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

PRINTED: 07/22/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185342	A. BUILDING _____ B. WING _____	07/09/2010

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS. A standard health survey was conducted on 07/07/10 through 07/09/10 and a Life Safety Code survey was conducted on 07/13/10. Deficiencies were cited with the highest scope and severity of an "E" with the facility having the opportunity to correct the deficiencies before remedies would be recommended for imposition.	F 000		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to provide medically-related social services to ensure residents attained the highest practicable mental and psychosocial well-being for two (2) of sixteen (16) sampled residents. Resident #7 and Resident #15 received comfort care/end-of-life care without any documented provisions or care plan for mental and psychosocial needs. In addition, neither resident was provided with assistance to obtain spiritual, financial, or counseling needs by the facility. The findings include: Interview with the Director of Nursing on 07/09/10 at 3:20pm revealed the facility did not have a policy for end-of-life care/comfort care.	F 250	F250 Colonial Health and Rehabilitation Center provides medically related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. The Director of Resident Services has met with Resident #7 regarding her wishes to receive comfort care only. This is documented in the Social Services notes and the resident care plan has been updated to reflect the resident's current needs. Resident 15 is no longer a resident of the facility. The care plans for all other residents requesting comfort care only will be reviewed by the interdisciplinary team by August 6, 2010. All necessary care plan revisions will be made.	August 13, 2010

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

X [signature] | X Administrator | X 7/29/10

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.

MP

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F 250	Continued From page 1 Review of the clinical record for Resident #7 revealed the resident was admitted to the facility with diagnoses of Pneumonia, Chronic Airway Obstruction, Respiratory Failure, and Diabetes. The facility completed an admission Minimum Data Set (MDS) assessment on 06/04/10 which revealed the resident was moderately impaired in the ability to make daily care decisions. The resident was nonambulatory, required extensive assistance to transfer from the bed to a chair and had chronic pain. On 06/14/10, the family determined that the resident would receive comfort care only. The resident was not to be resuscitated in the event of respiratory and/or cardiac arrest. Review of Resident #7's care plan revealed no evidence of interventions by the interdisciplinary team to address end-of-life care/comfort care/Do Not Resuscitate. Review of the clinical record for Resident #15 revealed the resident was admitted to the facility with diagnoses of Dementia, Failure to Thrive, and Unstageable Heel Pressure Ulcer. The facility completed an admission MDS on 06/09/10 which revealed the resident had a severe impairment in the ability to make daily care decisions with cognition varying over the course of the day. The resident required total assistance of staff with all care and was incontinent of bowel and bladder. A signed note, dated 06/14/10, from the resident's family revealed they wished the resident to be treated for pain and receive oxygen; there was to be no tube feeding; intravenous fluids could be administered if the physician ordered them; the resident was not to be sent to the hospital unless there was some form of injury sustained. The resident expired on	F 250	F250 (continued) The Director of Resident Services has developed a Palliative Needs checklist. This checklist was developed with input from Hosparus. It will be used to guide the Director of Resident Services in assessing the needs of residents receiving comfort care measures. The facility's Quality Improvement Organization is scheduled to provide palliative care in-service training to the nursing staff on August 13, 2010. The facility consultant will review the care plans for all residents requesting comfort care no less than quarterly. Any noted problems will be referred to the facility QA Committee.	

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F 250	Continued From page 2 06/15/10 in the facility. Review of Resident #15's care plan revealed no evidence of interventions by the interdisciplinary team to address end-of-life care/comfort care/Do Not Resuscitate. Review of the initial care plan for Resident #15 revealed the word "scared" was written on the care plan. There was no evidence provided by the facility to explain this documentation or to determine if the resident's concern was addressed. Interview with the Social Service Manager on 07/09/10 at 12:15pm, revealed the facility did not have a policy for providing palliative/comfort care/end-of-life care for residents with terminal diagnoses. She stated the facility nursing staff was able to meet all the medical needs of a dying resident. She revealed that she was available for the resident/family if asked; however, she had no direct resident role in comfort care. She stated she was responsible for meeting with the family and documenting the family's wish for comfort care. She stated she completed an assessment when a resident was determined to receive only comfort care; however, this assessment was not written or documented in the resident record and the assessment information was not used to develop a care plan to meet the resident's needs. She indicated documentation of behaviors and moods were her only responsibility when developing a care plan and Resident # 7 and Resident #15 did not have any behaviors or moods. She stated the residents' current care plan did not address any interventions to assist the resident in coping with spiritual, mental, emotional, financial, or counseling needs for the	F 250		

