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OFFICE OF INSPECTOR GENERAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185048	A. BUILDING _____ B. WING _____	03/29/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL MANOR CARE AND REHABILITATION CENTER	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 000	INITIAL COMMENTS A recertification survey and an abbreviated survey (KY #18059) were conducted on 03/27/12 through 03/29/12 to determine compliance with Federal requirements. The facility was found not to meet Federal requirements with deficiencies cited at the highest scope and severity of a "D." KY #18059 was substantiated with no deficiencies cited related to the allegation.	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	
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. 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 implement written policies and procedures that prohibit mistreatment, neglect and abuse of residents for one resident (#7), in the selected sample of twelve residents. A review of the clinical record revealed a psychiatric consult which stated the history of Resident #7's present illness and the reason for the referral was that the resident believed his/her breasts were being "fondled." Findings include: A review of the facility's policy/procedure, "Abuse and Neglect Prohibition Program," dated effective January 2008, revealed residents must not be subjected to abuse by anyone, including, but not	F 226	administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency." F 226 Resident #7 was interviewed by the Director of Nursing on 3/28/12, the resident denied anyone touching her breasts. Resident # 7 Brief Interview for Mental Status (BIM's) score is 14 per her last Minimum Data Set (MDS), dated 02/28/12. A skin assessment was completed by a Licensed Nurse on 03/28/12 that noted no concerns. Psychiatric evaluations were reviewed on current residents by the Director of Nursing Services for the last three months on 4/13/12. No allegations of abuse or neglect were identified. The Administrator re-educated the Director of Nursing on the Procedure for Psychiatrist Visits to include complete review of the progress notes and communication with	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 4/20/12

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 226	Continued From page 1 limited to facility staff, other residents, consultants, volunteers, visitors, legal guardians, friends, or other individuals. Immediate responses are taken to ensure the safety of the resident. Any and all allegations are reported immediately to the Administrator and/or the Director of Nursing (DON). Mandatory reporters are all employees of a center, regardless of position or department and are required, by law, to report any reasonable suspicion of a crime against a resident, including any known or suspected abuse, neglect or misappropriation of a resident's property, immediately, upon identifying a concern. A review of the facility's "Procedure for Psychiatrist Visits," undated, revealed after the physician saw the resident, the physician or assistant gave copies of the progress notes and orders to the DON. The physician or assistant informed the DON of any concerns and the DON reviewed order changes and/or new orders. Progress notes and orders from the visit were then distributed to the nurses for approval from the primary care physician and filed in the chart. A record review revealed the facility admitted Resident #7 on 09/08/11 with diagnoses to include Parkinson's Disease, Anxiety, Psychotic Disorder and Dementia Related Behaviors. A review of the quarterly Minimum Data Set (MDS), dated 02/28/12, revealed the resident scored a fourteen (14), on the Brief Interview for Mental Status (BIMS) score for cognition, which indicated he/she was independent in decision-making, and his/her short term memory and long term memory was intact. There was no documented evidence of delirium and his/her mood was described as	F 226	Physician or assistant of any concerns voiced by the residents on 3/30/12. The Administrator and Director of Nursing Services provided Abuse/Neglect re-education to staff completed 4/18/2012. The Administrator and Director of Nursing Services provided re-education to Licensed Nurses on Procedure for Psychiatric visits completed 4/18/12. Facility Abuse Policy to include reporting allegations of mistreatment, neglect, and abuse of residents was provided to Parkview Psychiatric Services on 4/16/2012. The Director of Nursing Services or Assistant Director of Nursing will review the Psychiatric consults in clinical stand up meeting following Psychiatric visits. Any findings will be investigated immediately. The Director of Nursing will report the findings to the Performance Improvement committee for three months for further recommendations. The Social Service Director will do two random resident interviews of alert and oriented residents for concerns of abuse and neglect per week for three weeks and monthly for two months. The Social Service Director will address any concerns immediately and report findings to the Performance Improvement Committee for three months for further recommendations. Compliance date:	4/20/12

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F 226	Continued From page 2 having a poor appetite and being restless. The resident required the extensive assistance of two staff members with all activities of daily living (ADLs), was continent of bowel and bladder and was prescribed antipsychotic and antidepressant medications. A review of the care plan for the potential side effects of psychoactive medications, dated. 12/07/11, revealed a history of depression, anxiety, yelling, cursing and visual hallucinations. Interventions were to observe for side effects of medications, monitor and observe for the resident's mood, state, and behaviors, every shift and for psychiatric services. Further review of Resident #7's clinical record revealed a "Psychiatric Initial Evaluation," dated 12/07/11, which stated the history of the present illness/reason for referral was due to the resident "fighting things that were not there, seeing children and family that were not there; believed breasts were being fondled when not being touched, and physical aggression toward the staff." Under the heading of "Psychotic Features," the resident was noted to have auditory and visual hallucinations "per the staff and family," and reported delusions such as, "believes breasts were being fondled." An observation of Resident #7, on 03/29/12 at 8:20 AM, revealed the resident was seated in a straight-backed chair at the bedside and able to verbalize his/her needs. An interview with Resident #7 revealed, "a few days don't go right, but things can't always be perfect," and further stated "needing to call the law, two to three weeks ago, while under the house, [he/she] could	F 226		

