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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185291	A. BUILDING _____ B. WING _____	09/17/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL TERRACE NURSING HOME	142 ROGER POWELL RD SEBREE, KY 42455

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An annual recertification survey was conducted 09/14/10 through 09/17/10 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with the highest S/S of "D". Additionally, an abbreviated survey (KY #15220) was conducted on 09/14/10 through 09/17/10 and was substantiated with deficiencies cited.	F 000	**Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law.**	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.	F 157	**F 157 Notification of Changes** The facility shall immediately inform the Resident; consult with the resident's Physician; and if known, notify the Resident's legal representative or an interested family member when there is (c) a need to alter treatment significantly. **Criteria #1** – MD is aware of labs that were not done on the date ordered. **Criteria #2** – An audit of all resident charts was performed to identify any lab tests that were not obtained timely, attending MD's were notified accordingly. **Criteria #3** –Licensed nurses received in-service education on 10/5/10 by the DON regarding notification of change policy. **Criteria #4** – The CQI indicator tool used for monitoring of physician notification shall be utilized monthly for 2 months, then quarterly as per established CQI calendar under the supervision of the Director of Nursing.	11/1/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Denise Puckett — TITLE: Administrator — (X6) DATE: 10-8-10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to consult with the resident's physician when there was a need to alter treatment for one resident (#16), not in the selected sample. Findings include: Resident #16 was admitted to the facility with diagnoses to include Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, and History of Deep Vein Thrombosis. A review of the physician order, dated 09/01/10, revealed an order for Pro-thrombin Times (PT)/International Normalizing Ratio (INR) to be conducted monthly. The PT/INR was obtained on 08/17/10 and the results were faxed to the physician. On 08/19/10, the physician faxed an order to the facility to increase the Coumadin to 7 mg and to repeat the INR in one week. Further review of the record revealed the PT/INR was not obtained as ordered a week later. The next PT/INR was not obtained until 08/31/10. Observation on 09/14/10 at 6:40 PM, revealed Kentucky Medication Aide (KMA) #1 administered Coumadin 6 milligrams (mg) one tablet and Coumadin 1 mg tablet for a total of 7 mgs to Resident #16. An interview, on 09/17/10 at 10:50 AM, with Licensed Practical Nurse #3 revealed she wrote	F 157		

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F 157	Continued From page 2 the telephone order for the Coumadin to be increased and the laboratory order for a PT/INR to be obtained in one week. She stated, "Normally a certain nurse on the unit was responsible for getting the labs noted on the calendar. The usual procedure required new telephone orders to be placed in a designated basket, an administrative nurse collected the orders and placed the lab orders on the tracking log and calendar." LPN #3 stated due to the recent turnover in staff, she was unsure who was responsible for placing the labs on the log and calendar. An interview with the Director of Nursing (DON), on 09/16/10 at 10:45 AM, revealed she discovered additional annual and every 6 month laboratory tests, which had not been obtained, during an audit conducted at the beginning of the month. She completed laboratory requests for the labs not obtained, and scheduled them for the next lab day and made the physician aware. The DON stated the physician should be notified if a test was not completed as ordered.	F 157		
F 160 SS=D	483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to convey	F 160	**F 160 Conveyance upon Death** Upon the death of a resident with a personal fund deposited with the facility; the facility shall convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. **Criteria #1**: Resident funds were conveyed to the individual or probate administering the residents' estate for residents' #18 on 9/9/10 and #19 on 8/30/10.	

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F 160	Continued From page 3 personal funds within 30 days for two residents (#18 and #19) not in the selected sample, after their death. Resident #18 expired on 07/16/10 and the final accounting of the resident's funds was not conveyed until 09/09/10. Resident #19 expired on 05/19/10 and the account and personal funds were not conveyed until 08/30/10. Findings include: Review of the facility's "Administrator of Resident Trust Funds" revealed the following; "Upon the death of the resident, personal funds will be conveyed within 30 days with a final accounting to the individual or probate jurisdiction administering the resident's estate." Record review and interview with the facility business office manager on 09/15/10 at 2:45 PM, revealed she was responsible for the resident's accounts. Resident #18 expired on 07/16/10. The resident's account was not reconciled until 09/09/10. Additionally, Resident #19 expired on 05/19/10, but the account was not closed until 08/30/10. The interview with the business office manager revealed she failed to refund Resident #18's personal funds timely. "I just did not get it refunded timely". Additionally, she stated she was not employed at the facility when Resident #19 expired and could not explain why Resident #19's funds were not conveyed timely.	F 160	**Criteria #2:** An audit has been performed of the accounts for all residents who have expired within the last 30 days to assure that the resident funds have been conveyed to the individual or probate administering the resident's estate. **Criteria #3:** In-service education has been provided for the business office manager by the corporate CFO on the regulatory requirements regarding management of resident funds upon their death. **Criteria #4:** The CQI indicator for the monitoring of resident trust accounts will be utilized monthly X 2 months and then every 6 months as per the established CQI calendar under the supervision of the Administrator.	11/1/10
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	F 282	**F 282 Care Plan** The services provided or arranged by the facility shall be provided by qualified persons in accordance with each resident's written plan of care.	

