

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

PRINTED: 08/01/2012  
FORM APPROVED  
OMB NO. 0938-0891

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185342	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  07/19/2012
--	--	--	--

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	<p>INITIAL COMMENTS</p> <p>A Standard Health Survey was conducted 07/17/12 through 07/19/12 and a Life Safety Code survey was conducted on 07/18/12. Deficiencies were cited with the highest scope and severity of a "F" with the facility having the opportunity to correct the deficiencies before remedies would be recommended for imposition.</p> <p>483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS</p> <p>Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.</p> <p>The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)</p> <p>The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.</p> <p>The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.</p> <p>The system must preclude any commingling of</p>	F 000	<p>The preparation and execution of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiency. This Plan of Correction is prepared and executed solely because it is required by Federal and State law.</p> <p>F159</p> <p>The Business Office Manager notified the Identified Sampled Resident and Responsible Party, July 20, 2012, that the account balance was over the financial limitations for Medicaid. The Resident and Responsible Party requested that personal items be purchased and the items were purchased August 6, 2012.</p> <p>The Business Office Manager notified the Responsible Party of Resident (H) that the resident was over the financial limitations for Medicaid on July 20, 2012. Responsible Party requested money to purchase personal items for the residents on July 26, 2012 and this was complete.</p>	
F 159 SS=E		F 159		

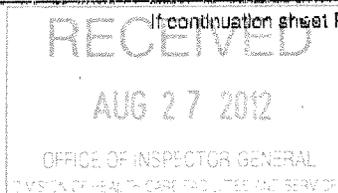
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *Administrator* (X6) DATE *8/24/2012*

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.

OFFICE OF INSPECTOR GENERAL  
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 08/01/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185342	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  07/19/2012
NAME OF PROVIDER OR SUPPLIER  COLONIAL HEALTH AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 708 BARTLEY AVENUE BARDSTOWN, KY 40004	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
F 159	<p>Continued From page 1</p> <p>resident funds with facility funds or with the funds of any person other than another resident.</p> <p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility failed to provide notification to the residents when their funds exceeded the two thousand dollar (\$2000.00) limit for one (1) of fifteen (15) sampled residents, Sampled Resident # 13 and two (2) of thirteen (13) unsampled residents, Unsampled Resident H and Unsampled Resident I.</p> <p>The findings included:</p> <p>The facility did not provide a policy for resident notification related to funds in accounts that would jeopardized benefits for the resident.</p> <p>Record review revealed Resident #4 had an account balance dated 06/18/12 of \$2089.36 and a current balance of \$2088.56, from 07/06/12</p>	F 159	<p>F159 (continued)</p> <p>The Business Office Manager notified the Responsible Party of Resident (I) that the resident was over the financial limitations for Medicaid on July 20, 2012. The Responsible Party requested the money be applied to the Residents current balance and the request was completed July 20, 2012.</p> <p>All Residents accounts were reviewed on July 24, 2012 by the Business Office Manager. No other notifications were necessary.</p> <p>The Business Office Manager is assigned the responsibility of monitoring the Resident Trust Accounts. Business Office Manager received re-education, by the Administrator, on August 2, 2012 regarding resources limits and responsibility to notify Resident/Responsible Party when funds reach \$200.00 less than the resource limitation.</p>



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

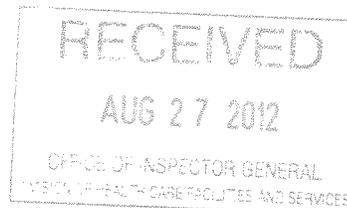
PRINTED: 08/01/2012  
FORM APPROVED  
OMB NO. 0938-0381

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185342	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  07/19/2012
--	--	--	--

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 159	Continued From page 2 through 07/19/12. Upon request, the facility was unable to provide a letter of notification the resident was notified of the balance.  Record review revealed Unsampled Resident H had a balance dated 06/18/12 of \$2258.50 and a current balance of \$2285.15, from 07/11/12 through 07/19/12. Upon request, the facility was unable to provide a letter of notification the resident was notified of the balance.  Record review revealed Unsampled Resident I had a balance dated 06/01/12 of \$2069.65, a balance dated 06/01/12 of \$2138.15, a balance dated 07/02/12 of \$2494.11 and a current balance of \$2514.04, from 07/11/12 through 07/19/12. Upon request, the facility was unable to provide a letter of notification the resident was notified of the balance.  Interview, on 07/19/12 at 2:20 PM, with the Business Office Manager (BOM) and the Bookkeeper revealed the facility did not have a policy regarding the accounts; however, they followed the regulations. The BOM reported the facility had sent letters in the past. She reported this responsibility was given to the bookkeeper earlier in the year and the letter was already in the computer. The Bookkeeper reported, she was not aware of the letter in the computer. The BOM reported, they had dropped the ball. The BOM stated she normally kept on top of the funds to keep them below the \$2000.00 level. However, that had not been reflected recently. The BOM reported, the residents run the risk of lost benefits if the balance remains above the \$2000.00 mark.	F 159	<b>F159 (continued)</b>  <b>Administrator to check account balance monthly for six months and no less than quarterly for one year to ensure sustained compliance. Thereafter, the Business Office Manager will submit a written accounting balance to the facility Quality Assurance Committee quarterly.</b>	August 17, 2012
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		