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F 226	Continued From page 3 see and hear a man talking through the screen in the basement window." The resident denied anyone touching his/her breasts. An interview with Certified Nurse Aides (CNAs) #1 and #2, on 03/29/12 at 4:16 PM and at 4:20 PM, respectively, revealed the resident refused to allow any male staff to assist with any bathing or dressing needs. Although the resident spoke of seeing family, grandbabies and snakes when they were not present, neither of them were aware of any statements the resident may have made regarding being "fondled." An interview with Licensed Practical Nurse (LPN) #1/Charge Nurse, on 03/29/12 at 10:50 AM, revealed the psychiatric evaluations were left in the DON's office. The psychiatrist and/or the APRN wrote recommendations, but the recommendations were evaluated by the attending physician before orders were actually written. Orders were written on 12/07/11, by the attending physician, for medications for Alzheimer's Disease, Depression, Antipsychotics and for testing of a Urinary Tract Infection (UTI). The LPN revealed she was unaware of any statements from the staff or the resident regarding any "fondling," and stated if this had been reported, it would have been investigated. An interview with Registered Nurse (RN) #1, on 03/28/12 at 4:20 PM, who had made an entry in the nursing notes regarding the Advanced Practice Registered Nurse's (APRN) visit on 12/07/11, revealed she made entries in the chart when the physician and the APRN visited, and she documented notification of the family about visits from the physician and the APRN. The RN	F 226		

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F 226	Continued From page 4	F 226		

stated she was there whenever the APRN visited, and she was not aware of any documentation regarding the resident's belief that his/her breasts were "fondled." She had not heard the resident voice that thought nor heard the staff speak about it, nor was she made aware by the APRN, that this was a concern.

An interview with the MDS Coordinator/RN, on 03/29/12 at 2:15 PM, revealed she had generated a care plan for delusional behaviors for Resident #7, based on the diagnosis for Dementia, when the Alzheimer's medication was ordered on 12/07/11. The RN's interviews with the resident, who complained of "seeing babies and snakes" that were not there, had not heard the resident or the staff say the resident thought they were being "fondled," and was not aware of the wording on the psychiatric evaluation. If the RN was made aware of anyone stating the resident thought he/she was being "fondled," she would have reported this information to the supervisor to be investigated.

An interview with the DON, on 03/28/12 at 4:24 PM, regarding the psychiatric evaluation, on 12/07/11, revealed as part of the process, she was given the form after the physician or the APRN evaluated the residents. The DON revealed she was not aware of the resident ever stating he/she thought someone had "fondled" his/her breasts and did not see this information on the form. She stated she "did not read every word," and this was not discussed with her or she would have initiated an investigation.

An interview with the APRN, on 03/29/12 at 3:40 PM, revealed she visited the resident for an initial

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F 226	Continued From page 5 evaluation, on 12/07/11, and the history of the present illness/reason for the referral was reported to the APRN by the facility staff or the family member. She stated, "I took this as known information, second and third-hand information." The APRN was unsure if being "fondled" was a new delusion for the resident and she could not recall who provided the information, but stated this information would not have been told by the resident. The resident was "confused and alert to self only," and there was a family member in the room at the time of the visit. The APRN stated, if the resident had stated he/she was being "fondled" or if the APRN thought this was more than a delusion, she revealed she would have "dug deeper and gotten more information." She did not discuss the "fondling" with anyone else in the facility, as she perceived this to be "known information." She also stated she was not an employee of the facility and did not have "Abuse/Neglect Training" through the facility, but was aware she was legally bound to report any abuse. An interview with Resident #7's family member, on 03/29/12 at 11:30 AM, who was present on 12/07/11 for the psychiatric evaluation, revealed the resident was awake all night the prior evening, and she was called in to sit with the resident as sometimes this helped to calm him/her. The family member was aware of the resident's history of seeing grandchildren and bugs that were not there. However, she was unaware of any conversation from the resident or the APRN discussing anyone "fondling" the resident, or of any staff discussing this information, before or after the APRN visited.	F 226		
F 281	483.20(k)(3)(i) SERVICES PROVIDED MEET	F 281		

