

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

PRINTED: 03/01/2013  
FORM APPROVED  
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  02/15/2013
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NAME OF PROVIDER OR SUPPLIER  COLONIAL MANOR CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2365 NASHVILLE ROAD BOWLING GREEN, KY 42101
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(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
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F 000	INITIAL COMMENTS  A recertification survey was conducted on 02/12/13 through 02/15/13 to determine the facility's compliance with Federal requirements. The facility failed to meet the minimum requirements for recertification with the highest scope and severity of a "F".	F 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Colonial Manor Care and Rehabilitation Center does not admit that the deficiency listed on this form exists, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."	
F 164 SS=E	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS  The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.  Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.  Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.  The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.  The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.	F 164	<b>F164 Personal Privacy/Confidentiality</b>  Nurse Aide #1 and RN #1 were re-educated on personal privacy to include complete pulling of privacy curtains by the Director of Nursing Services on 03/06/13. LPN #1 was re-educated on confidentiality of records to include covering medication administration records when not in use by the Director of Nursing Services on 2/27/13.  The Director of Nursing and Assistant Director of Nursing monitored resident care and medication pass on each shift for five days starting on 2/19/2013. No other issues were identified. The Director of Nursing reviewed Privacy and Confidentiality during Resident Council Meeting on 02/21/2013 no issues or concerns were addressed by the residents at that time.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Chris Swihart TITLE: Administrator (X6) DATE: 3/15/13

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 164	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy/procedure, it was determined the facility failed to ensure each resident had the right to personal privacy for two residents (#4 and #7), in the selected sample of twelve (12) residents, related to the utilization of a privacy curtain during resident care and failed to ensure the confidentiality of clinical records for one resident (#15), not in the selected sample.</p> <p>Findings include:</p> <p>A review of the "Resident Rights and Information for Residents Living in Kentucky", undated, revealed the resident had the right to personal privacy and confidentiality of his/her personal and clinical records.</p> <p>1. An observation of catheter care, on 02/14/13 at 2:00 PM, revealed Certified Nurse Aide (CNA) #1 provided care for Resident #4; however, did not pull the privacy curtain in front of the door leading out into the hallway.</p> <p>An interview with CNA #1, on 02/15/13 at 9:07 AM, revealed she should have pulled the curtain between the door and the resident during catheter care on 02/14/13.</p> <p>An interview with Licensed Practical Nurse (LPN) #2, on 02/14/13 at 4:18 PM, revealed CNA #1 should have pulled the privacy curtain completely around the bed while providing care to the resident.</p>	F 164	<p>Nursing staff was re-educated on personal privacy, confidentiality of records and resident rights education completed on 03/06/2013 by the Director of Nursing Services and Assistant Director of Nursing Services.</p> <p>The Director of Nursing /Assistant Director of Nursing will conduct medication pass and resident care observations three times a week for the next four weeks, then three times a month for two months. The Director of Nursing will report findings to the Performance Improvement Committee for the next three months for further recommendations.</p> <p>Completion date</p>	3/8/13	

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F 164	<p>Continued From page 2</p> <p>2. An observation of Resident #7's skin assessment, on 2/14/13 at 10:15 AM, revealed Registered Nurse (RN) #1 did not ensure the resident's privacy curtain was pulled completely around the bed, exposing the resident's bilateral legs and brief to the resident's roommate.</p> <p>An interview with RN #1, on 02/14/13 at 2:20 PM, revealed she did not realize the privacy curtain was not completely drawn. She revealed she should have closed the curtain to ensure full privacy for Resident #7.</p> <p>An interview with the Director of Nursing (DON), on 02/14/13 at 11:30 AM, revealed she expected healthcare staff to ensure a resident's privacy was respected and pull the curtain so that a resident is not exposed during a skin assessment and or any type of nursing care.</p> <p>3. An observation of a medication pass, on 02/14/13 at 9:35 AM, revealed LPN #1 left the medication cart to administer medication to Resident #15; however, she left the resident's Medication Administration Record (MAR) uncovered, on top of the medication cart.</p> <p>An interview with LPN #1, on 02/15/13 at 10:00 AM, revealed she was supposed to cover the MAR each time she leaves the medication cart, to ensure privacy for the resident.</p> <p>An interview with the Director of Nursing (DON), on 02/15/13 at 12:35 PM, revealed she expected staff to ensure resident information was covered</p>	F 164		

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F 164 F 241 SS=D	Continued From page 3 when left unattended. 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY  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.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy/procedure, it was determined the facility failed to promote care for residents in a manner that maintained or enhanced each resident's dignity and respect. During a medication pass, Licensed Practical Nurse (LPN) #1 failed to knock on each resident's door prior to entering the room.  Findings include:  A review of the "Resident Rights and Information for Residents Living in Kentucky", undated, revealed each resident should be treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs.  An observation of a medication pass, on 02/13/13 at 9:12 AM and on 02/14/13 at 9:25 AM and 9:35 AM, revealed LPN #1 did not knock on the resident's doors of three residents prior to entry.  An interview with LPN #1, on 02/15/13 at 10:00 AM, revealed she was supposed to knock on the	F 164 F 241	F241 Dignity and Respect  LPN #1 was re-educated by the Director of Nursing Services on 2/27/2013 on Dignity and respect specific to knocking on resident doors before entering.  The Director of Nursing and Assistant Director of Nursing monitored resident care and medication pass on each shift for five days starting on 2/19/2013. No other issues were identified. The Director of Nursing reviewed Dignity and Respect during the Resident Council Meeting on 02/21/2013 no issues or concerns were addressed by the residents at that time.  Nursing staff was re-educated on dignity and respect /resident rights on 03/06/2013 by the Director of Nursing Services and Assistant Director of Nursing Services.  The Director of Nursing /Assistant Director of Nursing will conduct medication pass and resident care observations three times a week for the next four weeks, then three times a month for two months. The Director of Nursing will report findings to the Performance Improvement Committee for the next three months for further recommendations.  Completion date	3/8/13

