeting were distributed to the nurses and CNAs who were unable to attend this meeting. This was done to educate the nursing staff on their role in verifying tray accuracy at the point of service as well as their responsibility to inform the kitchen staff when a substitute is needed. The Dietary Manager, or charge nurse as needed, will monitor tray accuracy, preference honoring, and adequacy of substitutions being offered by performing point of service tray audits rather than test trays. These audits will be done weekly, for four weeks and then monthly, thereafter and will include all meals, including weekends. The results of these audits will be presented to the QA committee so that compliance or need for further education, system modification, or staff change may be determined.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 07/18/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185342	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 07/02/2011
NAME OF PROVIDER OR SUPPLIER  COLONIAL HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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)	(X6) COMPLETION DATE
F 366	Continued From page 22 7:05 PM revealed the kitchen provided the drinks, while staff in the dining room served the drinks from a cart, according to the tray ticket. She stated the yogurt for Unsampld Resident G and the Magic Cup for Unsampld Resident C should have been placed on their trays in the kitchen. Continued interview revealed Unsampld Resident F should not have received carrots and should have been offered an alternate vegetable of similar nutritive value.	F 366		
F 371 SS=F	483.35(l) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy it was determined the facility failed to store, distribute and serve food under sanitary conditions. Observations revealed dented cans stored with non-dented cans, undated food items stored in dry storage, meat slicer stored dirty, noney cup stored wet, same scoop used for different meats and improper changing of gloves and washing of hands.  The findings include:	F 371	F371  CHRC stores, prepares, distributes, and serves food under sanitary conditions. The facility has had no food related outbreaks of gastrointestinal illness nor has any resident been diagnosed with a food borne related illness. All items referenced with this citation that were lacking a date, out of date, or not stored in a proper container have been discarded. The dented cans have been removed and placed in the return to vendor location. The meat slicer has been cleaned and is being maintained in a ready to use condition. The facility's consultant dietician will provide in-service education for the dietary manager and all dietary staff on July 29, 2011. The training topics included review of the dietary sanitation policies, (which includes meat slicer cleaning), hand washing policy, food storage policy, dented can policy, ware washing policy, and kitchen cleaning schedule. For the next four weeks and then monthly thereafter the dietary manager will conduct weekly kitchen inspections, focusing on the areas cited with this deficiency, to ensure deficient practice does not occur.	July 30, 2011

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 07/18/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186342	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 07/02/2011
NAME OF PROVIDER OR SUPPLIER  COLONIAL HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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)	(X6) COMPLETION DATE	
F 371	Continued From page 23  Review of the facility's policy titled "Dry Food Storage", dated 2006, revealed all dry food in storage is clearly labeled and dated. It further indicated all products, previously opened, are labeled and dated.  Review of the facility's policy titled "Dented Cans/Damaged Goods", dated 2006, revealed dented cans and damaged goods are placed in a designated area and clearly marked, such as "For Pick-Up - Damaged Goods - "Do Not Use".  Review of the facility's policy titled "Ware washing-Commercial Dish machine", dated 2006, revealed clean dry dishes are stacked in designated storage areas.  Review of the facility's policy titled "Cleaning of the Meat Slicer/Food Chopper", dated 2006, revealed the meat slicer/food chopper is cleaned and sanitized after each use.  Observation on 06/29/11 at 10:07 AM revealed flour stored in a plastic tub dated 01/08/07 and sugar stored in a plastic tub dated 05/02/07.  Interview with the Dietary Manager on 06/29/11 at 10:09 AM revealed she was usually responsible for dating the dry storage food items because she usually put up her own food stock. She indicated the dates should be changed when the bins are empty and new flour or sugar was added.  Observation on 06/29/11 at 10:10 AM revealed an eight (8) pound can of chocolate flavored syrup and two (2) 108 ounce cans of sweetened applesauce which were dented and stored with	F 371	F371 (continued)  For the next 4 weeks and then at least quarterly the consultant dietician will, on a weekly basis, perform random inspection of these same areas in addition to her regular sanitation audits. The dietician will report any negative findings to the facility administrator who will refer the matter to the QA committee for resolution.		