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F 282	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, it was determined the facility failed to implement care plan interventions for two residents (#1 and #5), in the selected sample of 15. Care plan interventions for Resident #1 revealed the lift chair was to be unplugged and the resident was not to be left unattended while up in the wheelchair. Resident #5's care plan revealed an intervention to apply a personal alarm to the wheelchair. Findings include: 1. A record review revealed Resident #1 was admitted to the facility, on 08/20/09, with diagnoses to include Subdural Hematoma, Fractured Neck of Femur, Chronic Obstructive Pulmonary Disease (COPD), Atrial Fibrillation, Ischemic Heart Disease, Diabetes Mellitus Type 2, Hypertension, Rheumatoid Arthritis, and Edema. A review of the annual Minimum Data Set (MDS), dated 07/22/10, revealed the facility identified Resident #1 as moderately cognitively impaired and required total assistance with activities of daily living. A review of the Nurse's Notes, dated 04/08/10 at 10:00 AM, revealed Resident #1 fell forward from an electric lift chair. The resident was assessed as having a medium size bump to the right side of his/her head. An order was received to send the resident to the emergency room for a CAT scan of the head. A review of an Event Report Investigation, dated 04/08/10, revealed Resident #1 used the remote	F 282	**Criteria #1:** Resident # 1's is not up in w/c unattended in his/her room in accordance with his/her written plan of care. Resident #5 's safety alarms/devices are applied and monitored in accordance with his/her written plan of care. **Criteria #2:** An audit of all resident alarms/safety devices was completed to ensure compliance with each resident's written plan of care. **Criteria #3:** Facility nursing staff members received educational in-service on the facility's policy and procedure for placement and monitoring of safety alarms/devices in accordance with each resident's written plan of care on 10/5/10 by the DON. **Criteria #4:** The CQI indicator tools used for monitoring of medication pass and application/monitoring of safety alarms/devices in accordance with each resident's written plan of care shall be utilized monthly for 2 months, then quarterly as per established CQI calendar under the supervision of the Director of Nursing.	11/1/10

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F 282	Continued From page 5 control on the lift chair to attempt to transfer him/herself unassisted. The investigation revealed the chair was supposed to be unplugged at the time of the accident. Review of a Care Plan, dated 09/12/09, revealed the reclining chair was to be unplugged and remain in a low position when the resident was not supervised. An interview with the(former) Director of Nursing (DON), on 09/16/10 at 4:15 PM, revealed she was the nurse working on 04/08/10 and responsible for sending Resident #1 to the emergency room. She was unsure whether someone gave Resident #1 the remote control or if the remote was left within the resident's reach. However, the chair was supposed to be unplugged. An interview with Registered Nurse (RN) #1, on 09/15/10 at 4:15 PM, revealed Resident #1 was assessed as unable to safely operate the lift chair, but the resident's family had insisted the resident keep the chair for comfort. The use of the lift chair was care planned to remain unplugged so the resident would not be able to operate the chair independently. A review of the Nurse's Notes, dated 06/01/10 at 7:45 PM, revealed Resident #1 sustained a fall from their wheelchair and was found lying on their right side tangled in the foot rests. A review of the Care Plan, "At Risk for Accidents/Injury", dated 09/12/09, revealed an entry dated on 06/02/10 reflecting the resident was not to be up in the wheelchair in his/her room unattended.	F 282		

