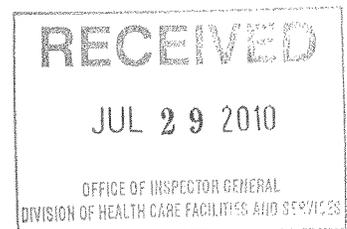


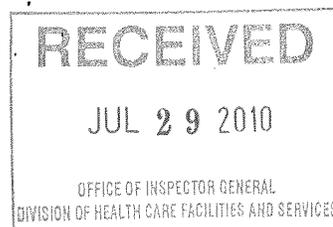
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CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 07/22/2010
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185342	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/09/2010
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 323	<p>Continued From page 10</p> <p>were documented as having been implemented on 03/22/10.</p> <p>On 05/10/10 at 2:45am, the resident was found on the floor without the alarm sounding. The facility documented the addition of a low bed and fall mats; however, these safety devices were documented as having been implemented on 03/22/10.</p> <p>On 06/13/10 at 1:45pm, the resident was found on the floor with the alarm sounding. The facility took the resident to activities.</p> <p>On 06/21/10 at 10:30pm, the resident was found on the floor with the alarm sounding. Again the facility documented a low bed and mats in place.</p> <p>Interview with Certified Nurse Aide (CNA) #1 on 07/08/10 at 4:15pm, revealed the staff made rounds of the residents every two (2) hours and would look in residents' rooms when passing the door. She stated Resident #6 tried to get out of bed and had learned to remove the alarms that alert staff. She stated the resident was toileted if needed. She stated there were no instructions from nursing to increase the amount of supervision for the resident to prevent falls.</p> <p>Interview with the Director of Nursing on 07/07/10 at 2:30pm, revealed Resident #6 did have multiple falls and had sustained minor injuries. She stated interventions on the care plan for falls were considered to be successful if the resident sustained no injuries, so less effort was placed on preventing falls and more on preventing injuries. She stated once a resident was placed on a low bed and had mats on the floor, there was not much left to do for the resident, so new</p>	F 323		



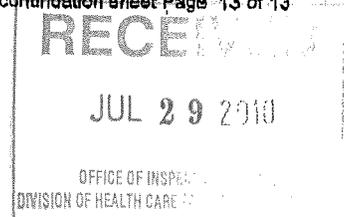
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F 323	Continued From page 11 interventions were not implemented. She stated she was aware of the facility falls policy and had received training regarding falls.	F 323		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY. The facility 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 and record review, it was determined the facility failed to ensure foods were stored, prepared, distributed, and served under sanitary conditions. Two (2) Dietary Aides were observed entering the dietary department after using a hand sanitizer mounted in the hallway, then proceeding to engage in food preparation in the kitchen without washing their hands with soap and water. The findings include: The facility's policy on handwashing, revised 2010, revealed handwashing reduces the spread of microorganisms that are transmitted through food. Pathogenic organisms can be transferred to the hands from a variety of sources and then move from hands to food during preparation and service. Employees involved in the storing, preparing, distributing and serving of food wash	F 371	F371 Colonial Health and Rehabilitation Center stores, prepares, distributes, and serves food under sanitary conditions. The employees cited with this deficiency have been counseled. Additionally, the hand gel dispenser was removed from the kitchen so it could not be used between tasks. On August 4, 2010, the facility's consultant dietician will provide in-service training to all dietary staff. The content of the inservice will include review of the facility policies related to storing, preparing, distributing, and serving food under sanitary conditions. Emphasis will be given to hand washing during the inservice. The Dietary Manager will make random weekly observations of hand washing in the food prep areas. These observations will be recorded for 3 months to ensure proper hand washing procedures. The Consultant Dietician will continue to complete monthly sanitation audits to include observation of hand washing procedures. These reports will be presented to the facility's QA committee for review.	August 4, 2010



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F 371	<p>Continued From page 12</p> <p>their hands frequently using proper cleaning procedures to prevent food contamination and the spread of food borne illness. 'HAND SANITIZERS MAY NOT BE USED IN PLACE OF REGULAR HANDWASHING'.</p> <p>Observation of Dietary Staff on 07/08/10 at 11:57am, revealed two (2) dietary aides (DA) walking down the hallway on the East resident wing. The DA's used a hand sanitizer mounted on the wall in the hallway to sanitize their hands, then entered the dietary department and began assisting with the lunch meal service. Neither DA was observed to wash their hands with soap and water prior to beginning their tasks.</p> <p>Interview with DA's #1 and #2 on 07/08/10 at 12:02pm revealed they did not wash their hands before assisting with the meal service. They stated hand sanitizer was available in the kitchen for use and they did use the sanitizer between tasks. They stated the facility had provided them with training on hand washing; however, they were not told that hand sanitizer could not be used in the kitchen. They revealed they were not aware that hand washing with soap and water was required.</p> <p>Interview with the Dietary Manager on 07/09/10 at 7:05pm revealed she was not aware that staff was using hand sanitizer, instead of washing hands, prior to coming into the kitchen area to prepare food. The Dietary Manager stated that the facility had just received training on washing hands and stated that staff must wash their hands to make friction to remove germs thoroughly.</p>	F 371		