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

 PRINTED: 07/18/2011  
 FORM APPROVED  
 OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185342	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 07/02/2011
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  COLONIAL HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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 371	<p>Continued From page 24 the non-dented canned items.</p> <p>Interview with the Dietary Manager on 06/29/11 at 10:10 AM revealed the dented cans should not be stored with the non-dented canned items. She further indicated they should be stored in the area of shelving labeled dented cans.</p> <p>Observation on 06/29/11 at 10:12 AM revealed a sixteen (16) ounce container of nutmeg, a sixteen (16) ounce container of cinnamon, an eighteen (18) ounce container of paprika and an eighteen (18) ounce container of chili powder which had been opened and not dated. Further observation revealed bread crumbs and buttermilk corn bread mix which were in their original bag containers opened and not sealed.</p> <p>Interview with the Dietary manager on 06/29/11 at 10:12 AM revealed normally spices were kept three (3) months before being discarded and should be dated. She further indicated the bags of bread crumbs and corn bread mix should be stored in a sealed container to prevent pest infestation.</p> <p>Observation of the walk-in refrigerator on 06/29/11 at 10:20 AM revealed a box of blue berry muffins which were dated 06/22/11.</p> <p>Interview with the Dietary Manager on 06/29/11 at 10:20 AM revealed after three (3) days the muffins should have been discarded.</p> <p>Observation on 06/29/11 at 10:30 AM revealed four (4) quarter sized hotel pans, three (3) half sized deep hotel pans and one (1) deep hotel pan stored wet.</p>	F 371		

PRINTED: 07/18/2011  
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:  185342	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 07/02/2011
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  COLONIAL HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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 371	<p>Continued From page 25</p> <p>Interview with the Dietary Manager on 06/29/11 at 10:30 AM revealed the pans should not be stored wet secondary to bacteria growth.</p> <p>Observation on 06/29/11 at 5:25 PM revealed Cook #16 dropped the alcohol pads which she was using to clean the thermometer she was checking temperatures with on the floor. Continued observation revealed she picked the alcohol pads up off of the floor and placed them on tray line and then used these same alcohol pads to clean the thermometer after checking the temperatures of food.</p> <p>Observation on 06/29/11 at 5:42 PM revealed Cook #16 used the scoop for the mechanical diet beef to scoop pureed beef off of a plate and then sprayed the scoop off with water at the three (3) compartment sink</p> <p>Observation at 5:45 PM on 06/29/11 revealed a nose cup stored wet.</p> <p>Interview with Cook #16 on 06/29/11 at 5:45 PM revealed the cup should not be stored wet secondary to the risk of bacteria growth.</p> <p>Observation at 6:00 PM on 06/29/11 revealed Dietary Aide #18 opened a drawer to obtain a scoop and did not wash her hands or change gloves prior to returning to tray line.</p> <p>Observation on 06/29/11 at 6:12 PM revealed the meat slicer was stored with particles which were light brown in color on the underside of the slicer near the blade.</p>	F 371		
-------	--	-------	--	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 07/18/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185342	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 07/02/2011
NAME OF PROVIDER OR SUPPLIER  COLONIAL HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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)	(X6) COMPLETION DATE	
F 371	Continued From page 26 Interview with the Dietary Manger on 08/29/11 at 6:14 PM revealed the meat slicer did not appear to have been cleaned well the last time after being used to slice meat. She further indicated the meat slicer should be cleaned after each use.  Interview with Cook #18 on 08/29/11 at 6:45 PM revealed she should have discarded the alcohol pads rather than laying them on the tray line surface. She further indicated she should have gotten another scoop after using the ground meat scoop to scrape off the pureed meat rather than spraying it off and continuing to use the scoop.  Interview with Dietary Aide #18 on 08/29/11 at 6:45 PM revealed she should have washed her hands and changed her gloves prior to returning to the resident tray line after opening the drawer.	F 371			
F 431 SS=D	489.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.  Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.  In accordance with State and Federal laws, the	F 431	F 431  CHRC, in accordance with State and Federal laws, stores all drugs and biologicals in locked compartments and permits only authorized personnel to have access to the keys. The facility has had no reported resident medication discrepancies nor have there been any adverse drug reactions resulting from this alleged deficient practice. On July 19, 2011, the DON verbally counseled RN #4 which included instruction for securing insulin in the med cart. The E-Z Cat barium solution has been discarded. To ensure all staff are aware proper procedure, on August 5, 2011, the ADON reviewed the facility policy for Medication Administration with the licensed staff and CMT's. All nurses and CMTs received a copy of the policy on August 12, 2011. All Med Rooms, Med Carts, and treatment carts were inspected by the ADON and Nursing Supervisor on July 27, 2011.	August 13, 2011	