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F 282	Continued From page 6 A review of the Certified Nurse Aide (CNA) Care Plan Record for September 2010, revealed Resident #1 was not to be unattended in the resident's room while up in his/her wheelchair. Observations on 09/14/10 at 6:30 PM and 09/15/10 at 5:00 PM, revealed Resident #1 was up in the wheelchair unattended in his/her room. 2. Resident #5 was admitted to the facility, on 03/17/08, with diagnoses to include Cerebral Vascular Accident, Osteoarthrosis, Deep Phlebitis of the Leg, and History of Breast Malignancy. A review of a significant change MDS, dated 06/10/10, revealed the facility identified Resident #5 as moderately cognitively impaired and requiring minimal assistance of one with ambulation. A review of an Investigation Report, dated 07/22/10, revealed Resident#5 was identified at high risk for falls. The report revealed the resident had attempted to get up unassisted and was found on the floor. Resident #5 had a mobility alarm, but there was no mention of whether the alarm was turned on and functioning, at the time of the fall. A review of the Physician's Order, dated 02/02/09, revealed Resident #5 should have a personal alarm to his/her wheelchair. A review of the Care Plan, "Potential for Injury", dated 06/15/10, revealed interventions included a personal alarm to the resident's wheelchair. A review of the CNA Care Plan Record, dated 09/10, revealed the resident had a personal	F 282		

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F 282	Continued From page 7 safety alarm when up in his/her chair. Observations, on 09/15/10 at 8:45 AM, 9:30 AM, 10:30 AM, and 11:30 AM, and on 09/17/10 at 9:25 AM, revealed Resident #5 was up in his/her wheelchair without a personal alarm. An interview with State Registered Nurse Aide (SRNA) #4, on 09/17/10 at 9:25 AM, revealed she checked placement and functioning of the personal alarms and sensor alarms anytime she assisted a resident to bed or into a chair. She stated information about how to take care of each resident was written on the CNA care plans. She stated "I have worked here long enough, I know who has alarms." An interview with the Quality Assurance RN, on 09/17/10, revealed it was expected that if a resident had an order for a personal alarm, the staff responsible for the care of the resident made sure the alarm was in place and functioning.	F 282		
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 observations, staff interviews and record reviews, it was determined the facility failed to ensure each resident received adequate	F 323	**F 323 Accidents** The facility shall ensure that the resident environment remains as free of accident hazards as is possible. **Criteria #1:** All interventions are implemented for Resident's # 1 and # 5 in accordance with his/her plan of care for prevention of falls.	

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F 323	Continued From page 8 supervision to prevent accidents and remained as free of accident hazards as is possible for two residents (#1 and #5), in the selected sample of 15. The facility failed to ensure Resident #1's electric lift chair was unplugged so he/she was unable to operate the chair. The facility failed to ensure Resident #1 was not left unattended while in his/her wheelchair. Additionally, the facility failed to ensure a personal alarm was utilized and a skin barrier cream was out of reach for Resident #5. Findings include: 1. A record review revealed Resident #1 was admitted to the facility, on 08/20/09 with diagnoses to include Subdural Hematoma, Fractured Neck of Femur, Chronic Obstructive Pulmonary Disease (COPD), Atrial Fibrillation, Ischemic Heart Disease, Diabetes Mellitus Type 2, Hypertension, Rheumatoid Arthritis, and Edema. A review of the annual Minimum Data Set (MDS), dated 07/22/10, revealed the facility identified Resident #1 as moderately cognitively impaired and requiring total assistance with activities of daily living. A review of the Nurse's Notes, dated 04/08/10 at 10:00 AM, revealed Resident #1 fell forward out of the electric lift chair. The note further revealed the resident sustained a medium size bump to the right side of his/her head. An order was received to send the resident to the emergency room for a CAT scan of the head. A review of a facility investigation, dated 04/08/10, revealed Resident #1 used the remote control from the lift chair and attempted to transfer	F 323	**Criteria #2:** An audit of all resident safety alarms/devices has been completed to ensure that all are being used in accordance with each resident's written plan of care. A review of all resident falls occurs in the past 30 days was conducted to ensure appropriate interventions were implemented. **Criteria #3:** Nursing staff members have received educational in-service by the DON on 10/5/10 on implementing and monitoring safety alarms/devices in accordance with the resident's written plan of care. Licensed nurses have received in-service education on the facility's Resident Safe Environment policy and protocol including immediate interventions to implement following a fall, and communicating care plan revisions to direct care staff members. Direct care staff members have received educational in-service on 10/5/10 by the DON on reviewing the Event Communication Log. **Criteria #4:** The CQI indicator tool used for the monitoring of care plan compliance of safety alarms/devices shall be utilized weekly X 4, then monthly X 2, then as per established by the CQI calendar under the supervision of the Director of Nursing. The CQI tool used for the monitoring of falls and implementation of appropriate interventions shall be utilized monthly X 2, then as per established by the CQI calendar.	11/1/10

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F 323	Continued From page 9	F 323		

him/herself unassisted. The investigation revealed the chair was supposed to be unplugged. Recommendations included removal of the lift chair from the resident's room and to find a chair without a remote for Resident #1.