PRINTED: 08/21/2012  
FORM APPROVED  
OMB NO. 0968-0361

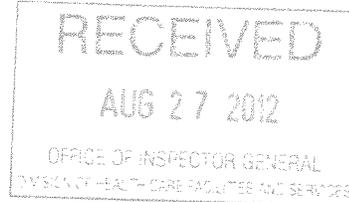
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135342	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  07/19/2012
--	--	--	--

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

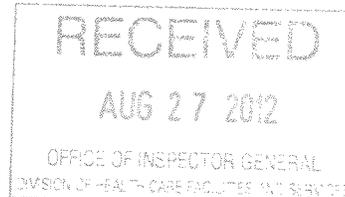
F 441	<p>Continued From page 8</p> <p>The facility must establish and maintain an infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility 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><b>F441</b></p> <p>The Ice Chest identified was removed from use on 7-19-12 by the Maintenance Director. All ice chests in use were inspected on 7-19-12 by the Dietary Manager to ensure they were clean and in good repair.</p> <p>The ice chests are to be cleaned weekly by Dietary staff and staff received re-education beginning July 23, 2012 by the Dietary Manager regarding the procedure for cleaning and for observing for signs that the ice chest should be replaced. Any noted substances that cannot be removed will result in the replacement of the ice chest.</p> <p>Dietary Manager or Weekend Nurse Supervisor to inspect ice chests daily for 2 weeks beginning 8-13-12 and then Dietary Manager will inspect ice chests weekly after cleaning to ensure compliance. Any noted substances that cannot be removed will result in the replacement of the ice chest.</p>	8-24-12
-------	--	-------	---	---------



PRINTED: 08/01/2012  
FORM APPROVED  
OMB NO. 0932-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  188242	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  07/16/2012
NAME OF PROVIDER OR SUPPLIER  COLONIAL HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 708 BARTLEY AVENUE BARDSTOWN, KY 40004		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	Continued From page 4  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policies, it was determined the facility failed to ensure: one (1) of two (2) ice chest carts were clean; failed to ensure shared equipment was disinfected between resident use for four (4) of thirteen (13) unsampled residents, Unsampled Residents J, K, L, and M; failed to ensure staff followed hand hygiene and/or proper glove changes during direct care for three (3) of thirteen (13) unsampled residents, Unsampled Residents J, K, and L, and for two (2) of fifteen (15) sampled residents, Resident #2 and Resident #6.  The findings include:  Review of the facility's policy titled Handwashing, undated, revealed hands should always be washed after gloves are removed, even if the gloves appear to be intact. Handwashing should be completed using the appropriate facilities, such as utility or restroom sinks. When hand washing facilities were not available, waterless antiseptic hand cleanser should be used.  Review of Lippincott's Nursing Procedures, 5th Edition, (2009), confirmed by the Director of Nursing (DCN), as the standard of practice followed by the facility for proper hand hygiene and glove use, revealed hands were to be washed before and after performing care or procedures, or having contact with contaminated objects even though gloves may have been worn. Always wash hands after removing gloves.  Review of the facility's policy regarding	F 441	F144 (continued)  Wound care nurse identified all stethoscopes, pulse oximeters, and blood pressure cuffs and had all equipment cleaned using the facility standard disinfectant. Cleaning was completed by staff nurses on 8-10-12.  As of August 27, 2012 reusable items such as IV poles, mini-neb machines, suction machines, will be cleaned when removed from a residents room and prior to use by another resident. All reusable items will be tagged as clean and disinfected prior to being placed in the clean storage area. The responsibility for cleaning the equipment is assigned to the third shift staff. The second shift super visor will check all equipment in the clean storage area weekly to ensure all items are tagged and ready for reuse. Reusable equipment such as stethoscopes, blood pressure cuffs, pulse oximeters, etc that come into contact with intact skin will be disinfected between residents. Disinfectant wipes or alcohol wipes are to be used and will be placed on the treatment carts by August 27, 2012		