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

PRINTED: 07/18/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185342	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 07/02/2011
NAME OF PROVIDER OR SUPPLIER  COLONIAL HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 431	<p>Continued From page 27</p> <p>facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to ensure all medications were locked up when not under direct observation of the nurse. During observation of blood sugar checks and insulin administration, the nurse left a tray of insulin on top of the medication cart in the hall while she was in the resident's room with the door closed. In addition, expired medications were discovered in the the medication room for Unit 2.</p> <p>The findings included:</p> <p>Review of the policy titled "Medication Administration-General Guidelines", dated 02/01/10, revealed the following: "During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide". Continued review</p>	F 431	<p>F431 (continued)</p> <p>These inspections confirmed that all drugs and biological are being labeled and stored per facility policy. To ensure ongoing compliance, the Director of Nursing assigned responsibility for weekly checks of the med rooms and med/treatment carts to the CMT. The DON will observe medication passes as part of her daily rounds to ensure medications are being properly controlled during medication administration. The facility's consultant pharmacist, who is an active member of the QA Committee, will monitor compliance with this requirement as part of routine consulting activities. If need be, she will report any adverse finding to the full QA committee so that additional corrective action can be initiated.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 07/18/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185342	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 07/02/2011
NAME OF PROVIDER OR SUPPLIER  COLONIAL HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 43f	Continued From page 28 revealed, "No medications are kept on top of the cart".  Observation on 06/30/11 at 11:00 AM revealed the treatment cart in the hall held a tray containing vials of insulin on top of the cart. Continued observation revealed the cart was unattended while Registered Nurse (RN) #4 was in a resident's room with the door closed.  Interview with RN #4 on 06/30/11 at 11:03 AM revealed she had left the cart while she checked the resident's blood sugar. She stated she did not usually pass medications but did check blood sugars and administer insulin. She further stated she had been trained to carry the insulin in the tray on top of the cart.  Interview with the Director of Nursing (DON) on 07/02/11 at 6:20 PM revealed insulin outside of a locked area should be in direct sight of the nurse at all times. She stated insulin left on the cart while the nurse was in a room with the door closed was "wrong and against policy".  In addition, observation of the Medication Room for Unit 1 on 06/29/11 at 11:00 AM revealed three (3) of five (5) bottles of E-Z-Cat Barium solution were expired. Interview with Certified Medical Technician (CMT) #5 on 06/29/11 at 11:15 AM revealed whoever did the ordering should have checked expiration dates. Interview with the DON on 06/29/11 at 11:20 AM revealed the medication nurse or CMT was responsible for checking expiration dates in the medication room.	F 43f			
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441			