A review of a Social Service Progress Note, dated 04/13/10, revealed a meeting with the resident's family was conducted regarding safety issues with the lift chair. A note on 04/14/10, revealed the chair was removed from the resident's room.

An interview with the Social Services Director, on 09/16/10, revealed the facility spoke with the resident's family member about removing the recliner, on 04/13/10, and the chair was removed on 04/14/10. She stated, "The chair was unplugged from 04/08/10 to 04/14/10, but remained available to the resident."

A review of an Electric Lift Chair Assessment, dated 09/12/09, revealed Resident #1 was assessed with a score of 7, which meant the resident was not a candidate for the use of an electric lift chair. The assessment further revealed the resident was not safe to operate the electric lift chair independently and the facility should consider a lock out/tag for lift chair or other chair alternative. Additional comments noted on the assessment revealed the lift chair was to be unplugged in the down position unless family members were with the resident.

Review of a Care Plan, dated 09/12/09, revealed the reclining chair was to be unplugged and in a low position when the resident not supervised.

An interview with Registered Nurse (RN) #1, on 09/15/10 at 4:15 PM, revealed Resident #1 was

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F 323	Continued From page 10 assessed as being unsafe to operate the lift chair, but the resident's family insisted he/she keep the chair for comfort. She further revealed the resident was care planned to have the lift chair unplugged to prevent operation of the chair independently. An interview with the (former) Director of Nursing (DON), on 09/16/10 at 4:15 PM, revealed she was the nurse working on 04/08/10 who was responsible for sending Resident #1 to the emergency room. She revealed she was unsure if someone gave Resident #1 the remote control or if the remote was left out within the resident's reach, but the chair was supposed to be unplugged. Additionally, she revealed residents were assessed for devices such as a lift chair on care plan reviews and any time a resident might be at risk for injury from a device. She further stated, "Yes, the recliner was unsafe for Resident #1." A review of the policy/procedure "Resident Safe Environment", dated 12/07, revealed staff should supervise resident use of assisted devices until safe and appropriate use was demonstrated. A review of the Nurse's Notes, dated 06/01/10 at 7:45 PM, revealed Resident #1 sustained a fall from his/her wheelchair. The notes further revealed the resident was found lying on his/her right side tangled in the foot rests. Redness and swelling was noted to the resident's right upper arm. An order for an x-ray to the right arm was obtained. A review of the facility investigation, dated 06/01/10, revealed recommended interventions were to ensure Resident #1 was not left	F 323		

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F 323	Continued From page 11 unattended in room, while in his/her wheelchair. A review of the Care Plan, "At Risk for Accidents/Injury", dated 09/12/09, revealed an entry dated 06/02/10, stated the resident was not to be in the wheelchair in his/her room unattended. A review of the Certified Nurse Aide (CNA) Care Plan Record for September 2010, revealed Resident #1 was not to be left unattended in the resident's room while in his/her wheelchair. Observations, on 09/14/10 at 6:30 PM and on 09/15/10 at 5:00 PM, revealed Resident #1 was in the wheelchair and unattended in his/her room. 2. Resident #5 was admitted to the facility on 03/17/08 with diagnoses to include Cerebral Vascular Accident, Osteoarthrosis, Deep Phlebitis of the Leg, and History of Breast Malignancy. A review of a significant change MDS assessment, dated 06/10/10, revealed the facility identified Resident #5 as moderately cognitively impaired and required minimal assistance of one with ambulation. A facility investigation, dated 07/22/10, revealed Resident #5 was found lying on his/her right side in the bathroom. The report revealed Resident #5 was attempting to transfer him/herself without assistance. A review of the Physician's Order, dated 02/02/09, revealed Resident #5 should have a personal alarm to his/her wheelchair. A review of the CNA Care Plan Record dated	F 323		