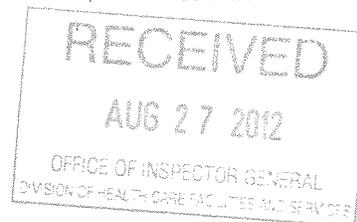


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/01/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185242	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  07/19/2012
NAME OF PROVIDER OR SUPPLIER  COLONIAL HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 700 BARTLEY AVENUE BARDSTOWN, KY 40004	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 5 Environmental Sanitation/Infection Control: Ice Dispensing, Policy 9.7, dated 2006, revealed ice was stored in equipment that was cleaned and sanitized on a routine basis.  Review of the facility's cleaning schedule revealed the ice carts were to be thoroughly cleaned weekly.  Observation, on 07/17/12 at 6:10 PM, an ice chest sat in the corridor near the door entrance to the ice room. The ice chest cart had a container on the shelf below the ice chest with an open white plastic container, which collected dripping water. Staff pulled the cart into the ice room and filled the ice chest with ice and began ice and water pass to the resident down the hall near the ice room. The ice chest's white band supports had a black splochy substance ingrained into the white band supports, which held the ice chest in place. The support bands were wet to touch.  Observation, on 07/18/12 at 8:30 AM, revealed a large amount of a yellowish, brown, and black substance on the cloth straps that held a cooler in place on the ice cart used to transport ice for filling residents' ice pitchers.  Interview, on 07/19/12 at 10:55 AM, with the Dietary Manager revealed the yellowish, black, and brown substance looked like mold to her. The Dietary Manager stated the substance should not be present near the ice that was passed to the residents, and the straps should be cleaned or replaced with new ones. During the interview, the Dietary Manager touched the straps and she stated they felt wet.	F 441	<b>F441 (continued)</b> Policy regarding cleaning and disinfecting equipment to be implemented by August 27, 2012 with in-services completed by August 27, 2012. Director of Nursing, Wound Care Nurse or Corporate Consultant to complete the education. All newly hired staff will receive education during orientation. The Director of Nursing will be responsible for ensuring the staff are educated. The policy will be reviewed with nursing staff monthly for 3 months then included in training no less than annually. The DON is responsible to ensure this education is provided.  Director of Nursing, Wound Care Nurse and Weekend Supervisor to visually observe no less than 5 nursing staff daily for 4 weeks as they clean and disinfect equipment after use to ensure proper cleaning and disinfecting is completed. There after they will observe no less than 15 nursing staff per week for 4 weeks. The cleaning of equipment will then be added to the facility staff skills check off and all nursing staff will be checked off annually on the procedure and all newly hired staff will be checked off within 60 days of hire. All non-compliance will be addressed at the time of observation. Director of Nursing will report on observations to the facility QA Committee no less than quarterly.	