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

 PRINTED: 07/18/2011  
 FORM APPROVED  
 OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185342	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 07/02/2011
NAME OF PROVIDER OR SUPPLIER  COLONIAL HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 441	<p>Continued From page 29</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and Infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it -</p> <ol style="list-style-type: none"> <li>(1) Investigates, controls, and prevents infections in the facility;</li> <li>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</li> <li>(3) Maintains a record of incidents and corrective actions related to infections.</li> </ol> <p>(b) Preventing Spread of Infection</p> <ol style="list-style-type: none"> <li>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</li> <li>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</li> <li>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</li> </ol> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p>	F 441	<p>F 441</p> <p>CHRC has established and maintains an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection. Resident #7 no longer resides in the facility. All residents have the potential to be affected. The DON, ADON, MDS Coordinator and charge nurse completed chart audits of every chart on August 12, 2011. The audit ensured that no noted infections have occurred over the past 30 days that were related to infection control practices. The nurse who failed to follow accepted professional practice for hand washing was verbally counseled by the DON on July 19, 2011. On July 1, 2011, the oxygen concentrator storage area was moved to the med room. The mop bucket storage area was moved to a mechanical room on July 25, 2011. To clarify any staff confusion regarding storage in the soiled room, signage has been put up prohibiting the storage of clean items. The ADON will provide an infection control inservice for the nursing staff on August 5, 2011. The training will highlight the facility's hand-washing policy. For the next 4 weeks and then monthly for the next 5 months, the DON or ADON will make observations of direct care provided by both nurses and CNAs to ensure compliance with the facility hand washing policy.</p>	August 13, 2011

PRINTED: 07/18/2011  
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:  185342	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 07/02/2011
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  COLONIAL HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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)	(X6) COMPLETION DATE
F 441	<p>Continued From page 30</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, record review and review of the facility's reference guide, Lippincotts Nursing Procedures (Fifth Edition) it was determined the facility failed to maintain an effective Infection Control Program to help prevent the development and transmission of disease and infection for one (1) of twenty-one (21) sampled residents, (Resident #7)..</p> <p>Observation of a wound care procedure on 06/29/11 for Resident #7 revealed improper infection control technique related to hand hygiene between glove changes. Observations also revealed clean oxygen concentrators were stored in the dirty linen room and a mop stored in a bucket in the dirty linen room.</p> <p>The findings include:</p> <p>Review of the facility's reference guide for hand hygiene, Lippincotts Nursing Procedures (Fifth edition), revealed hand hygiene is to be performed before performing wound care, after contamination, and always after removing gloves.</p> <p>1. Record review revealed Resident #4 was admitted to the facility on 05/24/07 with diagnoses which included Diabetes Mellitus II, Senile Dementia, Alzheimer, Stage IV Pressure Ulcer, and Failure to Thrive. Review of the 11/26/10 Annual Minimum Data Set (MDS) Assessment revealed the facility assessed Resident #4 as being at risk for and as having one Stage IV pressure ulcer.</p> <p>Observation of wound care to a Stage IV Pressure Ulcer located at the coccyx area on</p>	F 441	<p>F441 (continued)</p> <p>For the next four weeks and then monthly for the next the next 5 months, the Director of Housekeeping will include inspection of the soiled room as part of her routine rounds. Any noted problems will be referred to the facility QA committee.</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 07/18/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185342	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 07/02/2011
NAME OF PROVIDER OR SUPPLIER  COLONIAL HEALTH AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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)	(X6) COMPLETION DATE
F 441	<p>Continued From page 31</p> <p>06/29/11 at 3:25 PM for Resident #4 revealed the Wound Care Nurse (WCN) failed to follow the facility's hand hygiene guidelines related to performing hand hygiene after removing gloves. Prior to the procedure the WCN washed hands and put on gloves. During the dressing change, the WCN cleaned stool near the wound site and changed gloves, removed the soiled dressing and changed gloves, then applied the new dressing. After the wound care was completed, the WCN removed their gloves and performed hand hygiene.</p> <p>Observation revealed the WCN failed to wash her hands after removing her gloves following the stool cleaning and following the dressing removal.</p> <p>Interview with the WCN on 06/29/11 at 6:15 PM regarding the facility's hand hygiene guidelines and the wound care performed to Resident #4 revealed hand hygiene was not performed between all glove changes as required by the facility's hand hygiene procedures. Further interview revealed the WCN was nervous with being watched by surveyors and should have washed her hands after taking off the contaminated gloves before donning the clean gloves.</p> <p>Interview with the Director of Nursing (DON) on 06/29/11 at 6:30 PM regarding the facility's hand hygiene guidelines on glove changes during procedures revealed staff should wash their hands between gloves changes.</p> <p>Interview with the Assistant Director of Nursing (ADON), who oversees the Infection Control Program, on 07/02/11 at 6:30 PM regarding hand</p>	F 441		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 07/18/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185342	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 07/02/2011
NAME OF PROVIDER OR SUPPLIER  COLONIAL HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 441	Continued From page 32 hygiene, revealed if gloves become contaminated performing a procedure, when they take them off, they should perform hand hygiene prior to putting on a clean pair of gloves.  2. Observation on 06/28/11 at 10:00 AM revealed oxygen concentrators covered with plastic bags, however, the bottoms of the oxygen concentrators were exposed.  Interview with the DON on 06/30/11 at 10:25 AM revealed the oxygen delivery man had told the facility it was okay to store them in the dirty linen room because they were covered. She further indicated the oxygen concentrators were clean.  Interview with LPN #3 on 06/30/11 at 5:50 PM revealed the oxygen concentrators would be considered clean.  Interview with Licensed Practical Nurse (LPN) #5 on 06/30/11 at 5:45 PM revealed the oxygen concentrators would be considered clean.  3. Observation on 07/01/11 at 5:10 PM revealed a mop stored in a mop bucket with approximately one (1) inch of water in the bottom.  Interview with Housekeeper #17 on 07/01/11 at 5:10 PM revealed at night the mop is left in water and cleaner in the dirty linen room for nursing staff in case they have a spill during the night so it can be cleaned.	F 441		
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON  The facility must provide a safe, functional,	F 465		