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	185291	A. BUILDING _____ B. WING _____	09/17/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 323	Continued From page 12 09/10, revealed the resident had a personal safety alarm when in his/her chair. Observations on 09/15/10 at 8:45 AM, 9:30 AM, 10:30 AM, and 11:30 AM, and on 09/17/10 at 9:25 AM revealed Resident #5 was in his/her wheelchair without a personal alarm in place. An interview with State Registered Nurse Aide (SRNA) #4, on 09/17/10 at 9:25 AM, revealed she checked placement and functioning of the personal alarms and sensor alarms anytime she assisted someone to the bed or into a chair. She further revealed the CNA care plans contained information about how to take care of each resident. She stated, "I have worked here long enough, I know who has alarms." An interview with the Quality Assurance RN, on 09/17/10, revealed it was expected that if a resident had an order for a personal alarm, the staff taking care of the resident had the responsibility to make sure an alarm was in place and was functioning. A review of the policy/procedure "Personal Safety Alarms", dated 10/03, revealed it was the policy of the facility to utilize personal safety alarms as a non-restrictive device to promote a safe environment for residents whose assessments indicated they would benefit from such device. A review of a Nurse's Note, dated 05/21/10 at 9:00 PM, revealed Resident #5 had a thick layer of white cream covering his/her lips and inside his/her mouth. The note further revealed a moisture barrier cream was left on the bedside table and the resident thought the cream was chapstick. The Poison Control Center was	F 323		

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F 323	Continued From page 13 notified and it was determined the cream was non-toxic, but was a choking risk for Resident #5. An interview with RN #1, on 09/17/10 at 9:45 AM, revealed the cream should have been stored in the resident's closet, due to Resident #5 was assessed as cognitively impaired. She further revealed at 11:30 AM, no investigation had been completed after the resident applied the cream to his/her mouth, but should have been. Additionally, she stated, "No interventions have been put in place to avoid another incident." An interview with Licensed Practical Nurse #2, on 09/17/10 at 2:05 PM, revealed she was the nurse working, on 05/21/10, when Resident #5 used the barrier cream as chapstick. She stated "I made sure the cream was removed that night and talked to the aides on the floor." She stated no revisions to the care plans were made to ensure prevention of a recurrence. A review of the policy/procedure "Medication Storage in the Facility", (undated), revealed bedside medication storage was permitted for resident's who were able to self-administer medications, upon the written order of the prescriber and when it was deemed appropriate in the judgement of the facility's interdisciplinary resident assessment team.	F 323		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced	F 332	**F 332 Medication Errors** The facility shall ensure that it is free of medication error rates of five percent or greater.	

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F 332	Continued From page 14 by: Based on observations, interviews, and record reviews, it was determined the facility failed to ensure that it was free of medication error rates of 5% or greater. During the survey, a total of 40 opportunities were observed during the medication passes with six (6) medication errors noted, which affected two residents (#16 and #17), not in the selected sample. The facility's medication error rate was 6%. Findings include: 1. Resident #16 was admitted to the facility with diagnoses which included Congestive Heart Failure, Diabetes, Chronic Obstructive Pulmonary Disease and Urinary Retention. A review of the Physician's Orders dated 09/01/10 through 09/30/10, revealed orders for Advair Diskus 500-50 micrograms (mcg) inhale one puff by mouth twice daily-rinse mouth with water after administration-do not swallow 8:00 AM and 7:00 PM. An observation during a medication pass, on 09/14/10 at 6:40 PM revealed the staff administered the Advair Diskus but did not have the resident rinse his/her mouth with water and spit following the use of the inhaler. An interview with Kentucky Medication Assistant (KMA) #1,on 09/17/10 at 2:50 PM, revealed according to facility policy, she had one hour before and one hour after the scheduled administration time to pass the medication. She stated she gave Resident #16 his/her inhaler but did not have him/her to rinse afterwards. She was not aware the rinsing of his/her mouth was a	F 332	**Criteria #1:** Medication staff members are assisting Resident #16 to rinse his/her mouth after administering Advair Discus as per physician orders. Medications are being administered in a timely manner in accordance with each resident's medication orders. **Criteria #2:** Residents receiving Advair Discus are assisted to rinse their mouth after administration of inhaler as per physician's orders. Medications are being administered in a timely manner in accordance with each resident's medication orders. **Criteria #3:** All medication administration staff members have received education in-servicing on 10/5/10 by DON on the facility's policy and procedure on medication administration in accordance with physician orders. All medication administration staff members were required to successfully pass a written medication exam and skills review. **Criteria #4:** The CQI indicator tool used for the monitoring of medication administration shall be utilized monthly X2, then quarterly as per established CQI calendar under the supervision of the Director of Nursing.	11/1/10