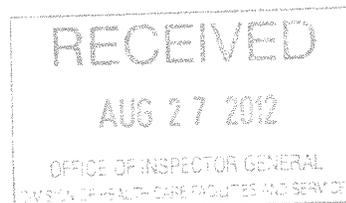
8-28-12



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

PRINTED: 08/01/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185842	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  07/19/2012
NAME OF PROVIDER OR SUPPLIER  COLONIAL HEALTH AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 708 BARTLEY AVENUE BARDSTOWN, KY 40004		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	<p>Continued From page 6</p> <p>Interview, on 07/19/12 at 2:55 PM, with the Dietary Manager revealed staff who clean the ice chests/carts weekly should identify any dirt and discolorations and clean the entire unit, but that she was ultimately responsible for the cleanliness of the portable ice chests and the carts that transport the ice from the kitchen to the residents.</p> <p>Observation, on 07/18/12 at 10:05 AM, of the skin assessment for Resident #6, revealed Licensed Practical Nurse (LPN) #2 did not wash her hands before donning gloves to perform the skin assessment in the shower room. LPN #2 separated Resident #6's buttocks to inspect the anal area first, but she did not remove her gloves, wash her hands, or apply a clean pair of gloves before proceeding to touch the residents arms, legs, back, and scalp. At the completion of the skin assessment, LPN #2 removed her gloves in the shower room, did not wash her hands, went immediately to the treatment cart in the hallway, and documented on the Treatment Administration Record (TAR).</p> <p>Interview, on 07/19/12 at 6:15 PM, with LPN #2 revealed she should have washed her hands prior to donning gloves before performing the skin assessment for Resident #6, and she should have removed her gloves and washed her hands before leaving the shower room to document on the TAR. LPN #2 revealed she did not change gloves after separating Resident #6's buttocks to inspect the anal area because she did not think she should necessarily change her gloves unless she touched urine or bowel movement during the skin assessment. LPN #2 stated she thought she had attended an infection control in-service in January 2012, but she was not sure.</p>	F 441	<p>F441 (continued)</p> <p>LPN # 2 was reeducated by Wound Care Nurse on hand washing and glove changing on August 10, 2012. LPN # 4 was reeducated on hand washing and glove changing by the Wound Care Nurse on August 10, 2012. Residents # 2 and # 6 have had skin assessments completed July 19, 2012 and review of those skin assessments by the Wound Care Nurse reveal no noted complications from the observed practice such as infection or skin rash or irritation.</p> <p>Wound Care Nurse has reviewed all skin assessments completed since July 19, 2012 to ensure there are no noted infections, skin irritations, or rashes that may be attributable to improper hand hygiene or glove changing during skin assessments. Wound Care Nurse has observed all wounds no less than weekly since July 19, 2012 and there are no noted signs or symptoms of infection that can be attributed to improper hand hygiene or glove changing during treatments. This was completed on August 24, 2012.</p> <p>The Director of Nursing or Wound Care Nurse or Corporate Consultant will reeducate nursing staff on the Infection Control Policy related to Hand Hygiene and Glove Changes beginning on August 15, 2012 and will be completed by August 27, 2012. All newly hired employees will receive this education during orientation. The Director of Nursing will be responsible to ensure the training is provided. The policy will be Reviewed with nursing staff monthly for 3 months then included in training no less than annually.</p>	



PRINTED: 08/01/2012  
FORM APPROVED  
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  125842	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  07/19/2012
--	--	--	--

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F441 (continued)

F 441 Continued From page 7

Observation, on 07/18/12 at 2:00 PM, of the skin assessment for Resident #2, revealed LPN #4, entered the resident's room, and did not wash her hands before donning gloves to perform the skin assessment. During the skin assessment, LPN #4 touched the resident's perineal area, but did not remove her gloves, sanitize her hands, and apply new gloves before touching Resident #2's legs, feet, toes, back, buttocks, and anal area. LPN #4 then covered the resident with a sheet and blanket, placed a pillow between the resident's legs, and lowered the bed touching the controls at the end of the bed without first removing her gloves.

Interview, on 07/19/12 at 3:30 PM, with LPN #4, revealed she should have washed her hands before donning gloves to begin the skin assessment for Resident #2, and she should have changed her gloves during the skin assessment after touching the resident's perineal area. LPN #4 stated she should have removed her gloves before touching the bed controls. The potential problem with not washing her hands before beginning care, was the transmission of infection to the resident. The problem with touching the bed controls with soiled gloved hands would be the potential transmission of germs to staff who would have contact with other residents in the facility.

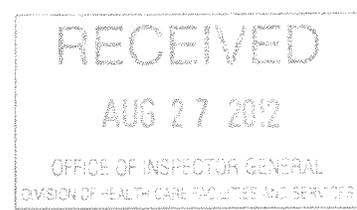
Interview, on 07/19/12 at 4:05 PM, with the Director of Nursing (DON), revealed the facility did not currently have a formal system in place to monitor, document, and track hand hygiene, glove changes, and wound care practices on the

F 441

The D O N is responsible to ensure this education is provided. Hand washing and use of gloves is part of the facility staff skills check off and all nursing staff will be checked off annually on the procedures and all newly hired staff will be checked off within 60 days of hire. The Director of Nursing is responsible for the Staff Skills Check Offs.

Director of Nursing, Wound Care Nurse and Weekend Supervisor to visually observe no less than 3 licensed nursing staff daily as they perform skin assessments or treatments observing for proper hand hygiene and glove changing. Thereafter they will observe no less than 5 nursing staff per week for 4 weeks. Thereafter all licensed staff will be observed no less than quarterly for 3 quarters to ensure compliance. All non-compliance will be addressed at the time of observation. Director of Nursing will report on observations to the facility QA Committee no less than quarterly.