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

 PRINTED: 07/18/2011  
 FORM APPROVED  
 OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185342	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 07/02/2011
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  COLONIAL HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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 465	<p>Continued From page 33</p> <p>sanitary, and comfortable environment for residents, staff and the public.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure a safe environment for residents, staff and the public as evidenced by exposed bolts on toilets in residents' bathrooms and loose towel racks in residents' bathrooms.</p> <p>The findings include:</p> <p>Observation on 07/01/11 at 1:30 PM revealed an exposed bolt on the right side of the toilet and a towel rack which was loose in Resident Room 31.</p> <p>Observation on 07/01/11 at 1:40 PM revealed exposed bolts on both sides of the toilet which stuck up approximately one half (1/2) an inch above the bottom of the toilet in Resident Room 22.</p> <p>Observation on 07/01/11 at 1:50 PM revealed exposed bolts on both sides of the toilet in the bathroom in Resident Room 4.</p> <p>Observation on 07/01/11 at 1:55 PM revealed an exposed bolt on the left side of the toilet and a loose towel rack in the bathroom in Resident Room 11.</p> <p>Observation on 07/01/11 at 2:00 PM revealed an exposed bolt on the left side of the toilet and a loose towel rack in the bathroom in Resident Room 10.</p>	F 465	<p>F465</p> <p>CHRC provides a safe, functional, sanitary, and comfortable environment for residents, staff and the public. The facility Maintenance Director installed bolt covers on all facility commodes, including those in resident 31, 22, 4, 11, and 10, on July 13, 2011. An inspection, and necessary repair/replacement of all towel bars, including those for residents 31, 11, and 10, was completed on July 17, 2011. The facility housekeeping staff has been assigned responsibility for reporting missing bolt covers and loose towel racks to maintenance on a daily basis. On August 5, 2011, the facility administrator provided written direction for all staff confirming their responsibility for removing any non-functional furnishings or equipment from service as well as their responsibility, and the process for, reporting any unsafe, unsanitary, or uncomfortable environmental condition to the Maintenance Director, Housekeeping Director, or Administrator if need be. A monthly check to confirm the bolt covers are in place and the towel racks are secure has been added to the facility's preventive maintenance program. These checks will be performed by the Maintenance Director or his assistant. If problems persist, the Maintenance Director will refer the matter to the safety committee for resolution.</p>	August 6, 2011