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F 241	Continued From page 4 resident's door or make her presence known prior to entry, as it was the resident's home.  An interview with the Director of Nursing (DON), on 02/15/13 at 12:36 PM, revealed she expected staff to knock on the resident's door prior to entry into the room.	F 241	<b>F281 Professional Standards</b>  Resident #16 picture was placed in the MAR/TAR on 02/19/13 by the Health Information Coordinator. LPN #1 was re-educated by the Director of Nursing Service on 2/27/2013 on the five rights of medication administration to include resident identification. The Health Information Manager was re-educated by the Director of Nursing on timeline for updating photos of new admissions on 2/26/13.  Medication/Treatment Administration Records were reviewed by Health Information Manager on 2/19/2013 all resident photos were current and no other issues were identified.	
F 281 SS=D	<b>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</b>  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy/procedure, it was determined the facility failed to ensure services provided by the facility met professional standards of quality for one resident (#16), not in the selected sample. Licensed Practical Nurse (LPN) #1 did not use the identifiers in place by the facility to ensure medications were given to the right resident.  Findings include:  A review of the Medication Administration policy/procedure, undated, revealed to remember the "five rights" of medication administration: right drug, right dose, right resident, right time, and right route.  An observation of a medication pass, on 02/13/13 at 9:25 AM, revealed LPN #1 prepared medication for Resident #16. During the	F 281	The Director of Nursing Services provided re-education to licensed nursing staff on policy and procedure for Medication Administration to include resident identifiers, completed 3/6/2013.  The Director of Nursing/Assistant Director of Nursing will conduct Medication Administration Record reviews three times a week for the next four weeks, then three times a month for two months. The Director of Nursing will report the findings to the Performance Improvement Committee for the next three months for further recommendations.	3/8/13
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F 281	Continued From page 5 observation, LPN #1 stated she had never met the resident before; however, continued with the medication pass. Observation of the Medication Administration Record (MAR), dated 02/01-28/13, revealed no picture of the resident.  An interview with LPN #1, on 02/15/13 at 10:00 AM, revealed the identifiers used during a medication pass included the resident's picture at the bottom of the MAR and the name plate located outside the resident's door.  An interview with the Director of Nursing (DON), on 02/15/13 at 12:35 PM, revealed she expected staff to use two identifiers when passing medication, to ensure the right medication was given to the right resident. She revealed the identifiers included the name plate beside the resident's door and the picture of the resident at the bottom of the MAR.	F 281	<b>F323 Free Of Accident Hazards</b>  On 2/15/2013 cough drops were removed from resident #17's room by the Director of Nursing Services. LPN #3 was re-educated on the residents' environment remains free of hazards to include locking the medication cart when not in use by Director of Nursing Services on 03/06/13.  Room reviews were conducted by the Director of Nursing Services on 2/15/13 and no other concerns noted for medications at bedside. The Director of Nursing and Assistant Director of Nursing conducted medication pass on each shift for five days starting on 2/19/2013. No other issues were identified. The Director of Nursing Services spoke with the residents' about medications at bedside during Resident Council meeting conducted 2/21/2013.		
F 323 SS=D	<b>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</b>  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, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure the	F 323	Staff was re-education on medications at bedside by Director of Nursing Services and Assistant Director of Nursing Services completed 03/06/13. Family notification was mailed on 3/4/2013 on over the counter medications and medications at bedside by Director of Nursing Services. Licensed nurses were re-educated on medication administration to include locking the med cart when not in use on 03/06/13 by the Director of Nursing Services and Assistant Director of Nursing Services.		

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F 323	<p>Continued From page 6</p> <p>resident environment remained as free of accident hazards as is possible for one resident (#17), not in the selected sample. Medications were observed at the resident's bedside without a physician's order. Additionally, the facility failed to ensure an unattended medication cart was locked during a medication pass.</p> <p>A review of a list of wandering residents provided by the facility revealed there were two wandering residents in the building.</p> <p>1. A review of the facility's "General Rules for Residents and Sponsors", undated, revealed residents are not permitted to keep any medications in their rooms. Responsible parties are asked to check with the charge nurse on any type of drops, cough medication, inhalants etc., before giving to the resident.</p> <p>A record review revealed Resident #17 was admitted to the facility on 06/15/12 with diagnoses to include Difficulty Walking, Pneumonia, Congestive Heart Failure, Hypocalcemia, Chronic Kidney Disease and Atrial Fibrillation. A review of the Minimum Data Set (MDS), dated 01/14/13, revealed the facility assessed the resident as moderately cognitively impaired.</p> <p>Observations, on 02/12/13 at 9:55 AM, on 02/13/13 at 9:35 AM and 2:45 PM, on 02/14/13 at 9:10 AM, and on 02/15/13 at 9:40 AM, revealed an opened bag of Honey Lemon cough drops on the night stand in the resident's room. The facility identified two residents in the facility with wandering behavior.</p> <p>A review of the Physician's Orders, dated</p>	F 323	<p>Room reviews and Medication Administration Reviews will be conducted three times a week for four weeks, then three times a month for two months to ensure no medications are kept at bedside without the proper physician order and med carts are locked when not in use by the Director of Nursing/Assistant Director of Nursing. The Director of Nursing will report the findings to the Performance Improvement Committee for the next three months for further recommendations.</p> <p>Completion Date:</p>	3/8/13	