8-28-12



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

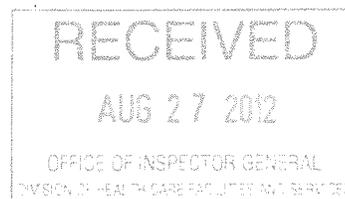
PRINTED: 08/01/2012  
FORM APPROVED  
OMB NO. 0930-0091

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  1D5842	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  07/19/2012
--	--	--	--

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 441	<p>Continued From page 8</p> <p>units. The DON stated the facility was in the process of hiring additional nurses (unit managers), who would be trained to monitor staff for proper infection control practices, but the DON stated she was ultimately responsible for ensuring the staff was properly trained and inserviced on infection control practices and monitored for compliance with the facility's infection control policies.</p> <p>Observation, on 07/18/12 at 2:00 PM, of Licensed Practical Nurse (LPN) #2 during nebulizer treatments revealed she did not practice hand hygiene prior to the removal of the two (2) medications (Atrovent and Xopenox Nebulizer Medications) from the medication cart. She removed the pulse oximetry (monitors the oxygen saturation level in the blood and the pulse rate) from the treatment cart for Unsampled Resident J. She placed the pulse oximetry on Unsampled Resident J and obtained the pulse rate and oxygen saturation. She listened to the resident's lung fields with her stethoscope and did not clean the stethoscope bell before or after touching the resident. She put the medications in the nebulizer and initiated the treatment. She picked up the pulse oximetry equipment, left the resident's room and returned to the medication cart and continued with documentation without cleaning the equipment. Continued observation, at 2:08 PM revealed she removed the nebulizer medication (Dunehb) for Unsampled Resident K and proceeded to the resident's room. She placed the pulse oximetry on the resident and used the stethoscope on Unsampled Resident K without cleaning the equipment or hand hygiene</p>	F 441		
-------	---	-------	--	--



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

PRINTED: 08/01/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185342	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  07/19/2012
NAME OF PROVIDER OR SUPPLIER  COLONIAL HEALTH AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 708 BARTLEY AVENUE BARDSTOWN, KY 40004	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 441	<p>Continued From page 9</p> <p>between residents J and K. Then she proceeded to the sink and completed hand hygiene after she came in contact with Unsampled Resident K. She initiated the nebulizer treatment. She returned to the treatment cart with the pulse oximetry and stethoscope and documented the resident's findings. Continued observation, at 2:15 PM revealed she removed the nebulizer medication (Albuterol) for Unsampled Resident L and proceeded to the resident's room. She placed the pulse oximetry on the resident and used the stethoscope on Unsampled Resident L without cleaning the equipment or hand hygiene between residents K and L. Then she proceeded to the sink and completed hand hygiene after she came in contact with Unsampled Resident L. She initiated the nebulizer treatment. She returned to the treatment cart with the pulse oximetry and stethoscope and documented the resident's findings. Upon completion of documentation she put the pulse oximetry in the bottom drawer without cleaning the equipment.</p> <p>Observation during the medication pass, on 07/19/12 at 7:15 AM, of Certified Medication Technician (CMT) #10 revealed she removed the blood pressure cuff from the bottom drawer of the medication cart and obtained the blood pressure of Unsampled Resident M. The blood pressure cuff was not cleaned prior to use or after the blood pressure was taken. The blood pressure cuff was returned to the case and placed in the medication cart without cleaning the equipment after it was used on Unsampled Resident M.</p> <p>interview, on 07/19/12 at 7:30 AM, with CMT #10 revealed the blood pressure cuffs are cleaned on Sunday nights. She reported the blood pressure</p>	F 441		
-------	---	-------	--	--

RECEIVED  
AUG 27 2012  
OFFICE OF INSPECTOR GENERAL  
DIVISION OF HEALTH REGULATORY SERVICES

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

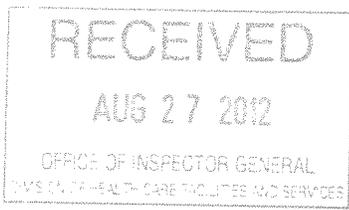
PRINTED: 08/01/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  132842	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  07/19/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  COLONIAL HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 706 BARTLEY AVENUE BARDSTOWN, KY 40004
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 441	<p>Continued From page 10</p> <p>cuffs are not dirty equipment and do not have have to be cleaned between resident use.</p> <p>Interview, on 07/19/12 at 3:51 PM, with the Director of Nurses reported the facility did not have a policy on cleaning equipment between resident use, other than the blood glucose monitors. She stated, there was not a regulation that addressed cleaning the equipment between resident use and they had a cleaning schedule for the Certified Nurse Aides (CNA) to clean the lihs, the blood pressure cuffs and the machines every Sunday night.</p> <p>Interview, on 07/19/12 at 6:08 PM, with Licensed Practical Nurse (LPN) #2 revealed the blood pressure cuffs and the pulse oximetry, plus any equipment used on a resident should be cleaned between resident use. She reported, by not cleaning the equipment, this practice could lead to cross contamination between residents. She reported this was an infection control concern.</p>	F 441		
-------	---	-------	--	--



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

PRINTED: 08/01/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185342	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  07/18/2012
--	--	--	--

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1966</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (111)</p> <p>SMOKE COMPARTMENTS: Six (6) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is Diesel.</p> <p>A standard Life Safety Code survey was conducted on 07/18/12. Colonial Health and Rehab Center was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility has sixty five (65) certified beds with a census of sixty five (65) on the day of the survey.</p> <p>The findings that follow demonstrates noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p>	K 000		
-------	---	-------	--	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: *X-Administrator* (X16) DATE: *8/24/12*

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.