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

PRINTED: 07/18/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  165342	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 07/02/2011
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  COLONIAL HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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 465	<p>Continued From page 34</p> <p>Interview with the Maintenance Director on 07/01/11 at 10:15 AM revealed the bolts could be potentially dangerous if a resident or someone fell in the bathroom and the loose towel racks could be dangerous also if someone fell in the bathroom and tried to hold onto the towel rack.</p> <p>F 514 SS=D 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure the clinical record was maintained on each resident in accordance with accepted professional standards and practices accurately for one (1) of twenty-one (21) sampled residents. Review of Resident #8's medical record revealed the resident had a diagnosis of Hypothyroidism, however, the resident was receiving no medication intended to treat this disease. Interview with the Physician revealed, to his knowledge, Resident #8 did not</p>	F 465	<p>F514 CHRC maintains clinical records on each resident in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible, and systematically organized. On July 25, 2011, an audit of #8's charts was completed by the facility MDS Coordinators. Following this audit, the physician was contacted and a new order was obtained to make accurate #8's current and historical diagnoses. The chart face sheet has been updated to reflect this change. On August 12, 2011, the DON, ADON, MDS Coordinator, and Charge nurse completed chart audits of every resident chart to ensure they were complete, accurate, accessible, and organized. The facility is currently training a new medical records clerk who will be responsible for ensuring the facility's medical records are complete, readily accessible, and systematically organized. On July 25, 2011, this training was enhanced through collaboration with a Medical Records Director with over 20 year's experience. This training emphasized techniques for maintaining diagnoses accuracy as well as chart organization, job duties, and departmental function. The DON or MDS Coordinator will audit 10 of the charts each month for the next 2 quarters to ensure clinical records are complete, accurate and organized. Any noted problems will be referred to the QA committee</p>	August 13, 2011

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 07/18/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185342	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 07/02/2011
---	---	--	--

NAME OF PROVIDER OR SUPPLIER

COLONIAL HEALTH AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

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 514	Continued From page 36 have a diagnosis of Hypothyroidism.  The findings include:  Record review revealed the facility admitted Resident #8 on 09/02/03 with diagnoses which included impaired Renal Function, Hypothyroidism, Hypercalcemia, Metabolic Cardiomyopathy and Alzheimer's Dementia.  Phone interview with Physician #13 on 07/01/11 3:15 PM revealed he had no concerns regarding Hypothyroidism and in review of his charting he saw no indications of Hypothyroidism. He further stated he would have blood work drawn just to be certain.  Interview with the Director of Nursing (DON) on 07/01/11 at 3:20 PM revealed Resident #8's Physician ordered a Thyroid-stimulating hormone (TSH) level be drawn on Resident #8 because it had been a while since she/he had one drawn. She further stated the resident's Power of Attorney had indicated the resident had a TSH level taken in 2001 and it was within normal limits.	F 514		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 07/18/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185342	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  06/29/2011
NAME OF PROVIDER OR SUPPLIER  COLONIAL HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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)	(X6) COMPLETION DATE
K 000	INITIAL COMMENTS  A Life Safety Code Survey was initiated and concluded on 06/29/2011. The facility was found not to meet the minimal requirements with 42 Code of the Federal Regulations, Part 483.70. The highest Scope and Severity deficiency identified was an "F".	K 000		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2  This STANDARD is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure fire drills were conducted at unexpected times under varied conditions. The deficiency had the potential to affect all smoke compartments, staff and residents. The facility is licensed for sixty five (65) beds with a census of sixty one (61) residents on the day of the survey.  The findings include:  Record review, on 06/29/11 at 10:45 AM, with the Maintenance Director revealed the fire drills were not being conducted at unexpected times under varied conditions.	K 050	K050 Colonial Health and Rehabilitation Center (CHRC) conducts fire drills at unexpected times under varying conditions, at least quarterly on each shift. On July 19, 2011, the Maintenance Director has reviewed the requirements of NFPA 101 19.7.1.2. Since the facility had documented fire drills for each shift every quarter, the Maintenance Director will now increase the variability, based on the time of the month as well as time of day, when the drills will occur. The Maintenance Director will present his fire drill documentation to the safety committee to verify that the drills are being conducted under various conditions. Any noted problems will be referred to the facility QA committee.	July 20, 2011