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F 281 SS=D	Continued From page 6 PROFESSIONAL STANDARDS 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, record review, review of the facility's professional standard of practice, and review of the facility's policy and procedure, it was determined the facility failed to ensure services provided by the facility met professional standards of quality for three residents (#18, #20 and #21), not in the selected sample. Observations during a medication pass, on 03/28/12, revealed the licensed staff passed thirty (30) medications to three residents without conducting three checks of each medication prior to administration. Resident #18 would have received a dose of Digoxin 0.125 milligrams (mg) if surveyor had not intervened. Findings include: An interview with the Director of Nursing (DON), on 03/29/12 at 1:45 PM , revealed the facility utilized Perry and Potter Clinical Nursing Skills and Techniques, 6th Edition, for its professional standards of practice for medication administration. A review of the standard of practice revealed when administering medications, the nurse should compare the label of the medication container with the medication form. The nurse should do this three times: 1) before removing the container from the drawer or shelf, 2) as the amount of medication ordered is removed from the container, and 3) before	F 281	F 281 LPN #2 received re-education on medication administration utilizing the three checks of each medication prior to administration by the Director of Nursing Services on 3/28/12. Current resident Medication Administration Records were reviewed by the Director of Nursing Services on 3/28/12 and no errors were identified. The Director of Nursing Services provided re-education to Licensed Nurses on the policy and procedure for Medication Administration to include conducting three checks of each medication prior to administration completed 4/14/2012. The Director of Nursing or Assistant Director of Nursing will complete two Medication pass observations per week for four weeks then monthly for three months. The Director of Nursing will report findings to the Performance Improvement Committee for three months for further recommendations. Compliance Date:	4/20/12

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F 281	Continued From page 7 returning the container to storage. A review of the facility's "Medication Administration" policy and procedure, dated 10/15/05, revealed the medication name, dosage and interval shall be read from the medication/treatment record. The label on each medication container shall be read and compared three times: 1) When taking from the unit dose box or drawer, 2) before opening or pouring it, and 3) when returning the container to the drawer or cabinet or before discarding the actual unit dose package. An observation of a medication pass for Residents #18, #20 and #21, on 03/28/12 at 8:25 AM, revealed Licensed Practical Nurse (LPN) #2 prepared thirty (30) medications by reading the order from the Medication Administration Record (MAR), then obtaining the medications from the drawer. No further comparisons of the medication packages to the MARs were conducted when the medications were removed from the container, or prior to discarding the actual dose packages. When passing medications to Resident #18, the LPN read the order for the Digoxin 0.125 mg every other day and obtained the medication package from the drawer. She placed the package in the medication cup stating she had to obtain the resident's pulse prior to administration of the Digoxin. The nurse entered the resident's room and obtained the resident's pulse, then proceeded to open the Digoxin. At that moment, the surveyor stopped the nurse and asked her to recheck the MAR. The nurse rechecked the MAR and saw that the Digoxin was not supposed to be administered. The nurse had not compared	F 281		

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F 281	Continued From page 8 the MAR with the medication package before she opened the medication. An interview with LPN #2, 03/28/12 at 9:15 AM, revealed she overlooked that the Digoxin was not to be administered that day. She stated she should have checked the medications with the physician's order when she opened the medication packages, when she placed the medication in the cup, and prior to discarding the medication packages. She stated she should have taken the MAR with her to the room to check the order with the Digoxin package, prior to opening and administering the Digoxin. An interview with the DON, on 03/29/12 at 1:45 PM, revealed the nurse should have completed three medication checks prior to administration of the medication.	F 281	F 333 Resident #18 was assessed by a Licensed Nurse on 3/28/12 with no negative outcomes from medication administration. LPN #2 received re-education on medication administration utilizing the three checks of each medication prior to administration by the Director of Nursing Services on 3/28/12. Current residents Medication Administration Records were reviewed by the Director of Nursing Services on 3/28/12 and no errors were identified. The Director of Nursing Services provided re-education to Licensed Nurses on the policy and procedure for Medication Administration to include conducting three checks of each medication prior to administration completed 4/14/2012. The Director of Nursing or Assistant Director of Nursing will complete two Medication pass observations per week for four weeks then monthly for three months. The Director of Nursing will report findings to the Performance Improvement Committee for three months for further recommendations. Compliance Date:	4/20/12
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. 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 one resident (#18), not in the selected sample, was free from a significant medication error. An observation of a medication pass, revealed Licensed Practical Nurse(LPN) #2 would have administered Digoxin (cardiovascular drug) 0.125 milligrams (mg) to Resident #18, on a day that the medication was not ordered to be given, if the	F 333		

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F 333	Continued From page 9 surveyor had not intervened. Findings include: A review of the facility's "Medication Administration" policy and procedure, dated 10/15/05, revealed the medication name, dosage and interval shall be read from the medication/treatment record. The label on each medication container shall be read and compared three times: 1) When taking from the unit dose box or drawer, 2) before opening or pouring it, and 3) when returning the container to the drawer or cabinet or before discarding the actual unit dose package. A record review revealed the facility admitted Resident #18 on 06/09/07 with diagnoses to include Congestive Heart Failure, Altered Mental Status and Dementia. A review of the physician's orders, dated March 2012, revealed "administer Digoxin 0.125 mg by mouth (po) every other day (qod)." A review of the Medication Administration Record (MAR), dated March 2012, revealed "to administer Digoxin 0.125 mg po qod." Further review of the MAR revealed there was an "X" marked in every other box to indicate administration of the Digoxin every other day. Further review of the MAR revealed there was an "X" in the box, dated 03/28/12. Observation of a medication pass for Resident #18, on 03/28/12 at 9:10 AM, revealed LPN #2 read the order for the Digoxin and obtained the unit dose package of the Digoxin from the	F 333		