PRINTED: 08/01/2012  
FORM APPROVED  
OMB NO. 0938-0391

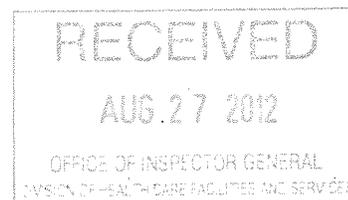
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  105342	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  07/18/2012
--	--	--	--

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

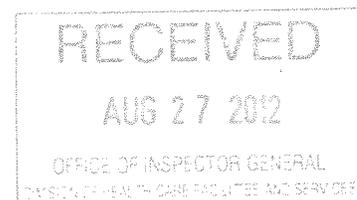
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

K 000	Continued From page 1	K 000		
K 018 SS=E	<p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 1/4 inch solid-banded 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</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p>	K 018	<p><b>K018</b></p> <p>The gap at the corridor door to room number #11 will be fixed by August 17, 2012. A complete audit of all doors will be complete by August 17, 2012 and repairs will be made as necessary. An Environmental audit will be conducted monthly, as part of preventative maintenance. All of the above functions will be the responsibility of the Maintenance Director. Reports from environmental audits are kept in the Preventative Maintenance Binder and will be reviewed by the Regional Maintenance Director quarterly. The Maintenance Director will submit a quarterly report to the Quality Assurance Committee for review, to ensure continued compliance.</p>	
	<p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure doors protecting corridor openings were constructed to resist the passage of smoke in accordance with NFPA standards. The deficiency had the potential to affect three (3) of six (6) smoke compartments, residents, staff and visitors. The facility has sixty five (65) certified beds with a</p>		<p>Nursing Staff to receive re-education regarding Fire Safety and appropriate use of privacy curtains by the Administrator, Director of Nursing, Administrative Nurse or Nursing Manager, beginning August 10, 2012</p>	



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 08/01/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  165042	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  07/18/2012	
NAME OF PROVIDER OR SUPPLIER  COLONIAL HEALTH AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 708 BARTLEY AVENUE BARDSTOWN, KY 40004		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 018	<p>Continued From page 2</p> <p>census of sixty five (65) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 07/18/12 at 2:00 PM, with the Maintenance Director revealed the corridor door to room number #11 had a gap too large around the jamb and would not resist the passage of smoke.</p> <p>Interview, on 07/18/12 at 2:00 PM, with the Maintenance Director revealed he was not aware of the door having a gap that would not resist the passage of smoke.</p> <p>Observations, on 07/18/12 between 1:00 PM and 2:30 PM, with the Maintenance Director revealed some of the corridor doors to resident rooms were blocked from closing by the privacy curtain hanging in the doorway. The doors affected by this were rooms #1, 2, 9, and 13. Further observation revealed the corridor door to room #20 was blocked from closing by the oxygen tube passing through the doorway from the oxygen concentrator which was sitting in the egress path. (See K-72)</p> <p>Interviews, on 07/18/12 between 1:00 PM and 2:30 PM, with the Maintenance Director confirmed the observation of the doors not closing due to the privacy curtains hanging into the doorway, also the oxygen tube passing through the doorway.</p> <p>Observation, on 07/18/12 at 2:17 PM, with the Maintenance Director revealed the corridor door</p>	K 018	<p><b>K018 (continued)</b></p> <p>The corridor door will be closed when the privacy curtain is in use. When the privacy curtain is not in use, it will be positioned to not obstruct the door from closing. There are ties in each room to hold the curtains back when not in use or as necessary. To monitor the effectiveness of the re-education and ensure continued compliance, Nursing Managers will make daily checks for seven days, weekly checks for four weeks, and monthly checks thereafter, beginning August 13, 2012. These reports will be submitted to the Director of Nursing upon completion and any concerns will be reported to the Quality Assurance Committee quarterly.</p> <p>The oxygen concentrator belonging to Resident #20 was placed inside of the room on July 19, 2012. Upon tour of the facility on July 19, 2012 there were no other oxygen concentrators in the hallway. The Director of Nursing addressed this concern with Resident #20 and nursing staff on July 19, 2012. Nurses to receive re-education regarding Fire Safety and means of egress beginning</p>	