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

TITLE

(X8) DATE

*New Foot**Administrash**8/16/11*

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 07/18/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  165342	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  06/29/2011
NAME OF PROVIDER OR SUPPLIER  COLONIAL HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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)	(X6) COMPLETION DATE
K 050	Continued From page 1  Interview, on 06/29/11 at 11:45 AM, with the Maintenance Director revealed that he was unaware that fire drills were not being conducted as required.  Reference: NFPA Standard NFPA-101 19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts.	K 050		
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5  This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to maintain the sprinkler system according to NFPA standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, residents, staff and visitors. The facility is licensed for sixty five (65) beds with a census of sixty one (61) the day of the survey.  The findings include:  Observation on 06/29/11 at 2:15 PM with the Maintenance Director revealed insulation on the sprinkler heads located in the attic of the	K 062	K062 CHRC's automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. The insulation on the sprinkler heads in the personal care wing was removed on July 26, 2011. An inspection of all attic sprinkler heads, and subsequent removal of any insulation, was completed on July 27, 2011. To ensure continued compliance with this requirement, attic sprinkler head inspections will now be completed two times a month. The results of these inspections will be documented with the facility's preventive maintenance program. Any noted problems will be referred to the QA committee for resolution.	July 28, 2011

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

PRINTED: 07/18/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185342	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  06/29/2011
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  COLONIAL HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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
--------------------	--	---------------	---	----------------------

K 062	Continued From page 2 Personal Care Wing.  Interview on 06/29/11 at 2:15 PM, with the Maintenance Director confirmed the observation.  Reference: NFPA 13 (1999 Edition)  5-5.5.2* Obstructions to Sprinkler Discharge Pattern Development. 5-5.5.2.1 Continuous or noncontiguous obstructions less than or equal to 18 in. (457 mm) below the sprinkler deflector that prevent the pattern from fully developing shall comply with 5-5.5.2.	K 062		
K 070 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8  This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure portable space heaters used in the facility were according to NFPA standards. Portable space heaters used in health care facilities must be of an approved type to limit the risk of fire. The deficiency had the potential to affect one (1) of five (5) smoke compartments. The facility is licensed for sixty five (65) beds with a census of sixty one (61) the day of the survey.	K 070	K070 CHRC prohibits the use of portable space heating devices. On July 11, 2011, the Maintenance Director removed the improperly mounted space heater from the Central bath and replaced it with a UL listed, approved for wall mounting, auxiliary heater to maintain resident comfort while bathing. He also confirmed that the 3 other auxiliary heaters in use in the bathing areas are designed for such use. The Administrator made all staff aware that portable space heaters are prohibited in the facility via memo posting on July 26, 2011.	July 27, 2011

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

STATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185342	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  06/29/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  COLONIAL HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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
K 070	Continued From page 3  The findings include:  Observation on 06/29/11 at 11:15 AM with the Maintenance Director revealed a portable space heater mounted on the wall and hard wired to an electrical junction box located inside the Men's central bathroom in the Personal Care Hall.  Interview on 06/29/11 at 11:15 AM with the Maintenance Director, revealed a previous Maintenance Director had installed the heater and was unaware that changing a portable device to a permanent device voided the UL Listing.  Reference: NFPA 101 (2000 edition) 19.7.8 Portable Space-Heating Devices. Portable space-heating devices shall be prohibited in all health care occupancies. Exception: Portable space-heating devices shall be permitted to be used in nonsleeping staff and employee areas where the heating elements of such devices do not exceed 212°F (100°C). NFPA 101 MISCELLANEOUS	K 070	K070 (continued)  The Maintenance Director will, as part of routine preventive maintenance physical plant inspections, verify that portable heaters are not in use. Any noted problems will be referred to the facility QA committee.	
K 130 SS=E	OTHER LSC DEFICIENCY NOT ON 2786  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain doors within a required means of egress. This	K 130	K 130 CHRC maintains its doors within a required means of egress. On July 21, 2011, the Maintenance Director removed slide bolts from the conference room bathroom and therapy service doors. The facility maintenance staff completed removal of all slide bolts and installation of new locksets on August 4, 2011	August 5, 2011