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F 250	Continued From page 3 dying resident. She was unable to say if the residents had a will or other instructions for the family upon their deaths'. She stated she was unable to name what medically-related social services should be provided for comfort care residents and had received no training. She stated the residents should have had a care plan developed for comfort care. She stated no referrals were made to provide residents with any specific comfort care needs. Interview with Licensed Practical Nurse (LPN) #1 on 07/08/10 at 4:00pm revealed that comfort care meant pain management, turning the resident, and keeping them comfortable. She stated she was not sure the facility had a policy and she had received no training from the facility on providing comfort care to residents. Interview with the Assistant Director of Nursing (ADON) on 07/09/10 at 3:10pm, revealed comfort care meant pain management, positioning, and comfort, and if they were daily issues, a care plan should be developed. She agreed that fear should be addressed if the resident revealed/expressed fear. Interview with the Director of Nursing (DON) on 07/09/10 at 3:20pm, revealed the facility did not have a policy for comfort care for dying residents. She stated a policy should be developed. Interview with the Minimum Data Set (MDS) Nurse on 07/09/10 at 3:45pm, revealed comfort care meant different things for different residents and there was no written guide. She stated comfort care should include more than nursing; however, she had not received training from the facility regarding comfort care.	F 250		

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F 250	Continued From page 4 Interview with the Administrator on 07/09/10 at 4:30pm, revealed he was not aware that care plans for comfort care were not being developed and implemented.	F 250		
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 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to periodically review and revise the comprehensive care plans for two (2) of sixteen (16) sampled residents. Resident #7 and #15 were to receive comfort care and the facility failed to review the comprehensive care plans and revise the plans to	F 280	F280 The interdisciplinary team, including the resident or the resident's family/ legal representative when appropriate, of Colonial Health and Rehabilitation Center develops a comprehensive care plan within 7 days after completion of the comprehensive assessment. This assessment is periodically reviewed and revised by a qualified team after each assessment. The Director of Resident Services has met with Resident #7 regarding her wishes to receive comfort care only. This is documented in the Social Services notes and the resident care plan has been updated to reflect the resident's current needs. Resident 15 is no longer a resident of the facility. The care plans for all other residents requesting comfort care only will be reviewed by the interdisciplinary team by August 6, 2010. All necessary care plan revisions will be made	August 13, 2010

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F 280	Continued From page 5 reflect the change in care or to address the care plan for new interventions to meet the residents' needs. The findings include: Observation of Resident #7 on 07/07/10 at 11:30am and 12:30pm, and on 07/08/10 at 10:10am, 2:20pm, and 4:20pm, revealed the resident in bed dressed in a gown with oxygen at two (2) liters a minute by nasal cannula. The resident was alert. Review of the clinical record for Resident #7 revealed the resident was admitted to the facility with diagnoses of Pneumonia, Chronic Airway Obstruction, and Diabetes. The facility completed an admission Minimum Data Set (MDS) assessment on 06/04/10 which revealed the resident had a moderate impairment in the ability to make daily care decisions. The resident required extensive to total assistance from staff for all care and was nonambulatory. Social Services notes from 06/04/10 revealed the resident spent most of the time in bed. On 06/14/10, the social service notes indicated the resident's family requested the resident receive comfort care. The resident was not to be resuscitated in the event of respiratory and/or cardiac arrest. The family did not want the resident to have a tube feeding and they felt the resident had no quality of life. Review of the care plan for Resident #7 revealed no evidence that the change in the resident's status to comfort care along with some care restrictions was care planned by the facility. Review of the clinical record for Resident #15	F 280	F280 (continued) The Director of Resident Services has developed a Palliative Needs checklist. This checklist was developed with input from Hosparus. It will be used to guide the Director of Resident Services in assessing the needs of residents receiving comfort care measures. The facility's Quality Improvement Organization is scheduled to provide palliative care inservice training to the nursing staff on August 13, 2010. Due to frequent changes in condition for residents receiving comfort care measures, these residents will be reviewed no less than monthly by the interdisciplinary team to ensure all changes are reflected in the care plan. The facility consultant will review the care plans for all residents requesting comfort care no less than quarterly. Any noted problems will be referred to the facility QA Committee.	

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F 280	Continued From page 6 revealed the resident was admitted with diagnoses of Dementia, Failure to Thrive, and a Multiple Unstageable Pressure Ulcers. The facility completed an admission MDS assessment on 06/09/10 which revealed the resident had a severe impairment in the ability to make daily care decisions and required extensive to total care assistance by staff. The resident had two (2) Stage III and Two (2) Stage IV pressure ulcers. The resident was not to be resuscitated in the event of respiratory and/or cardiac arrest. On 06/13/10, the physician ordered all medication to be discontinued except for an antibiotic given by injection. On 06/14/10, comfort care was ordered by the physician as requested by the family. The resident was to receive comfort care, pain medication, and oxygen. Review of the care plan for Resident #15, revealed no evidence the care plan was revised by the facility to reflect the changes in the resident's status as they occurred. Interview with the Social Services Manager on 07/09/10 at 12:15pm revealed the residents' care plans were not reviewed and revised to reflect the residents' changes to comfort care. She stated she was only responsible for care planning behaviors and moods so the care plans was not revised. She stated the care plans should have been revised to meet the residents' changing needs. Interview with the MDS Nurse on 07/09/10 at 3:45pm, revealed she reviewed care plans every three months for revisions. She stated she did not know the facility's policy for providing comfort care and had never written a care plan for comfort care. She revealed she had not received	F 280		