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F 332	Continued From page 15 part of the physician's order. She had been employed in the facility for three years and the resident had not rinsed his/her mouth after using the inhaler that she recalled. KMA #1 did not offer the water to the resident and had not informed her supervisor, the resident never rinsed after using the inhaler. 2. Resident #17 was admitted to the facility with diagnoses which included Alzheimer's Disease, Hypertension, Depressive Disorder and Convulsions. A review of the Physician's Orders dated 09/01/10 through 09/30/10, revealed an order for Colace 100 mg one capsule twice daily 8:00 AM and 8:00 PM, Geodon 20 mg one capsule by mouth twice a day 8:00 AM and 8:00 PM, Lamictal one tab twice daily 8:00 AM and 8:00 PM, Namenda 10 mg one tab by mouth twice daily 8:00 AM and 8:00 PM, and Paxil 20 mg one tab by mouth at bedtime 8:00 PM. An observation during a medication pass, on 09/14/10 at 6:45 PM, revealed Resident #17 received his/her 8:00 PM medications at 6:45 PM. An interview with KMA #1, on 09/17/10 at 2:50 PM revealed she did not realize she gave Resident #17 his/her medications early. She stated she gave the medications out of the time frame and was 15 minutes early. An interview with the Director of Nursing (DON), on 09/14/10 at 10:45 AM, revealed according to facility policy, the staff have an hour before or after to administer the resident's medication. She expected the staff to follow instructions of the physician's order and to administer the	F 332		

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F 332	Continued From page 16 medications as ordered. The DON stated the medication's due at 8:00 PM could be given as early as 7:00 PM but not before.	F 332		
F 444 SS=D	483.65(b)(3) PREVENTING SPREAD OF INFECTION The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record review, it was determined facility staff failed to wash their hands after each direct resident contact for three residents (#1, #5, and #8), in the selected sample of 15, as indicated by acceptable professional practice. Findings include: 1. Resident #1 was admitted to the facility on 08/20/09 with diagnoses to include Subdural Hematoma, COPD, Atrial Fibrillation, Diabetes Mellitus II, Hypertension, Rheumatoid Arthritis, and Femur Fracture. A review of an annual Minimum Data Set (MDS) dated 07/22/10, revealed Resident #1 was identified as mildly cognitively impaired. The MDS further revealed Resident #1 required extensive assistance with activities of daily living (ADLs). According to the MDS, Resident #1 was frequently incontinent of bowel and bladder. An observation, on 09/15/10 at 10:40 AM, revealed State Registered Nurse Aide (SRNA) #1 put on gloves before assisting with incontinent	F 444	**F 444 Infection Control** The facility must require staff to wash their hands after each direct resident contact for which hand-washing is indicated by accepted practice. **Criteria #1:** Direct care staff members are practicing proper hand-washing protocol when performing incontinent care/indwelling catheter care. **Criteria #2:** Direct care staff members are practicing proper hand-washing protocol when performing incontinent care/indwelling catheter care. **Criteria #3:** Direct care staff members have received educational in-servicing on hand-washing, and infection control during incontinent care on 10/5/10 by the DON. Skills review has been completed with each direct care staff member. **Criteria #4:** The CQI indicator tool used for the monitoring of handwashing shall be utilized weekly X 4, then monthly X 2, then as per established CQI calendar.	11/1/10

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F 444	Continued From page 17 care for Resident #1 without first washing her hands. After providing care, SRNA #1 took off her gloves and put a new pair of gloves on without washing her hands. SRNA #1 assisted the resident in changing his/her clothing, then took off her gloves without washing her hands. She did not wash her hands before leaving the room with dirty linen. An observation, on 09/15/10 at 10:40 AM, revealed SRNA #2 put on gloves before providing incontinent care for Resident #1 without washing her hands. After providing care, SRNA #2 took off her gloves and put a new pair of gloves on without washing her hands. Resident #1 was transferred to the wheelchair, then SRNA #2 took off her gloves and washed her hands before leaving the resident's room. An interview with SRNA #2, on 09/15/10 at 11:00 AM, revealed handwashing should be performed anytime a staff member entered of left a resident's room. She further revealed she should have washed her hands before putting on gloves. Additionally, she stated, "I didn't wash my hands after taking off my gloves and I should have." An interview with SRNA #1, on 09/15/10 at 11:10 AM, revealed she should have washed her hands before and after resident contact. She further revealed, she did not wash her hands before and after donning gloves. She stated, "I should have washed my hands before leaving the room." 2. Resident #5 was admitted to the facility, on 03/17/08, with diagnoses to include Cerebral Vascular Accident, Osteoarthritis, Deep Phlebitis, and History of Breast Malignancy.	F 444		