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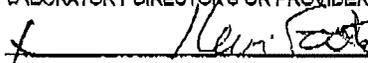
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NAME OF PROVIDER OR SUPPLIER COLONIAL HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 708 BARTLEY AVENUE BARDSTOWN, KY 40004
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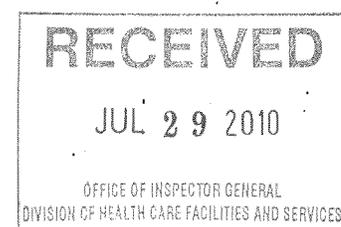
K 000	INITIAL COMMENTS A Life Safety Code survey was initiated and concluded on 07/13/10, for compliance with Title 42, Code of Federal Regulations, §483.70. The facility was found not to be in compliance with NFPA 101 Life Safety Code, 2000 Edition. Deficiencies were cited with the highest deficiency identified at "E" level.	K 000		
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and Interview, the facility failed to utilize proper access doors in the fire/smoke wall assembly in the attic area. This deficient practice affected three (3) of four (4) smoke compartments, staff and approximately forty five (45) residents. The facility has the capacity for 95 beds with a census of 78 the day of survey. The findings include: During the Life Safety Code survey on 07/13/10 at	K 025	K025 The smoke barriers of Colonial Health and Rehabilitation Center are constructed to provide at least one half hour fire resistance rating in accordance with 8.3. Additional, maintenance inspections of fire dampers are conducted every four years to verify they fully close; the latch, if provided, shall be checked; and moving part lubricated as necessary. Access doors of an approved design and rating have been ordered to replace all make shift doors. Provided they arrive from the manufacture as scheduled, these will be installed August 22, 2010. If they do not arrive in time, the make shift doors will be sealed using fire rated and approved materials, until the access doors can be installed. All fire dampers will be inspected by the facility's HVAC contractor by August 22, 2010. Inspection included routine maintenance service and verification that dampers fully close.	August 22, 2010

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X8) DATE 7/29/10
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

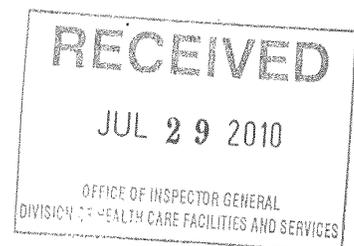
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K 025	<p>Continued From page 1</p> <p>12:15pm, with the Director of Maintenance, in the attic above the cross corridor doors, next to the beauty shop, was noted to have an unapproved make shift door in the fire/smoke barrier wall. This type of access door is required to be of an approved design and rating to help prevent fire/smoke from spreading to other areas of the building in a fire situation. The fire/smoke barrier wall was also noted to have ductwork that contained a fire damper. A fire damper closes to prevent fire and hot gases from penetrating the fire/smoke barrier wall and is required to be inspected and maintained every four (4) years.</p> <p>An interview revealed the Director of Maintenance was going to go through the building and seal these types of unapproved doors and provide access to the attic from the floor below. The Director of Maintenance was not aware the fire damper should be maintained. During the survey an unapproved make shift door and fire damper was noted to be located in the attic above cross corridor doors next to the dietary manager's office.</p> <p>Reference: NFPA 101 2000 edition</p> <p>8.2.3.2.1 Door assemblies in fire barriers shall be of an approved type with the appropriate fire protection rating for the location in which they are installed and shall comply with the following. (a) * Fire doors shall be installed in accordance with NFPA 80, Standard for Fire Doors and Fire Windows. Fire doors shall be of a design that has been tested to meet the conditions of acceptance of NFPA 252, Standard Methods of Fire Tests of Door Assemblies.</p>	K 025	<p>K025 (continued)</p> <p>By August 22, 2010, the Director of Maintenance will complete inspection of all remaining fire doors and attic fire/smoke wall assemblies for penetrations. Any needed repairs will be made to verify proper fire door operation and to confirm the fire/smoke wall integrity.</p> <p>Scheduled inspections of fire doors and the fire/smoke wall integrity will continue to be part of the facility's preventive maintenance program. Damper inspections have been added to the PM computer based scheduling and tracking program to ensure that required maintenance will be performed every 4 years. On a monthly basis, the Regional Director of Maintenance will review the preventive maintenance program and documentation and report any concerns to the Administrator for resolution. The Administrator will present identified concerns to the QA committee so the need for additional supervision, system modification, or personnel change may be determined.</p>	