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F 323	Continued From page 7 February 2013, revealed Resident #17 did not have an order for the cough drops.  An interview with Registered Nurse (RN) #1, on 02/15/13 at 9:40 AM, verified the resident should not have the cough drops at the bedside as he/she does not have an order for them. She revealed the family may have brought the cough drops to the resident.  An interview with the Director of Nursing (DON) on, 02/15/13 12:30 PM, revealed she would have expected the staff to report any medications found at the bedside as it required a physician's order.  2. A review of the Medication Administration policy/procedure, undated, revealed to keep the medication cart locked when not in full site.  An observation of a medication pass, on 02/13/13 at 2:40 PM, revealed Licensed Practical Nurse (LPN) #3 left the side cabinet of the medication cart unlocked and unattended while administering medications to a resident. The cabinet contained multiple bottles of Milk of Magnesia (laxative) and Mylanta (antacid).  An interview with the Director of Nursing (DON), on 02/15/13 at 12:35 PM, revealed she expected staff to lock the medication cart when left unattended.	F 323	<b>F332 Medication Error Rate</b>  Resident # 10 and Resident #16 were assessed by the Director of Nursing Services on 02/13/13 without change in condition. LPN #1 was re-educated on Medication administration to include crushable meds, five rights of medication administration on 02/27/13 by the Director of Nursing Services.  The Director of Nursing and Assistant Director of Nursing monitored medication pass on each shift for five days starting on 2/19/2013. No other issues were identified in these reviews. The Director of Nursing reviewed current resident Medication Administration Records on 02/21/13 and no other issues were identified.  The Director of Nursing Services provided re-education to licensed nursing staff on policy and procedure for Medication Administration, to include crushable medications completed 3/6/2013.		
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.	F 332			

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F 332	Continued From page 8  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure it was free of medication errors of five (5) percent or greater. The facility had two medication errors out of forty opportunities to equal a medication error rate of five (5) percent.  Findings include:  A review of the Medication Administration policy/procedure, undated, revealed not to crush medications without a physician's order and to remember the "five rights" of medication administration: right drug, right dose, right resident, right time, and right route.  1. An observation of a medication pass for Resident #10, on 02/13/13 at 9:12 AM, revealed Licensed Practical Nurse (LPN) #1 administered the following medication to the resident, crushed in pudding: Pantoprazole Sodium (Delayed Release (DR) 40 milligrams (mg) tablet.  A review of the Medication Administration Record (MAR), dated February 2013, revealed the order for Pantoprazole Sodium DR 40 mg tablet every twelve hours for Gastroesophageal Reflux Disease (GERD). The MAR does not specify to crush the tablet.  An interview with LPN #1, on 02/15/13 at 10:00 AM, revealed she should not crush delayed release medications. She thought all of the	F 332	The Director of Nursing/Assistant Director of Nursing will conduct Medication Administration Record reviews three times a week for the next four weeks then three times a month for two months. The Director of Nursing will report findings to the Performance Improvement Committee for the next three months for further recommendations.  Completion Date	3/8/13

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F 332	Continued From page 9 resident's medications could be crushed and she "did not pay attention."  2. An observation of a medication pass for Resident #16, on 02/13/13 at 9:25 AM, revealed Aspirin 81 mg was administered to Resident #16 from the emergency box.  A review of the resident's physician's orders and MAR, dated February 2013, revealed an order for Aspirin Enteric Coated (EC) 81mg delayed release tablet every day. A review of the Emergency Box Usage Sheet, revised 02/17/12, revealed the contents of the box did not include Aspirin EC 81mg tablets.  An interview with LPN #1, on 02/15/13 at 10:00 AM, revealed she did not "pay attention" to the resident's specified order for Aspirin EC 81mg; therefore, administered the Aspirin 81mg tablet from the emergency box.  An interview with the Director of Nursing (DON), on 02/16/13 at 12:35 PM, revealed she expected staff to check the MAR three times prior to administration, to ensure the correct medication was given. She also verified delayed release medications should not be crushed.	F 332	<b>F364 Food Appearance</b>  Nutritional Services Director re-educated the cook on 2/18/13 on foods prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature to include separating foods. Dinnerware was ordered by the Nutritional Services Director on 02/13/13.  The Director of Nursing reviewed appearance of food at the Resident Council Meeting on 02/21/2013 no issues or concerns were addressed by the residents at that time. Meal service reviews were conducted by the Nutritional Services Director for five days starting 2/18/13, no concerns identified at that time.  The Dietary department was re-educated on foods prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature to include separating foods, on 02/28/2013. The Cook received one on one re-education to include visual appearance of food on 02/18/2013 by Nutritional Services Director.		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP.  Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.	F 364			