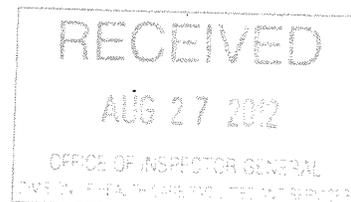
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/01/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185342	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X5) DATE SURVEY COMPLETED  07/18/2012
--	--	--	--

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 018	<p>Continued From page 3</p> <p>to the Dish Room was equipped with a self-closing device, however the door was held open with a roller latch.</p> <p>Interview, on 07/18/12 at 2:17 PM, with the Maintenance Director revealed he was not aware roller latches were prohibited.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>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 1 3/4-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.</p> <p>Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials.</p> <p>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.</p> <p>19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is</p>	K 018	<p><b>K018 (continued)</b></p> <p>August 10, 2012 by the Administrator, Director of Nursing, Administrative Nurse or Nursing Manager. To monitor the effectiveness and ensure continued compliance, the Nursing Supervisor will monitor the hallways daily for one week, weekly for four weeks, and monthly thereafter, beginning August 13, 2012. These reports will be submitted to the Director of Nursing upon completion and any concerns will be reported to the Quality Assurance Committee quarterly.</p> <p>The roller latch on the dish room door will be removed by August 10, 2012 by the Maintenance Director. Upon tour of the facility July 19, 2012 there were no other roller latches in the facility. The Maintenance Director received re-education on July 19, 2012, by the Administrator, regarding the use of roller latches. As part of the monthly fire drill, the Maintenance Director will monitor all doors for proper closure. Reports will be kept in the Preventative Maintenance Binder and will be reviewed by the Regional Maintenance Director quarterly.</p>	



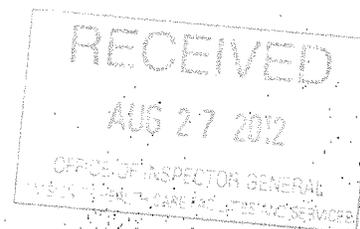
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/01/2012  
FORM APPROVED  
OMB NO. 0998-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185342	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  07/18/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  COLONIAL HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 709 BARTLEY AVENUE BARDSTOWN, KY 40004
---	--

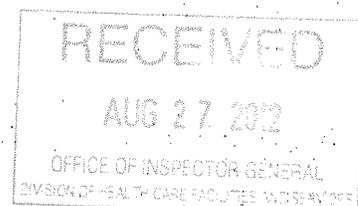
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 018	Continued From page 4 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 NFPA standards.	K 018	<b>K018 (continued)</b>  The Maintenance Director will submit a quarterly report to the Quality Assurance Committee for review, to ensure continued compliance.	August 24, 2012
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 1 7/8-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 potential to affect six (6) of six (6) smoke compartments, residents, staff and visitors. The facility has sixty five (65) certified beds with a census of sixty five (65) on the day of the survey.  The findings include:	K 027	<b>K027</b>  A Coordinating Device will be installed to the cross-corridor doors to ensure that the doors without a t-astragal will close first after the initial close, to resist the passage of smoke, in the event of a fire. The Maintenance Director will install the device by August 24, 2012. The devices will be tested upon installation and monthly as part of the fire drill. Reports from monthly fire drills are kept in the Preventative Maintenance Binder and will be reviewed by the Regional Maintenance Director quarterly. The Maintenance Director will submit a quarterly report to the Quality Assurance Committee for review, to ensure continued compliance.	August 25, 2012



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

PRINTED: 08/01/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185342	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  07/18/2012
NAME OF PROVIDER OR SUPPLIER  COLONIAL HEALTH AND RENABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 708 BARTLEY AVENUE BARDSTOWN, KY 40004	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 027	<p>Continued From page 5</p> <p>Observation, on 07/18/12 between 1:00 PM and 2:30 PM, with the Maintenance Director revealed the cross-corridor doors located throughout the facility would not close completely when tested. This was due to the doors not having a coordinating device to ensure the door without the t-astragal would close first after the initial close.</p> <p>Interview, on 07/18/12 between 1:00 PM and 2:30 PM, with the Maintenance Director revealed he was unaware the doors needed a coordinator to ensure the doors would close properly in the event of an emergency.</p> <p>NFPA Standard: NFPA 101, 19.3.7.6*. Requires doors in smoke barriers to be self-closing and resist the passage of smoke.</p> <p>Reference: NFPA 80 (1999 Edition)</p> <p>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 each door closes and latches independently of the other.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>8.3.4.1* Doors in smoke barriers shall close the opening leaving</p>	K 027		