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F 444	Continued From page 18 A review of a significant change MDS dated 06/10/10, revealed Resident #5 was identified as mildly cognitively impaired and required limited assistance with ADLs. An observation, on 09/15/10 at 3:15 PM, revealed Licensed Practical Nurse (LPN) #1 provided care for Resident #5 by changing a dressing to his/her right heel. During the dressing change, LPN #1 put on a pair of gloves without washing her hands. After the dressing change was completed, LPN #1 took off the gloves and touched the resident's doorknob to the resident's room, as well as the treatment cart in the hallway, before washing her hands. LPN #1 changed the bag in the resident's trash and washed her hands before leaving the room. An interview with LPN #1, on 09/15/10 at 3:35 PM, revealed she realized she didn't wash her hands between glove changes but stated, "I didn't even think about it." She further revealed she should have washed her hands before touching objects in the resident's room and in the hallway. An interview with the Director of Nursing (DON), on 09/15/10 at 11:00 AM, revealed she expected staff to wash their hands before and after taking off gloves, as well as before any resident care. A review of the policy/procedure, "Handwashing", (undated), revealed handwashing and hand antisepsis shall be regarded by this facility as the single most important means of preventing the spread of infections. The policy further revealed the use of gloves did not replace handwashing/hand antisepsis. 3. Resident #8 was admitted to the facility, on	F 444		

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F 444	Continued From page 19 07/09/10, with diagnoses to include Acute Renal Failure, Hypoxemia, Cardiopulmonary Disease, Diabetes Mellitus Type II, Dementia, Hyperlipidemia, Hypertension and Hypothyroidism. A review of the annual Minimum Data Set (MDS), dated 05/20/10, revealed the facility identified Resident #8 as severely cognitively impaired and required assistance with all ADLs. Observations throughout the survey process, on 09/14-17/10, revealed the resident had an indwelling catheter to bedside drainage. An observation, on 09/17/10 at 10:30 AM, revealed SRNA #3 washed her hands and donned gloves to provide catheter care for Resident #8; however, after she completed the catheter care, she repositioned the resident's gown and g-tube with the contaminated gloves. An interview with SRNA #3, on 09/17/10 at 11:00 AM, revealed she did not realize the error until it was too late. No further explanation was provided.	F 444		
F 502 SS=D	483.75(j)(1) PROVIDE/OBTAIN LABORATORY SVC-QUALITY/TIMELY The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, it was determined the facility failed to ensure labs were	F 502	**F 502 Laboratory Services** The facility shall provide or obtain laboratory services to meet the needs of the residents. The facility is responsible for the quality and timeliness of the services. **Criteria #1:** MD is aware of labs that were not done on the date ordered. **Criteria #2:** An audit of all resident charts was performed to identify any lab tests that were not obtained timely, attending MD's were	