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

PRINTED: 03/01/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  02/15/2013
NAME OF PROVIDER OR SUPPLIER  COLONIAL MANOR CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2365 NASHVILLE ROAD BOWLING GREEN, KY 42101	
(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 364	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure food served to residents was attractive in appearance.  Findings include:  An observation of the tray line, on 02/12/13 at 11:20 AM, revealed the cook was "sloshing" juice from the cabbage into other foods on the tray line. The trays were not visually appetizing, as the plate was visibly wet with cabbage juice.  An observation of the tray line, on 02/13/13 at 11:25 AM, revealed the cook prepared multiple trays of chicken and dumplings with green beans. There was excess juice from the chicken and green beans in the plates, with no attempt to separate the foods. A test tray was obtained, on 02/13/13 at 12:00 PM, with chicken, dumplings, and green beans. The test tray was observed with the Nutritional Services Director (NSD) present. Observation of the tray revealed a chicken patty with watery juice on the plate with dumplings poured over the chicken. There was juice from the dumplings over into the green beans. The foods were not separated and the appearance was not appetizing.  An interview with the NSD, on 02/13/13 at 12:00 PM, revealed she expected the presentation of the food to be more appetizing. She stated the chicken and dumplings should be in a bowl; however, they ran out of bowls in the kitchen.	F 364	Meal service reviews will be completed three times a week for four weeks, then three times a month for two months by the Nutritional Services Director or Administrator. The Nutritional Services Director will report findings to the Performance Improvement Committee for the next three months for further recommendations.  Completion Date:	3/8/13
F 371 SS=E	483.35(l) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		

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

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OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER  COLONIAL MANOR CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2386 NASHVILLE ROAD BOWLING GREEN, KY 42101		
(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 11</p> <p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy/procedure, it was determined the facility failed to store, prepare, distribute, and serve food under sanitary conditions.</p> <p>Findings include:</p> <p>1. A review of the Cold Food Storage policy, dated 07/08, revealed the Nutrition Services Director (NSD) would ensure an accurate thermometer was kept in each refrigerator and freezer. The NSD would ensure all items were stored properly in covered containers, labeled, and dated.</p> <p>A review of the Dry Food Storage policy, dated 07/08, revealed NSD should ensure the storage area was not subject to contamination by leakage.</p> <p>Observations during the initial tour of the kitchen, on 02/12/13 at 10:00 AM revealed:</p> <p>A. No thermometer inside the refrigerator.</p>	F 371	<p><b>F371 Food Procure; Store/Prepare/Serve-Sanitary</b></p> <p>The thermometer was replaced inside the refrigerator on 2/12/2013. The cottage cheese was discarded on 2/12/2013. Thickened liquids without dates were discarded on 2/12/2013. Water around water pitcher was cleaned on 2/12/013. Vegetable oil was discarded on 2/12/2013. Bologna was discarded on 2/12/2013. Cook received one on one re-education on 2/18/13 on food service and preparation by Nutritional Services Director to include glove use, hair net usage, drying of dishes.</p> <p>Meal service reviews were conducted by the Nutritional Services Director for five days starting 2/18/13. Sanitation review was completed on 2/18/2013 by the Nutritional Services Director. No issues were identified in this review.</p> <p>Dietary Staff was re-education on 2/28/2013 by the Nutritional Service Director, education included food service procedures, hand washing, food appearance, food storage procedures, proper temperature techniques, sanitation, drying of dishes and hairnets.</p>		

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

PRINTED: 03/01/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  02/15/2013
NAME OF PROVIDER OR SUPPLIER  COLONIAL MANOR CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2386 NASHVILLE ROAD BOWLING GREEN, KY 42101		
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F 371	Continued From page 12 B. (1) open container of cottage cheese in the refrigerator, undated. C. (12) cups of thickened liquids in the refrigerator, uncovered and undated. D. Multiple opened containers of thickened liquids in the refrigerator, undated. E. (1) pitcher stored on a lower shelf with water visible around the pitcher. F. (1) bottle of vegetable oil stored with the top off, in the dry storage area. G. (1) box of bologna in the freezer, exposed with frost build up noted.  2. A review of the Food Preparation policy, dated 07/08, revealed the NSD should ensure all staff practice proper hand washing technique and practice proper glove use. The Cook was responsible for food preparation procedures that avoid contamination.  A review of the Staff Attire policy, dated 07/08, revealed all staff members should have their hair confined in a hair net or cap.  Observation of the tray line, on 02/12/13 at 11:20 AM revealed :  A. The cook verified the temperature of (11) foods on the steam table; however, cleaned the temperature probe with the same alcohol wipe between foods.  B. The cook served food on wet plates, divided	F 371	Meal service reviews will be completed three times a week for four weeks, then three times a month for two months by the Nutritional Services Director or Administrator. Sanitation audits will be conducted once a week for a month, then monthly for two months by the Nutritional Services Director. The Nutritional Services Director will report findings to the Performance Improvement Committee for the next three months for further recommendations.  Completion Date	3/8/13	