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F 280	Continued From page 7 training on comfort care; however, she knew it meant different things to different people. Interview with the Director of Nursing on 07/09/10 at 3:20pm, revealed there was no policy for the revision of the comprehensive care plan when a resident's condition or status changed. She stated the care plans should have been revised to reflect specific comfort care needs for each residents.	F 280		
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, interview, and record review, it was determined the facility failed to ensure that residents received adequate supervision and assistive devices to prevent accidents for one (1) of sixteen (16) sampled residents (#6). Resident #6 repeatedly fell from a low bed to a floor mat, and determined by the facility to require evaluation, without the facility reviewing the care plan and implementing new interventions to prevent accidents. The findings include: Review of the facility's Fall Management policy, dated 01/01/10, revealed the facility would identify	F 323	F323 Colonial Health and Rehabilitation Center ensures 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. On July 29, 2010, resident #6's falls for the past 6 months were reviewed by the falls committee in an attempt to identify a pattern or causations for the falls. In addition, resident 6's pain assessment, bowel and bladder assessments, therapy screenings, activity patterns, social service assessment, dietary assessments as well as environmental conditions of her room were reviewed so these areas could be considered when developing a plan to ensure the resident is receiving adequate services and assistance devices to prevent accidents. Resident 6's care plan has been reviewed and revised.	August 22, 2010

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F 323	Continued From page 8 residents' risk factors for falls and manage those residents, who experience a fall, to minimize the risk of a fall recurring. The facility would monitor the residents' interventions and modify when necessary. After a fall, the facility would review the current plan of care and if necessary revise interventions to reduce the likelihood that a fall would recur. Review of the clinical record for Resident #6 revealed the resident was admitted with diagnoses of Anxiety, Insomnia, Major Affective Disorder, Dementia, and Seizures. The facility completed a significant change Minimum Data Set (MDS) assessment on 04/12/10 which revealed the resident was severely impaired in the ability to make daily care decisions and had short and long term memory deficits. The resident at times was understandable and understood. The resident exhibited an increase in behaviors which included: distraction, restlessness, unpleasant mood, negative statements, abusive behavior towards staff, repetitive negative verbalizations, and had cognition that varied over the course of the day. Review of the records of fall investigations, for Resident #6, completed by the facility revealed the resident was found on the floor on 01/14/10 at 12:00pm. The facility determined that the resident was trying to get to the bedside commode. A sensory alarm in place was sounding and the resident was wearing non-skid footwear. The care plan revealed the resident had a history of unplugging the alarms since 09/27/09; however, the sensory alarms were continued to be used on the resident. The resident was to have all meals in the dining room as the falls were occurring during meal time. The	F 323	F323 (continued) The falls Committee will complete reviews of all residents with falls for the past 6 months by August 22, 2010. Any needed care plan revisions will be made. On August 16, 2010, a new process will be implemented by the facility to investigate and respond to incidents. The incident response will include a concurrent care plan review to ensure that interventions put in place have been carried over to the care plan. The effectiveness of these interventions will continue to be reviewed weekly by the falls committee. To enhance the effectiveness of these evaluations and to ensure that all options for interventions are considered, the composition of the committee will be expanded to include front line nursing staff who are more intimately familiar with the residents as well as representatives from Activities and Social Services. On August 13, 2010, the facility's Quality Improvement Organization will provide inservice training related to falls for the nursing staff. The training will address using root cause analysis to guide the development of effective interventions.	

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F 323	Continued From page 9 current care plan revealed no evidence the resident was to eat meals in the dining room. On 01/31/10 at 1:00am, the resident was found on the floor. The resident was wearing non-skid footwear and the sensory alarm was sounding. The facility determined the resident was getting out of bed. The resident was given a reminder by the staff to use the call light; however, the resident had both long and short memory deficits. The bedside commode was removed from the resident's room. On 02/16/10 at 12:55am, the resident was found on the floor and the sensory alarm sounding. The facility determined the resident was getting out of bed going to the bathroom. The resident sustained a bitten lip, abrasions on the head and shoulder, and was sent to the emergency room where a urinary tract infection was diagnosed. The sensory alarm was exchanged for a tab alarm connected to the resident's clothing. On 03/04/10 at 1:45pm, the resident was found on the floor complaining of hip and back pain. The tab alarm was not in place. The resident was evaluated and found to have no injuries. On 03/22/10 at 00:30am, the resident was found on the floor. The tab alarm was sounding. The resident sustained a red raised area on the side of the head and a skin tear to the right shoulder. Fall mats and a low bed were implemented. On 05/05/10 at 11:45pm, the resident rolled out of the low bed and the tab alarm sounded. The resident was sent to the hospital with a head laceration and right shoulder pain. The facility implemented floor mats; however, floor mats	F 323	F 323 (continued) To gauge the effectiveness of the weekly falls committee meetings, for the next 6 months the facility's nurse consultant will attend at least one meeting a quarter and review that week's incidents, facility investigation of the same , intervention implementation, and care plan documentation. The consultant will include her findings in her written consultant reports which are reviewed by the QA committee. The committee will determine if compliance has been achieved or the need for additional training, system modification, or personnel change is needed.	

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