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F 333	Continued From page 10 medication drawer. The LPN placed the medication package in the medication cup and stated she needed to obtain the resident's pulse prior to administration to ensure the resident's pulse was above 60. When LPN #2 entered the resident's room, she obtained the resident's pulse and then proceeded to open the Digoxin package and placed the pill in the medication cup with the other medication. The surveyor stopped LPN #2 and asked her to look at the MAR again. LPN #2 walked out to the medication cart and read the MAR again, stating the resident was not supposed the get the Digoxin that day. She stated she overlooked the "X" in the box, dated 03/28/12, and she should have checked the MAR three times with the medication package. An interview with the DON, on 03/29/12 at 1:45 PM, revealed the nurses were suppose to complete three checks of the medication with the MAR prior to administration of the medication.	F 333	F 365 The Registered Dietician and Nutrition Services Director have conducted food preference interviews with residents #16 and #19. Preferences were added to tray cards on 04/17/12. CNA # 1 was re-educated by Director of Nursing Services on 04/18/11 regarding reading tray cards and honoring food preferences. The Registered Dietician and Nutrition Services Director conducted food preference interviews with current residents and updated tray cards on 04/18/12. The Nutrition Services Director re – educated dietary staff on food preferences and tray accuracy on 04/06/12. The nursing staff was re-educated by the Director of Nursing Services on 04/18/12 regarding reading tray cards and honoring food preferences. The Nutrition Services Director will conduct tray audits for accuracy of honoring food preferences five times a week for four weeks, then weekly for two months. The Nutrition Services Director will report findings to the Performance Improvement Committee for three months for further recommendations. Compliance date:	04/20/12
F 365 SS=D	483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS Each resident receives and the facility provides food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure two residents (#16 and #19), not in the selected sample, received food according to their dietary preferences. The facility failed to ensure Resident #16 was served ice cream with the supper meal, and Resident #19 did not receive			

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F 365	Continued From page 11 ice in his/her water. Findings include: An interview with the Director of Nursing (DON), on 03/29/12 at 1:45 PM, revealed there was no written policy and procedure related to following dietary slips. A record review revealed the facility admitted Resident #16 on 10/01/06 with a diagnosis of Alzheimer's Disease. A review of the "Medical Nutrition Therapy Assessment," dated 03/07/12, revealed Resident #16 was suppose to receive ice cream with both lunch and supper. Observation of the supper meal, on 03/27/12 at 5:15 PM, revealed Resident #16 was served his/her supper tray in the dining room. A review of the dietary slip revealed the resident should be served ice cream with lunch and supper. An observation of the supper tray revealed there was no ice cream on Resident #16's tray. An interview with the Dietary Manager, on 03/29/12 at 2:10 PM, revealed Resident #16 should have received ice cream with his/her meal and it was an oversight. 2. A record review revealed the facility admitted Resident #19 on 10/1/06 with diagnoses to include Esophageal Reflux, Anxiety and Dementia. Observation of Resident #19, on 03/27/12 at 5:30 PM, revealed he/she had ice in his/her water	F 365		

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	185048	A. BUILDING _____ B. WING _____	03/29/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL MANOR CARE AND REHABILITATION CENTER	2365 NASHVILLE ROAD BOWLING GREEN, KY 42101

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F 365	Continued From page 12 glass. Further review of the dietary slip revealed a request of "no ice in water." An interview with Certified Nurse Aide (CNA) #1, on 03/27/12 at 5:35 PM, revealed, "I was not aware it was on the dietary slip, I knew [he/she] was not getting ice in [his/her] water pitcher, and I should have looked at [his/her] dietary slip." An interview with Licensed Practical Nurse (LPN) #1, on 03/29/12 at 10:00 AM, revealed, "I knew [he/she] did not like ice in [his/her] water, but I believe it's more of a preference, and not a physician's order." An interview with the Dietary Manager, on 03/29/12 at 2:10 PM, revealed the dietary aide checked the tray to ensure everything was on the tray according to the dietary slip and the staff who served the trays should also check the dietary slips. An interview with the DON, on 03/29/12 at 1:45 PM, revealed dietary staff should have checked the tray prior to the tray coming out of the kitchen, and nursing staff who served the tray should have checked the tray to ensure the dietary slip was followed.	F 365	F 441 Contact precautions were discontinued on resident #6 on 3/30/2012 per physicians order. Resident is free of signs and symptoms of active infection. Current residents were re-assessed by the Director of Nursing on 3/28/2012 no other resident required precautions. The Director of Nursing Services audited current infection control reports on 3/28/12 with no findings. Licensed Nurses were re-educated by the Infection Control Coordinator on the Policy and Procedure for infection control and contact precautions, to include proper signage on doorways completed 4/14/12. The Director of Nursing or Assistant Director of Nursing will audit infection control reports weekly for four weeks, then monthly for two months. The audit will include monitoring residents for need of contact precautions and ensuring adequate signage displayed per policy. The results of the observations will be brought to the Performance Improvement Committee by the Director of Nursing for review and further recommendations for three months. Compliance date:	4/20/12
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 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. (a) Infection Control Program	F 441		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL MANOR CARE AND REHABILITATION CENTER	2385 NASHVILLE ROAD BOWLING GREEN, KY 42101