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

PRINTED: 03/01/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  18504B	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  02/15/2013
NAME OF PROVIDER OR SUPPLIER  COLONIAL MANOR CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2366 NASHVILLE ROAD BOWLING GREEN, KY 42101		
(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 13 plates, and trays.</p> <p>C. The cook left the tray line to get food from the stove on multiple occasions; however, did not change his gloves or wash his hands.</p> <p>D. The cook served food from the steam table using his gloved hand, on multiple occasions</p> <p>E. The cook prepared, cooked, and served two grilled cheese sandwiches using his soiled gloved hands, then went back to the tray line to serve more food without a glove change.</p> <p>F. The cook did not completely cover his hair with a hair net during the tray line observation on 02/12/13 at 11:20 AM and 02/13/13 at 11:25 AM.</p> <p>An interview with the NSD, on 02/15/13 at 11:00 AM, revealed a thermometer should be in the refrigerator at all times. She revealed if something is opened in the refrigerator, it should be dated. Liquids prepared for the next meal should be covered, dated, with the resident's name on it. She stated she "tried" to check the refrigerator daily. Dinnerware should be stored clean and dry. Any item in the dry storage area, such as the vegetable oil, should be covered and secured. Staff are expected to ensure items in the freezer are closed to avoid "freezer burn". Staff should have multiple alcohol wipes when obtaining food temperatures. They should change wipes between each food. Items out of the dishwasher should air dry completely before using. She was aware the cook served food on wet trays and plates; however, stated he should have let them dry first. If staff leave the tray line, they should always wash their hands and change</p>	F 371			

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

PRINTED: 03/01/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  188048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  02/15/2013
NAME OF PROVIDER OR SUPPLIER  COLONIAL MANOR CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2366 NASHVILLE ROAD BOWLING GREEN, KY 42101	
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F 371	Continued From page 14 gloves before coming back to serve food. Hair nets should completely cover all the hair. She stated she observed the cook on 02/12/13 and 02/13/13; however, did not notice the cook's hair was not completely covered.	F 371	<b>F372 Garbage Disposal</b>  The lid was re-placed on the trash can on 2/15/2013 by the Maintenance Director.	
F 372 SS=D	483.35(j)(3) DISPOSE GARBAGE & REFUSE PROPERLY  The facility must dispose of garbage and refuse properly.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to dispose of garbage properly.  Findings include:  An observation, on 02/15/13 at 8:00 AM, revealed one trash can without a lid on the north side. The trash can was partially full, located outside near the oxygen tank storage area.  An interview with the Housekeeping Supervisor, on 02/15/13 at 8:45 AM, revealed staff were supposed to empty the trash outside as soon as possible in the morning, and then again around 2:00 PM. She revealed each trash can was supposed to have a lid; however, they sometimes get "blown away".  An interview with the Administrator, on 02/15/13 at 12:00 PM, revealed housekeeping should have ensured the trash can lid was in place after it was emptied. He revealed there were plenty of trash can lids at the facility.	F 372	Maintenance Director and Housekeeping supervisor conducted audits of trash cans for five days starting 2/18/2013. No issues were identified in these audits.  The Director of Nursing Service, Assistant Director of Nursing and administrator conducted education with staff on disposal of garbage completed 3/6/2013 including securing lid placement.  The Maintenance Director or Housekeeping Supervisor will conduct reviews of trash disposal three times a week for four weeks, then three times a month for two months. The Maintenance Director will report findings to the Performance Improvement Committee for the next three months for further recommendations.  Completion Date	3/8/13

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

PRINTED: 03/01/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  02/15/2013
NAME OF PROVIDER OR SUPPLIER  COLONIAL MANOR CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2386 NASHVILLE ROAD BOWLING GREEN, KY 42101	
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F 441 SS=E	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</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 - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (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. (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.</p> <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 Infection Control</p> <p>A McGreer's assessment was conducted for resident # 7 by the Registered Nurse on 02/14/13 to assess for any complications related to infection control procedures specifically hand washing with glove changes. The Infection Control Coordinator re- educated Registered Nurse #1 on performing routine hand washing before and after resident contact and use of gloves for potential or actual exposure to blood or body fluids on 03/06/13. LPN #1 was re-educated by the Director of Nursing Services on 2/27/13 on proper medication administration to include hand hygiene. LPN #3 was re-educated by the Director of Nursing Services on the proper cleaning of the glucometer machine with bleach wipes on 02/21/13.</p> <p>Current residents were re-assessed by licensed nurses on 02/18/2013 using the McGreer's assessment to assess for any complications related infection control, hand washing and glucometer testing. The infection control coordinator reviewed infection control reports for trending with no noted concerns.</p>	