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 07/18/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185342	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED  06/29/2011
NAME OF PROVIDER OR SUPPLIER  COLONIAL HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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)	(X6) COMPLETION DATE	
K 130	Continued From page 4 deficiency had the potential to affect one (1) of five (5) smoke compartments, residents, staff, and visitors. The facility is licensed for sixty five (65) beds, with a census of sixty one (61) on the day of the survey.  The findings include:  Observation, on 06/29/11 between 10:00 AM and 3:00 PM, with the Maintenance Director revealed an unapproved lock (slide bolt type) was installed on the egress side of the bathroom door in the Conference Room, and the Therapy Services corridor door.  Interview, on 06/29/11 between 10:00 AM and 3:00 PM, with the Maintenance Director revealed he was aware of the locks, but not aware they could not be used.  NFFA 101 (2000 Edition) 19.2.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side.	K 130	K130 (continued)  To assure daily surveillance for im- properly installed slide bolt, the house- keeping staff has been instructed on the requirements of NFFA 101 19.2.2.2.4. If a slide bolt is found, housekeeping will notify the mainte- nance director and administrator so it can be removed. The facility mainte- nance director and his assistant, will confirm that no slide bolts have been installed as part of monthly preventive maintenance room checks. Any noted problems will be referred to the facil- ity QA committee.		
K 147 SS=D	NFFA 101 LIFE SAFETY CODE STANDARD  Electrical wiring and equipment is in accordance with NFFA 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 according to NFFA	K 147	K147 CHRC's electrical wiring and equipment is in accordance with NFFA 70, National Electric Code 9.1.2. On July 14, 2011, additional receptacles were installed in the Resident Services office eliminating the need for the piggy backed power strip.	July 27, 2011	

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

 PRINTED: 07/18/2011  
 FORM APPROVED  
 OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185342	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  06/29/2011
---	---	--	---

NAME OF PROVIDER OR SUPPLIER

COLONIAL HEALTH AND REHABILITATION CENTER

 STREET ADDRESS, CITY, STATE, ZIP CODE  
 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)	(X6) COMPLETION DATE
K 147	<p>Continued From page 5</p> <p>standards. The deficiency had the potential to affect two (2) of five (5) smoke compartments, including residents, staff, and visitors.</p> <p>The findings include:</p> <p>Observations on 06/29/11 at 1:30 PM, with the Maintenance Director revealed an electrical panel located in the resident corridor was unlocked.</p> <p>Interview on 06/29/11 at 1:30 PM, with the Maintenance Director revealed OSHA told them it had to be unlocked.</p> <p>Observation on 06/29/11 at 2:00-PM, with the Maintenance Director revealed piggy backed power strips in the Resident Services Office.</p> <p>Interview on 06/29/11 at 1:30 AM, with the Maintenance Director revealed he was unaware of the power strips being plugged into each other in the office.</p> <p>Reference: NFPA 99 (1999 edition)</p> <p>3-3.2.1.2 D</p> <p>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.</p>	K 147	<p>K147 (continued)</p> <p>On the same day, the electrical panel was secured to prevent unauthorized access. On July 26, 2011, the Administrator communicated to all office staff that power strips or extension cords cannot take the place of permanent wiring. To assure compliance with this requirement, the Maintenance Director added office checks to his routine, monthly preventive maintenance inspections. Verification that the breaker panel remains secured will occur monthly. Any noted problems will be referred to the QA committee.</p>	