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F 441	Continued From page 13 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. (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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy and procedure, it was determined the facility failed to have a system in place to help prevent the transmission of infection and disease related to not having	F 441		

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F 441	Continued From page 14	F 441		

proper signage on the doorway for one resident (#6), in the selected sample of twelve residents. Resident #6 was diagnosed with C-Difficile (infection of the stool) on 01/30/12. The facility failed to follow their system for infection control related to placing signage on Resident #6's door, instructing staff, visitors and residents to go the nurses station prior to entering Resident #6's room. Due to Resident #6 refusing to let staff . place signage on door, the facility failed to establish a system to ensure staff, visitors and residents did not enter Resident #6's room without prior knowledge of proper infection control procedures.

Findings include:

A review of the facility's, "Precaution Guidelines," dated October 2009, revealed, "Standardized precaution signs are used to alert staff, visitors, and residents of rooms where there is a potential exposure to infectious materials."

A record review revealed the facility admitted Resident #6 on 06/08/10 with diagnoses to include Dementia, Psychosis and Parkinsonism.

A review of a lab report, dated 01/30/12, revealed Resident #6 was positive for C-Difficile (C-diff).

A review of a physician's order, dated 01/30/12, revealed Resident #6 was placed on C-diff precautions every shift every day.

An observation of Resident #6,on 03/27/12 at 10:00 AM, revealed an isolation set-up kit was in Resident #6's room with no signage on the resident's door.

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F 441	Continued From page 15 An interview with Registered Nurse (RN) #2, on 03/29/12 at 1:50 PM, revealed "There was a notice up on the door, but [he/she] demanded it be taken down." An interview with the Director of Nursing (DON), on 03/29/12 at 2:00 PM, revealed "[Resident #6] refused to have it up, and we have tried to put it up twice. I know it's the policy, but I am between a rock and a hard place, that's why I have it written on [his/her] nursing care plan and Certified Nurse Aide Care Plan." An interview with Resident #6, on 03/29/12 at 2:45 PM, revealed "I got mad and made them take the sign off my door, I did not want people to know anything about me, the nurse told me people could not get anything unless they touched my stool." An interview with RN #3, on 03/29/12 at 3:55 PM, revealed "If anyone else was to walk into the resident's room, they would not know." An interview with the DON on 03/29/12 at 4:05 PM, revealed "I did not feel I was putting anyone at risk by not having the sign up. I had to decide between causing the resident anxiety and putting the sign up, and I thought it was in the best interest of the resident to leave the sign off. I did not feel I was putting anyone at risk."	F 441		

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

PRINTED: 04/12/2012
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
	185048	A. BUILDING 01 - MAIN BUILDING 01 B. WING	03/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL MANOR CARE AND REHABILITATION CENTER	2365 NASHVILLE ROAD BOWLING GREEN, KY 42101

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K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) BUILDING: 01 PLAN APPROVAL: 1963 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One (1) story, Type V (000) SMOKE COMPARTMENTS: Three (3) smoke compartments FIRE ALARM: Complete fire alarm system with heat and smoke detectors SPRINKLER SYSTEM: Complete automatic dry sprinkler system. GENERATOR: Type II generator. Fuel source is natural gas. A standard Life Safety Code survey was conducted on 3/28/12. Colonial Manor Care and Rehab was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for forty eight (48) beds and the census was forty seven (47) on the day of the survey. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)	K 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." K18 The Maintenance Director added hardware to door jams to resist passage of smoke on rooms # 1, 5, 11, 12, 19, 16, 14 and 13 on 4/16/12. The Maintenance Director completed an inspection of other corridor doors on 3/28/2012 and no other doors required repair. The Administrator conducted re-education with the Maintenance Director on 3/30/12 to ensure all doors do not exceed 1/8 inch gap to meet the standards of NFPA to resist passage of smoke. The Maintenance Director will conduct corridor door audits monthly for three months and report finding to Performance Improvement Committee for further recommendations for three months. Completion Date	5/04/12

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

TITLE: Administrator

(X6) DATE: 4/20/12

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

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K 000	Continued From page 1 Deficiencies were cited with the highest deficiency identified at "F" level.	K 000		
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure there were no impediments to the closing of corridor doors to resist the passage of smoke, in accordance with NFPA standards. The deficiency had the potential to affect two (2) of three (3) smoke compartments, residents, staff and visitors. The facility is licensed for forty eight (48) beds and the	K 018		

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K 018	Continued From page 2 census was forty seven (47) on the day of the survey. The findings include: Observations, on 03/28/12 between 9:47 AM and 10:47 AM, with the Maintenance Director revealed the corridor doors to rooms 1, 5, 11, 12, 19, 16, 14 and 13 had a gap too large around the jamb and would not resist the passage of smoke. Interviews, on 03/28/12 between 9:47 AM and 10:47 AM, with the Maintenance Director confirmed the observation of the doors having too large a gap that would not resist the passage of smoke. Reference: NFPA 101 (2000 edition) 19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and	K 018		