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

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FORM APPROVED  
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER  COLONIAL MANOR CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2366 NASHVILLE ROAD BOWLING GREEN, KY 42101	
(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 16  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and a review of the facility's policies and procedures, it was determined the facility failed to ensure licensed staff washed their hands and changed gloves as required to help prevent the spread and transmission of disease when providing care to one resident (#7) in the selected sample of twelve (12) residents and before leaving a resident's room after providing care. Additionally, the facility failed to ensure proper handwashing during a medication pass and failed to clean the glucometer machine with a bleach wipe per the glucometer equipment quick reference guide.  The findings include:  1. An observation of a skin assessment by Registered Nurse (RN) #1, on 02/14/13 at 10:15 AM, revealed she washed her hands, applied gloves, began to examine residents bilateral feet, lower extremities and partially removed Resident #7's incontinence brief and examined the resident's perineal area by touching the area with gloved hands. RN #1 then reapplied the resident's incontinence brief and proceeded to touch the skin of the resident's back, abdomen, bilateral upper extremities, and neck while still wearing the soiled gloves used to examine the resident's perineal area. RN #1 failed to remove the gloves, wash her hands, and apply clean gloves after contact with Resident#7 perineal area and prior to the examination of the resident's	F 441	Staff were re-educated by the Infection Control Coordinator on performing routine hand washing before and after resident contact and use of gloves for potential or actual exposure to blood or body fluids completed on 3/6/12. The Director of Nursing Services provided re-education to licensed nursing staff on policy and procedure for Medication Administration, completed 3/6/2013 to include glucometer cleaning procedure.  The Director of Nursing will observe direct resident care by staff three times a week for four weeks, then three times a month for two months. The observations will include performing routine hand washing before and after resident contact and use of gloves for potential or actual exposure to blood or body fluids. The Director of Nursing/Assistant Director of Nursing will conduct Medication Administration Record reviews three times a week for the next four weeks, then three times a month for two months. The Director of Nursing will report findings to the Performance Improvement Committee for the next three months for further recommendations.  Compliance date:	3/8/13

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

PRINTED: 03/01/2013  
FORM APPROVED  
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER  COLONIAL MANOR CARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2365 NASHVILLE ROAD BOWLING GREEN, KY 42101		
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F 441	<p>Continued From page 17 back, abdomen, bilateral upper extremities, and neck.</p> <p>An interview conducted on 02/14/13 at 2:20 PM with RN #1 revealed she was knowledgeable of the facility's policies related to proper hand hygiene and gloving techniques. However, RN #1 stated that she was nervous because she was being watched, and forgot to change her gloves and wash her hands in accordance with facility policy during the observation.</p> <p>An interview conducted with the Director of Nursing (DON), on 2/14/13 at 11:30 PM, revealed that all licensed healthcare personnel were instructed on policies and procedures related to infection control during their orientation, and reviewed annually during the competency fair.</p> <p>2. A review of the Medication Administration policy, undated, revealed to follow infection control practices.</p> <p>An observation of a medication pass, on 02/13/13 at 9:12 AM, revealed Licensed Practical Nurse (LPN) #1 did not wash her hands prior to preparation of the medications. During preparation, she obtained medications from the package using her bare hand and administered the medication to a resident. An observation, on 02/14/13 at 9:25 AM, revealed LPN #1 knocked over a cup of medications on the med cart. She picked up the medication, placed it back into the cup, and administered the medications to a resident.</p>	F 441		

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

PRINTED: 03/01/2013  
FORM APPROVED  
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER  COLONIAL MANOR CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2366 NASHVILLE ROAD BOWLING GREEN, KY 42101	
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F 441	<p>Continued From page 18</p> <p>An interview with LPN #1, on 02/15/13 at 10:00 AM, revealed she was supposed to wash her hands prior to preparation of medications. She revealed it was difficult, at times, to get the medications into the cup; however, she should not use her hands. She stated if the medications spill onto the med cart, she should dispose of the medications and obtain new ones.</p> <p>3. A review of the Quick Reference Guide, revised 02/2010, revealed 10 percent (%) bleach must be used to clean and disinfect glucose meter equipment between resident use.</p> <p>An observation, on 02/13/13 at 4:00 PM, revealed LPN #3 cleaned the glucometer machine with an alcohol wipe. In addition, after completion of the glucometer test, he walked out of the resident's room wearing soiled gloves. He took them off at the nurse's station and washed his hands.</p> <p>An interview with the Director of Nursing (DON), on 02/15/13 at 12:35 PM, revealed staff were supposed to wash their hands prior to and after a medication pass. She revealed they should not use their hands to prepare medications. Staff should dispose of medications if spilled onto the med cart. The DON further revealed bleach wipes should be used for cleaning the glucometer machine, not an alcohol wipe. She revealed gloves should be removed and hands should be washed prior to exiting a resident's room.</p>	F 441		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185048	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  02/13/2013
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NAME OF PROVIDER OR SUPPLIER  COLONIAL MANOR CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2365 NASHVILLE ROAD BOWLING GREEN, KY 42101
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01.</p> <p>PLAN APPROVAL: 1963.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (200).</p> <p>SMOKE COMPARTMENTS: Three (3) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1963, upgraded in 2012 with 18 smoke detectors and 75 heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system installed in 1973.</p> <p>GENERATOR: Type II generator installed in 2009. Fuel source is Natural Gas.</p> <p>A standard Life Safety Code survey was conducted on 02/13/13. Colonial Manor Care &amp; Rehab was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for Forty-Eight (48) beds with a census of Forty-Six (46) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from</p>	K 000	<p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Colonial Manor Care and Rehabilitation Center does not admit that the deficiency listed on this form exists, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p> <p>K027</p> <p>The Maintenance Director added wooden strip to astragal to resist passage of smoke on cross-corridor doors on North and South wings completed 03/04/2013.</p> <p>The Maintenance Director completed an inspection of other corridor door on 2/18/2013 and no other doors required repair.</p> <p>The Administrator conducted re-education with the Maintenance Director on 03/04/2013 to ensure smoke barrier doors do not exceed 1/8 inch gap to meet the standards of NFPA to resist passage of smoke.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Chris Swihart TITLE: Administrator (X6) DATE: 3/15/13