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F 502	Continued From page 20 obtained as ordered by the physician for one resident (#10), in the selected sample of 15, and for one resident (#16), not in the selected sample. Findings include: 1. Resident #10 was admitted to the facility, on 06/08/10, with diagnoses to include Atrial Fibrillation, Congestive Heart Failure, Pneumonia, Malaise/Fatigue, Nausea/Vomiting, Renal Failure, Cerebrovascular Disease, Dementia and Gout. A review of a physician's order, dated 06/11/10, revealed "CBC (Complete Blood Count) next Thursday due to abnormal labs." Further record review revealed a CBC was obtained on 06/16/10, five days after the physician's order was written, which was not in accordance with the order to obtain the lab on 06/17/10. The record indicated the CBC was obtained on a "scheduled lab day" instead. An interview with Registered Nurse (RN) #4, on 09/16/10 at 11:50 AM, revealed she picked up the order, made a copy of the order and gave the lab a copy of the order. It was placed on the calendar for the "scheduled" lab days, which were on Tuesday and Wednesday each week, unless the physician ordered labs for different days, other than the scheduled lab days. At the end of last month, an audit was completed on the charts to ensure the facility was on track with obtaining labs and the audit revealed there were some labs that needed to be drawn on the next lab day. RN #4 stated she was not getting the lab logs back, so she had no way to verify the labs were drawn without calling the hospital. Nursing staff were inserviced regarding how to fill out the order, lab request and where the lab technician would find the form.	F 502	notified accordingly. **Criteria #3:** The facility has contracted with a new laboratory service provider; services began 10/1/10. The facility's lab protocol has been reviewed and revised to ensure timely completion of lab tests. Licensed nurses received in-service education on 9/30/10 and 10/5/10 by the DON regarding the changes in laboratory protocol and new lab provider services. **Criteria #4:** The new laboratory service is to audit all charts monthly to ensure that no labs are missed and obtained timely.	11/1/10

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F 502	Continued From page 21 A review of the facility's policy/procedure "Laboratory Protocol," (undated), revealed "The nurse receiving the order for routine lab work will complete an order in the chart. If this is going to be a routinely scheduled lab, then fax the order to the pharmacy. Complete a lab requisition form, make a copy of the face sheet and the lab order, and place all of these documents in the lab folder for routine lab draws. Add the lab to the lab log (if posted): routine lab days are Tuesday and Wednesday, lab specimens for urinalysis (UA), culture and sensitivity (C & S), hemoccults are done by 10:00 PM - 6:00 AM shift. Lab phlebotomist does blood specimens. The nurse receiving an order for labs to be done on days other than Tuesday or Wednesday: complete an order in the chart. RN House Supervisor will follow up on all lab orders on a daily basis. Unit Managers will issue a routine lab list to each nursing station and to the DON bi-weekly. Unit managers will assure lab requisitions are completed for labs due and check off list as complete." 2. Resident #16 was admitted to the facility with diagnoses to included Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, and History of Deep Vein Thrombosis. A review of the record revealed the resident's physician ordered a Pro-thrombin Time (PT)/International Normalizing Ratio (INR) on 08/19/10, to be obtained in one week on 08/26/10. Further review of the record revealed the PT/INR was not obtained as ordered. The next PT/INR obtained was on 08/31/10. An interview, on 09/17/10 at 10:50 AM, with LPN	F 502		

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F 502	Continued From page 22 #3 revealed she wrote the telephone order for the medication and for the PT/INR to be obtained in one week. She stated, "Normally a certain nurse on the unit was responsible for getting the labs on the calendar. The new telephone orders were placed in a basket, then an administrative nurse collected the orders, placed the lab on the tracking log and calendar." LPN #3 stated due to the recent turnover in staff, she was unsure who was responsible for placing the labs on the log and calendar. An interview with the corporate nurse consultant, on 09/16/10 at 9:55 AM, revealed she served as interim Director of Nursing as of July,2010. She stated there were two unit managers in the facility and they were responsible for putting the labs on the log. The unit manager for wing 1 left the facility without notice and the unit manager from unit 2 started helping out. She stated they completed some audits and identified the former unit manager (wing 1) did not put some labs on the log. The corporate nurse consultant revealed she was unaware laboratory tests were not being obtained as ordered. An interview with the Director of Nursing (DON), on 09/16/10 at 10:20 AM, revealed Registered Nurse (RN) #4 received the physician orders daily and placed the information on the calendar and the lab log. She completed an audit of the charts at the end of August to ensure everything was current and up to date. The audit identified there were annual and every six month labs not completed. The DON stated two labs due in the month of July were missed. They notified the resident's physicians and obtained orders for the labs to be the next lab day.	F 502		

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	185291	A. BUILDING 01 - MAIN BUILDING 01 B. WING	09/16/2010

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COLONIAL TERRACE NURSING HOME	142 ROGER POWELL RD SEBREE, KY 42455

(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 000	INITIAL COMMENTS A Life Safety Code survey was initiated and conducted on 09/16 /10 to determine the facility's compliance with Title 42, Code of Federal Regulations, 483.70 (Life Safety from Fire) and found the facility to be in compliance with NFPA 101 Life Safety Code 2000 Edition. No deficiencies were identified during this survey.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Denise Imfeld
TITLE: Administrator
(X6) DATE: 10/8/10

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.