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K 018	Continued From page 3 similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke. 19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with	K 018	K25 The Maintenance Director added mortar to the barrier to extend to the ceiling on 4/17/12. Wire was relocated by Comstar Systems on 4/3/2012. All penetrations were sealed with fire caulk on 3/30/12. The Maintenance Director completed an inspection of other smoke barriers on 3/29/12 , no other repairs required. The Maintenance Director was re-educated by the Administrator on 3/30/12 on conducting routine inspections of Smoke barriers to ensure they met NFPA standards. The Maintenance Director will conduct inspections of facility smoke barriers quarterly for six months and report findings to the Performance Improvement Committee for further recommendations quarterly for six months.	
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observations and interview, it was	K 025	Completion Date:	5/04/12

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K 025	Continued From page 4 determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance with NFPA standards. The deficiency had the potential to affect two (2) of three (3) smoke compartments, residents, staff and visitors. The facility is licensed for forty eight (48) beds and the census was forty seven (47) on the day of the survey. The findings include: Observation, on 03/28/12 at 10:55 AM, with the Maintenance Director revealed the smoke partition, extending above the ceiling located above the cross corridor doors on the South area of the Main Hall, were not properly sealed. The barrier failed to extend to the roof of the facility. The barrier also was penetrated by a sleeve for wiring which was not sealed. Interview, 03/28/12 at 10:55 AM, with the Maintenance Director revealed he was not aware of the penetrations. Reference: NFPA 101 (2000 Edition). 8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows: (a) The space between the penetrating item and the smoke barrier shall 1. Be filled with a material capable of maintaining	K 025		

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K 025	Continued From page 5 the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (c) Where designs take transmission of vibration into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose.	K 025	K27 The Maintenance Director added Door Coordinators to North and South cross-corridor doors located in main hallway on 4/11/2012. The Maintenance Director completed inspection of other cross corridor doors on 3/28/12 and no other repairs required. The Administrator conducted re-education with the Maintenance Director on 3/30/12 regarding cross-corridor doors close to meet standards of NFPA to resist the passage of smoke. The Maintenance Director will conduct audit of door closer during fire drill three times per month 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:	5/04/12
K 027 SS=F	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. 19.3.7.5, 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	K 027		

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K 027	Continued From page 6 potential to affect three (3) of three (3) smoke compartments, residents, staff and visitors. The facility is licensed for forty eight (48) beds and the census was forty seven (47) on the day of the survey. The findings include: Observation, on 03/28/12 between 9:47 AM and 10:47 AM, with the Maintenance Director revealed the cross-corridor doors located on the main hall, would not close completely when tested, due to the doors not having a coordinator to ensure the door without the t-astragal would close first. Interview, on 03/28/12 between 9:47 AM and 10:47 AM, with the Maintenance Director they were unaware the doors needed a coordinator to ensure the doors would close properly in the event of an emergency. NFPA Standard: NFPA 101, 19.3.7.6*. Requires doors in smoke barriers to be self-closing and resist the passage of smoke. Reference: NFPA 80 (1999 Edition) 2-4.1 Closing Devices. 2-4.1.1 Where there is an astragal or projecting latch bolt that prevents the inactive door from closing and latching before the active door closes and latches, a coordinating device shall be used. A coordinating device shall not be required where	K 027		

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K 027	Continued From page 7 each door closes and latches independently of the other.	K 027	K029	
K 029 SS=D	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: 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, residents, staff and visitors. The facility is licensed for forty eight (48) beds and the census was forty seven (47) on the day of the survey. The findings include: Observation, 03/28/12 at 12:51 PM, with the Maintenance Director revealed the door to the dry storage area in the kitchen did not have a smoke resistant door with a closer installed.	K 029	The Maintenance Director replaced the door to the dry storage area in the kitchen and equipped door with closure device on 4/17/12. The Maintenance Director conducted rounds of the facility on 3/28/12 and no other doors were identified that required a self closing device. The Maintenance Director was re-educated on 3/30/12 by the Administrator on use of smoke resistant door and automatic door closure in relation to hazardous areas. The Maintenance Director will monitor automatic door closure function for three months and report findings to the Performance Improvement Committee for further recommendations for three months. Completion date:	5/04/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185048	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL MANOR CARE AND REHABILITATION CENTER	2365 NASHVILLE ROAD BOWLING GREEN, KY 42101

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K 029	Continued From page 8 Interview, 03/28/12 at 12:51 PM, with the Maintenance Director revealed they were not aware the dry storage area was considered hazardous storage thus requiring a door and a self closer. Reference: NFPA 101 (2000 Edition). 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 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 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction	K 029		