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 SERVICES

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185048	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED  02/13/2013
NAME OF PROVIDER OR SUPPLIER  COLONIAL MANOR CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2365 NASHVILLE ROAD BOWLING GREEN, KY 42101		
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K 000	Continued From page 1 Fire).	K 000	The Maintenance Director will conduct audit of door closure during fire drills for the next three months. Findings will be reported by the Maintenance director to the Performance Improvement Committee for further recommendations for three months.  Completion date:	3/08/13	
K 027 SS=E	Deficiencies were cited with the highest deficiency identified at "F" level. NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.6, 19.3.7.6, 19.3.7.7  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure cross-corridor doors located in a smoke barrier would resist the passage of smoke in accordance with NFPA standards. The deficiency had the potential to affect two (2) of three (3) smoke compartments, twenty-four (24) residents, staff and visitors. The facility is certified for Forty-Eight (48) beds with a census of Forty-Six (46) on the day of the survey. The facility failed to ensure the cross corridors doors would close properly with the installed door coordinators.  The findings include:  Observation, on 02/13/13 at 10:49 AM with the Maintenance Supervisor, revealed the	K 027			

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K 027	Continued From page 2 cross-corridor doors located next to Director of Nursing Office had a gap between them larger than 1/8 of an inch.  Interview, on 02/13/13 at 10:49 AM with the Maintenance Supervisor, revealed he was unaware of the maximum allowable gap between the smoke doors.  Reference: NFPA 101 (2000 Edition), 19.3.7.6*. Requires doors in smoke barriers to be self-closing and resist the passage of smoke.  Reference: NFPA 101 (2000 edition) 8.3.4.1* Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles. NFPA 101 LIFE SAFETY CODE STANDARD  One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1  This STANDARD is not met as evidenced by:	K 027	K 029  The Maintenance Director closed the dry storage door and removed strap on 2/13/2013.  The Maintenance Director conducted rounds of the facility on 2/13/2013 and no other concerns were identified.  The Maintenance Director and Dietary Staff were re-educated on 2/28/2013 by the administrator on the proper use of self-closing doors in relation to hazardous areas.  The Maintenance Director and Dietary staff will monitor dry storage door for closure three times a week for four weeks then monthly for two months. The Maintenance Director will report findings to the Performance Improvement Committee for further recommendations for three months.  Completion date:	3/08/13	
K 029 SS=D		K 029			

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NAME OF PROVIDER OR SUPPLIER  COLONIAL MANOR CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2365 NASHVILLE ROAD BOWLING GREEN, KY 42101	
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K 029	<p>Continued From page 3</p> <p>Based on observation and interview, it was determined the facility failed to meet the requirements of Protection of Hazards in accordance with NFPA Standards. The deficiency had the potential to affect one (1) of three (3) smoke compartments, no residents, staff and visitors. The facility is certified for Forty-Eight (48) beds with a census of Forty-Six (46) on the day of the survey. The facility failed to ensure the door to the dry storage room would self-close.</p> <p>The findings include:</p> <p>Observations, on 02/13/13 at 10:54 AM with the Maintenance Supervisor, revealed the door to the dry storage room in the kitchen was tied open with a plastic band. The room was not occupied and was unable to close without taking the strap off.</p> <p>Interview, on 02/13/13 at 10:54 AM with the Maintenance Supervisor, revealed he was unaware the plastic tie had been installed and was aware this door must be self-closing.</p> <p>Reference:</p> <p>NFPA 101 (2000 Edition).</p> <p>19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler</p>	K 029		

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K 029	Continued From page 4 option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft <sup>2</sup> (9.3 m <sup>2</sup> ) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft <sup>2</sup> (4.6 m <sup>2</sup> ), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029		
K 040 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  Exit access doors and exit doors used by health care occupants are of the swinging type and are at least 32 inches in clear width. 10.2.3.5  This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure exit	K 040		

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K 040	Continued From page 5 discharge doors opened in the direction of egress in accordance with NFPA standards. The deficiency had the potential to affect one (1) of three (3) smoke compartments, twenty-six (26) residents, staff and visitors. The facility is certified for Forty-Eight (48) beds with a census of Forty-Six (46) on the day of the survey. The facility failed to ensure the gate off the front deck swung in the outward position.  The findings include:  Observation, on 02/13/13 at 11:22 AM with the Maintenance Supervisor, revealed the exit gate off the front deck at room #13 swung against the egress direction.  Interview, on 02/13/13 at 11:22 AM with the Maintenance Supervisor, revealed he was not aware the exit discharge gate needed to open in the direction of egress.  NFPA 101 (2000 edition) 7.2.1.4.3 A door shall swing in the direction of egress travel where used in an exit enclosure or where serving a high hazard contents area, unless it is a door from an individual living unit that opens directly into an exit enclosure.	K 040	K 040  The Maintenance Director removed the exit gate off the front deck on 2/13/2013.  The Maintenance director completed an inspection of exits of the facility on 2/13/2013. No other exits required repair.  The Maintenance Director was re-educated by the Administrator on 03/04/2013 on exit doors shall swing in the direction of egress for safety purposes.  The Maintenance director will conduct exit door audits monthly for three months. Findings will be reported by the Maintenance director to the Performance Improvement Committee for further recommendations for three months.  Completion date:	3/08/13
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of	K 056		