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K 025	Continued From page 2 Reference: NFPA 80 1999 edition 11-1.2 Components. An access door shall be an integral unit including the door, frame, hinges, latch, and closing device (where required) bearing a label that reads " Frame and Fire Door Assembly. " Exception: A vertical access door shall be permitted to have hinges that are not part of the labeled assembly, provided the hinges conform to Table 2-4.3.1. 11-1.2.1 Access doors shall be self-closing. 11-1.2.2 Access doors shall be self-latching. Exception: A horizontal access door that does not open downward and that remains in place when an upward force of 1 psf (48 N/m ²) is applied over the entire exposed surface of the door shall not be required to be self-latching. 11-1.2.3 Self-closing access doors that are intended to be used to allow a person to enter the concealed space behind the door completely shall be operable from the inside without the use of a key or tool. 11-1.2.4 Access doors shall be installed in accordance with their listing. 11-2 Types of Doors. 11-2.2 Vertical Access Doors. 11-2.2.1 Vertical access doors shall have a fire protection rating of 3/4 hour, 1 hour, or 1 1/2 hours. (See Appendix F.) 11-2.2.2 Vertical access doors shall be used only in walls.	K 025			



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K 026	Continued From page 3 Reference: NFPA 90a 1999 edition 3-4.7 Maintenance. At least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify that they fully close; the latch, if provided, shall be checked; and moving parts shall be lubricated as necessary.	K 025		
K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that the building fire alarm system functioned as required by NFPA standards. The findings include: Observation during the Life Safety Code survey on 07/13/10 at 11:30am, with the Director of Maintenance, during a test of the fire alarm	K 052	K052 Colonial Health and Rehabilitation Center's fire alarm system is installed, tested, and maintained according to the requirements of NFPA 70 and 72 as well as the National Electrical Code. On July 12, 2010, the notification instructions with the monitoring station were changed. The facility will now be called with notice of phone line failure. If contact with the facility cannot be made, the Director of Maintenance and Administrator are designated as the back-up contacts. On July 13, 2010, the Director of Maintenance simulated a phone line failure for both lines. The facility was contacted within 4 minutes.	July 13, 2010 07/14/10 per review Foster KH

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K 052	<p>Continued From page 4</p> <p>automatic dialer panel revealed when the panel was placed in trouble from phone line failure the unit did send a trouble signal to a continuously occupied location within the facility; however, the monitoring station did not contact the facility for the phone line failure as required. A call to the monitoring station by the Director of Maintenance revealed the monitoring station did not have instructions to notify the facility about this phone line failure.</p> <p>Reference: NFPA 72 1999 edition</p> <p>5-2.6.1.4 Upon receipt of trouble signals or other signals pertaining solely to matters of equipment maintenance of the fire alarm systems, the central station shall perform the following actions: (1) *Communicate immediately with persons designated by the subscriber A-5-2.6.1.4(1) The term immediately in this context is intended to mean "without unreasonable delay." Routine handling should take a maximum of 4 minutes from receipt of a trouble signal by the central station until initiation of the investigation by telephone.</p> <p>5-5.3.2.1.6.2 The following requirements shall apply to all combinations in 5-5.3.2.1.6.1: (1) Both channels shall be supervised in a manner approved for the means of transmission employed. (3) The failure of either channel shall send a trouble signal on the other channel within 4 minutes. (8) Failure of telephone lines (numbers) or cellular service shall be annunciated locally.</p>	K 052	<p>K052 (continued)</p> <p>Testing of the monitoring station's compliance with the facility's notification directions will be performed quarterly. These tests have been added to the preventative maintenance program. The Director of Maintenance will present the results of these tests to the QA Committee so that compliance or need for re-evaluation of the facility's relationship with its alarm contractor may be determined</p>	

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K 064 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the kitchen had signage in place for the proper use of the Class-K portable fire extinguisher.</p> <p>The findings include:</p> <p>During the Life Safety Code tour on 07/13/10 at 11:55am, with the Director of Maintenance, a Class-K portable fire extinguisher was noted not to have signage near the extinguisher for the proper use of this type of extinguisher. This type of extinguisher is used as a secondary measure to the range hood extinguishing system.</p> <p>An interview revealed a kitchen staff member was not aware of the proper use of this type of extinguisher.</p> <p>Reference: NFPA 10 1998 edition</p> <p>2-3.2.1 A placard shall be conspicuously placed near the extinguisher that states that the fire protection system shall be activated prior to using the fire extinguisher.</p>	K 064	<p>K064</p> <p>Colonial Health and Rehabilitation Center provides portable fire extinguishers in accordance with 9.7.4.1 and 19.3.5.6, NFPA 10.</p> <p>The signage for the Class K fire extinguisher was rehung on July 23, 2010. Additionally, all dietary employees will receive instruction on the proper use of a Class K extinguisher as part of inservice training scheduled for August 4, 2010.</p> <p>As part of department specific orientation, the Director of Dietary will ensure that all new dietary employees receive instruction in the correct usage of the Class K extinguisher. This will also be reviewed monthly with the dietary staff present during routine fire drills. The Director of Maintenance will confirm that proper signage is present and visible near the extinguisher. This check will be added to the monthly preventive maintenance program.</p> <p>The Director of Maintenance will report the findings from these monthly checks to the QA Committee so that compliance or the need for additional training and/or sign security and placement may be determined.</p>	August 4, 2010

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