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K 029	Continued From page 9 (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	K038 On 4/18/12 Stewart-Richey Construction Company was contracted to construct a 5 foot wide durable surface to a public way on south corridor exit. Handrails will be added to stairs according to NFPA standards. Surface and handrail is to be completed by 05/4/12. Trash was removed from exit area on 3/28/12 by Housekeeping Services. Corridor exits were inspected by the Maintenance Director on 3/29/12 and all other exits were found to be in compliance with NFPA standards. The Maintenance Director was re-educated by the Administrator on 3/30/12 on exit access in accordance with NFPA standards. The Maintenance Director will conduct audits of exits monthly for three months to ensure all exits are readily accessible and will report finding to the Performance Improvement Committee for further recommendations for three months. Completion date:	5/04/12
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the exits were maintained in accordance with NFPA standards. The deficiency had the potential to affect one (1) of three (3) smoke compartments, residents, staff and visitors. The facility is licensed for forty eight (48) beds and the census was forty seven (47) on the day of the survey. The findings include: Observation, on 03/28/12 at 1:15 PM, with the Maintenance Director revealed the rear of the south hall exit does not have a 4 ' wide durable surface to a public way and the exit is blocked by trash that is stacked up.	K 038		

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K 038	Continued From page 10 Interview, on 03/28/12 at 1:15 PM, with the Maintenance Director revealed he was unaware the exit needed a durable surface to the public way and that 4 feet wide is required, since the exit sign was taken down. Exits must terminate directly at a public way or at an exterior exit discharge. Yards, courts, open spaces, or other portions of the exit discharge must be of required width and size to provide all occupants with safe access to a public way. 7.7.1. Reference: NFPA 101 (2000 edition) 7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. 7.5.1.1 Exits shall be located and exit access shall be arranged so that exits are readily accessible at all times. 7.7.1* Exits shall terminate directly at a public way or at an exterior exit discharge. Yards, courts, open spaces, or other portions of the exit discharge shall be of required width and size to provide all occupants with a safe access to a public way. Exception No. 1: This requirement shall not apply to interior exit discharge as otherwise provided in 7.7.2. Exception No. 2: This requirement shall not apply to rooftop exit discharge	K 038		

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

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K 038	Continued From page 11 as otherwise provided in 7.7.6. Exception No. 3: Means of egress shall be permitted to terminate in an exterior area of refuge as provided in Chapters 22 and 23. CMS S&C letter 5-38	K 038	K066 The Maintenance Director placed approved ashtrays in designated smoking areas on 4/10/12. The ashtray was removed from the deck on south entrance and the area was designated as a non smoking area. Signage was placed on the front deck to reflect a non smoking area on 4/11/12. The Maintenance Director inspected the facility designated smoking area for ashtrays that do not meet NFPA standards and none were found on 4/11/12. The Maintenance Director was re-educated on 3/30/12 by the Administrator on required self-closing ashtrays in designated smoking areas. The Maintenance Director will monitor designated smoking areas monthly for two months to validate proper self-closing ashtrays are used and report finding to the Performance Improvement Committee for further recommendations for two months. Completion date:	5/04/12
K 066 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was	K 066		

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K 066	Continued From page 12 determined the facility failed to ensure the use of approved ashtrays in the designated smoking area, in accordance with NFPA standards. The deficiency had the potential to affect two (2) of three (3) smoke compartments, residents, staff and visitors. The facility is licensed for forty eight (48) beds and the census was forty seven (47) on the day of the survey. The findings include: Observation, on 03/28/12 between 9:53 AM and 11:53 AM, with the Maintenance Director revealed the ashtrays located at the staff smoking area and the deck on the front of the South entrance were not of the unapproved type. They did not have a metal container with a self-closing lid. Interview, on 03/28/12 between 9:53 AM and 11:53 AM, with the Maintenance Director revealed he was not aware of the requirement for self-closing ashtrays. Reference: NFPA 101 (2000 edition) 19.7.4* Smoking. Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such areas shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. Exception: In health care occupancies where	K 066		

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K 066	Continued From page 13 smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (2) Smoking by patients classified as not responsible shall be prohibited. Exception: The requirement of 19.7.4(2) shall not apply where the patient is under direct supervision. (3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.	K 066	K73 The facility implemented fire retardant procedure on 4/17/12. The Maintenance Director completed an inspection of resident rooms to ensure items were treated according to procedure on 4/18/12. The Maintenance Director was educated on fire retardant procedure by the Administrator on 4/17/12. The Maintenance Director will conduct monthly audits for three months of resident rooms to ensure contents meet requirements of flame retardant procedure. The Maintenance Director will report findings to the Performance Improvement Committee for further recommendations for three months. Completion date:	5/04/12
K 073 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4 This STANDARD is not met as evidenced by: Based on observation and Interview, it was determined the facility failed to ensure that no combustible decorations were used in the facility, according to NFPA standards. The deficiency had the potential to affect three (3) of three (3) smoke compartments, residents, staff and visitors. The facility is licensed for forty eight (48) beds and the census was forty seven (47) on the day of the survey.	K 073		