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K 056	<p>Continued From page 6</p> <p>Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>This STANDARD is not met as evidenced by: Based on observations and interview, it was determined the facility failed to ensure complete sprinkler coverage in accordance with NFPA standards. The deficiency had the potential to affect three (3) of three (3) smoke compartments, all residents, staff and visitors. The facility is certified for Forty-Eight (48) beds with a census of Forty-Six (46) on the day of the survey. The facility failed to ensure sixteen (16) sprinkler heads were not blocked by light fixtures and a ceiling fan</p> <p>The findings include:</p> <p>Observations, on 02/13/13 between 10:40 AM and 12:00 PM with the Maintenance Supervisor, revealed the sprinkler heads located in rooms # 7, #6, #4, #2, #1, #3, #22, #21, #19, #16, #15, and #24 were blocked by light fixtures, within 1 foot of the sprinkler head, extending below the sprinkler heads. Further observation revealed the sprinklers were blocked by light fixtures in the laundry room, the sprinkler riser room, dry storage room, and behind the south nurses' station.</p> <p>Interview, on 02/13/13 between 10:40 AM and</p>	K 056	<p>K056</p> <p>The Maintenance Director relocated light fixtures in rooms #7, #6, #4, #2, #1, #3, #22, #21, #19, #16, #15 and #24. He also replaced light fixtures in laundry room, the sprinkler riser room, dry storage room, and behind the south nurse's station on 2/25/13. Ceiling fan in room #6 was removed by the Maintenance Director and replaced with florescent light fixture on 2/25/13.</p> <p>The Maintenance Director conducted an audit of the sprinkler heads throughout the facility and relocated lights as needed to be in compliance with NFPA 13, 5-5.5.2.2.</p> <p>The Maintenance Director was re-educated by the administrator on 3/4/2012 on the maximum allowable distance of sprinkler heads and an obstruction per NFPA standards.</p> <p>The Maintenance Director will conduct Monthly audits of sprinkler heads for three months. Findings will be reported by the Maintenance director to the Performance Improvement Committee for further recommendations for three months.</p> <p>Completion date:</p>	3/08/13	

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K 058	<p>Continued From page 7</p> <p>12:00 PM with the Maintenance Supervisor, revealed he was unaware that the light fixtures could block the spray pattern of the sprinkler head.</p> <p>Reference: NFPA 13 (1999 ed.) 5-5.5.2.2 Sprinklers shall be positioned in accordance with the minimum distances and special exceptions of Sections 5-6 through 5-11 so that they are located sufficiently away from obstructions such as truss webs and chords, pipes, columns, and fixtures. Table 5-6.5.1.2 Positioning of Sprinklers to Avoid Obstructions to Discharge (SSU/SSP)</p> <table border="0"> <thead> <tr> <th colspan="2">Maximum Allowable Distance</th> </tr> <tr> <th>Distance from Sprinklers to above Bottom of Side of Obstruction (A)</th> <th>of Deflector Obstruction (In.)</th> </tr> </thead> <tbody> <tr> <td>(B) Less than 1 ft</td> <td>0</td> </tr> <tr> <td>1 ft to less than 1 ft 6 in.</td> <td>2 1/2</td> </tr> <tr> <td>1 ft 6 in. to less than 2 ft</td> <td>3 1/2</td> </tr> <tr> <td>2 ft to less than 2 ft 6 in.</td> <td>5 1/2</td> </tr> <tr> <td>2 ft 6 in. to less than 3 ft</td> <td>7 1/2</td> </tr> <tr> <td>3 ft to less than 3 ft 6 in.</td> <td>9 1/2</td> </tr> <tr> <td>3 ft 6 in. to less than 4 ft</td> <td>12</td> </tr> <tr> <td>4 ft to less than 4 ft 6 in.</td> <td>14</td> </tr> <tr> <td>4 ft 6 in. to less than 5 ft</td> <td>16 1/2</td> </tr> <tr> <td>5 ft and greater</td> <td>18</td> </tr> </tbody> </table> <p>For SI units, 1 in. = 25.4 mm; 1 ft = 0.3048 m. Note: For (A) and (B), refer to Figure 5-6.5.1.2(a). Reference: NFPA 13 (1999 ed.) 5-6.3.3 Minimum Distance from Walls, Sprinklers</p>	Maximum Allowable Distance		Distance from Sprinklers to above Bottom of Side of Obstruction (A)	of Deflector Obstruction (In.)	(B) Less than 1 ft	0	1 ft to less than 1 ft 6 in.	2 1/2	1 ft 6 in. to less than 2 ft	3 1/2	2 ft to less than 2 ft 6 in.	5 1/2	2 ft 6 in. to less than 3 ft	7 1/2	3 ft to less than 3 ft 6 in.	9 1/2	3 ft 6 in. to less than 4 ft	12	4 ft to less than 4 ft 6 in.	14	4 ft 6 in. to less than 5 ft	16 1/2	5 ft and greater	18	K 058		
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K 056	Continued From page 8 shall be located a minimum of 4 in. (102 mm) from a wall.	K 056			