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K 073	Continued From page 14 The findings include: Observation, on 03/28/12 at 1:25 PM, with the Maintenance Director revealed no policy for flame retardant spraying at the facility. Interview, on 03/28/12 at 1:25 PM, with the Maintenance Director revealed the facility did not have a policy or system in place to ensure the decorations were treated with a flame retardant material. Reference: NFPA 101 (2000 Edition). 19.7.5.4 Combustible decorations shall be prohibited in any health care occupancy unless they are flame-retardant.	K 073	K104 On 04/19/12 Comstar Systems cleaned and inspected dampers to validate operation in accordance with NFPA standards. All dampers were inspected by the Maintenance Director and Comstar Systems on 04/19/12. Damper links were replaced on 4/19/12 and were functioning properly. The Administrator provided re-education with the Maintenance Director to schedule inspections of the dampers with Comstar Systems every two years and link replacement every four years on 3/28/12.	
K 104 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Penetrations of smoke barriers by ducts are protected in accordance with 8.3.6. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure fire/smoke dampers were maintained in accordance with NFPA standards The deficiency had the potential to affect three (3) of three (3) smoke compartments, residents, staff and visitors. The facility is licensed for forty eight (48) beds and the census was forty seven (47) on the day of the survey.	K 104	The Maintenance Director will monitor inspection reports on an annual basis to ensure inspection is completed annually. The Maintenance Director will report next annual inspection to Performance Improvement Committee for further recommendations. Completion date:	5/04/12

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K 104	Continued From page 15 The findings include: Observation, on 03/28/12 at 1:25 PM, with the Maintenance Director revealed no documentation for fire damper testing. Interview, on 03/28/12 at 1:25 PM, with the Maintenance Director revealed that no maintenance documentation was kept on the fire/smoke dampers. Reference: NFPA 90A (1999 edition) 3-4.7 Maintenance. At least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify that they fully close; the latch, if provided, shall be checked; and moving parts shall be lubricated as necessary.	K 104	K130 The not an exit sign was removed from south corridor exit by the maintenance director on 3/30/12. An illuminated exit sign was placed on the door on 3/30/12. Corridor exits were inspected by the Maintenance Director on 3/29/12 and other exits were found to be in compliance with NFPA standards. The Maintenance Director was re-educated by the Administrator on 3/30/12 on exit access in accordance with NFPA standards. The Maintenance Director will conduct audits of exits monthly for three months to validate all exits are identified and readily accessible and will report finding to the Performance Improvement Committee for further recommendations for three months.	
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure dead-end corridors were maintained in accordance with NFPA standards. The deficiency had the potential to affect one (1) of three (3) smoke compartments, residents, staff and visitors. The	K 130	Completion date:	5/04/12

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K 130	Continued From page 16 facility is licensed for forty eight (48) beds and the census was forty seven (47) on the day of the survey. The findings include: Observation, on 03/28/12 at 1:15 PM, with the Maintenance Director revealed the exit sign on the rear of the south hall exit was taken down and a sign that read not an exit was placed on the door. Making this exit not an exit made this a 47 ' dead end corridor. Further observation showed the facility map that was provided showed this door marked exit on the facility map. Interview, on 03/28/12 at 1:15 PM, with the Maintenance Director revealed he was unaware that they could not change an exit to not an exit without checking with the State Fire Marshall office first. Reference: NFPA 101 (2000 Edition) 19.2.5.10 Existing dead-end corridors shall be permitted to be continued to be used if it is impractical and unfeasible to alter them so that exits are accessible in not less than two different directions from all points in aisles, passageways, and corridors.	K 130	K147 The extension cord was removed from room 9 on 3/28/12 by the Maintenance Director. The extension cord was removed from the kitchen on 4/14/2012 by Nutrition Services Director. The power strips are no longer plugged into one another and extension cord was removed from DON office on 4/16/12 by the Maintenance Director. On 3/28/2012 the Maintenance Director conducted facility rounds and no other extension cords or power strips required removal. The Administrator conducted re-education on 3/30/2012 with the Maintenance Director on the use of power strip and extension cords to the standards of NFPA 70. The Maintenance Director will conduct monthly audits of the facility for three months to validate the facility meets standard of electrical wiring in accordance with NFPA 70. The Maintenance Director will report findings to the Performance Improvement Committee for further recommendations for three months.	
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2	K 147	Completion date:	5/04/12

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K 147	Continued From page 17 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect one (1) of three (3) smoke compartments, residents, staff and visitors. The facility is licensed for forty eight (48) beds and the census was forty seven (47) on the day of the survey. The findings include: Observations, 03/28/12 between 12:15 PM and 1:30 PM, with the Maintenance Director revealed in room 9 there was a extension cord that was going to a lamp, in the DON office there was a power strip that had an extension cord leading to another power strip. Further observation showed that the first power strip also had another power strip plugged into it in the DON office. The final observation showed an extension cord in use in the kitchen. Interview, 03/28/12 between 12:15 PM and 1:30 PM, with the Maintenance Director revealed he was not aware the extension cords were in use, or the power strips were being misused. Reference: NFPA 99 (1999 edition) 3-3.2.1.2 D Minimum Number of Receptacles. The number	K 147		

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K 147	Continued From page 18 of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.	K 147		