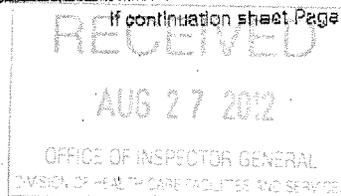
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/01/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185542	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  07/18/2012
--	--	--	--

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 027	Continued From page 6 only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles.	K 027		
K 029 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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 18.3.5.4 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</p> <p>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 six (6) smoke compartments, residents, staff and visitors. The facility has sixty five (65) certified beds with a census of sixty five (65) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 07/18/12 at 2:26 PM, with the Maintenance Director revealed the door to the dry storage room located in the Kitchen did not have</p>	K 029	<p><b>K029</b></p> <p>A self-closing device will be placed on the door to the dry storage room located in the Kitchen by the Maintenance Director, by August 24, 2012. Upon tour of the facility, July 19, 2012, there were no other doors identified as needing a self-closing device. The Maintenance Director received re-education on July 19, 2012, by the Administrator, regarding the need for self-closing devices in hazardous areas. An Environmental audit will be conducted monthly by the Maintenance Director, to assess for fire safety, as part of the monthly fire drill. Reports from monthly fire drills are kept in the Preventative Maintenance Binder and will be reviewed by the Regional Maintenance Director quarterly. The Maintenance Director will submit a quarterly report to the Quality Assurance Committee for review, to ensure continued compliance.</p>	August 25 2012



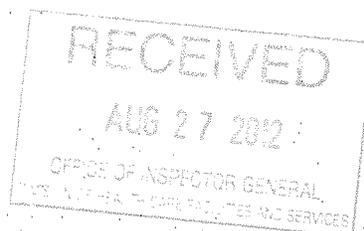
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/01/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185342	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  07/12/2012
--	--	--	--

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029	<p>Continued From page 7 a self-closing device.</p> <p>Interview, on 07/18/12 at 2:26 PM, with the Maintenance Director revealed he was unaware the dry storage room door was required to be self-closing.</p> <p>Reference: 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 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:</p>	K 029		
	<p>(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</p>			



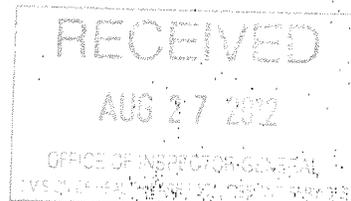
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/01/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185342	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  07/18/2012
--	--	--	--

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LQC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029	Continued From page 8 (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. NFPA 101 LIFE SAFETY CODE STANDARD	K 029		
K 062 SS=E	Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5  This STANDARD is not met as evidenced by: Based on observation, and interview, it was determined the facility failed to maintain the sprinkler system in accordance with NFPA standards. The deficiency had the potential to affect three (3) of six (6) smoke compartments, residents, staff and visitors. The facility has sixty five (65) certified beds with a census of sixty five (65) on the day of the survey.	K 062	K062  The Maintenance Director will ensure that there are no obstructions to sprinkler discharge and that sprinkler heads within each compartment have the same response time, by August 24, 2012. The Maintenance Director received re-education on July 19, 2012, by the Administrator, regarding fire safety. An Environmental audit will be conducted monthly by the Maintenance Director, to check each sprinkler head and ensure that all sprinkler heads are free of corrosion, foreign materials, paint, and physical damage and they are installed in the proper orientation. Preventative Maintenance reports are kept in the Preventative Maintenance Binder and will be reviewed by the Regional Maintenance Director quarterly. The Maintenance Director will submit a quarterly report to the Quality Assurance Committee for review, to ensure continued compliance.	August 25, 2012
	The findings include:  Observations, on 07/18/12 between 1:00 PM and 2:30 PM, with the Maintenance Director revealed sprinkler heads of mixed response ratings were located in the rooms; 2, 39, 46, Back T.V. Room, PC Ladies central Bath, and the Therapy Room.			



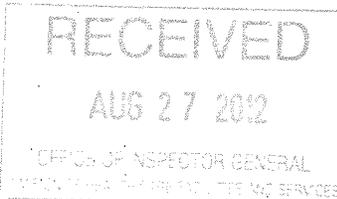
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/01/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185342	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  07/18/2012
--	--	--	--

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 062	<p>Continued From page 9</p> <p>Interview, on 07/18/12 between 1:00 PM and 2:30 PM, with the Maintenance Director revealed the facility was not aware of the mixed response sprinkler heads in these areas.</p> <p>Observation, on 07/18/12 between 1:00 PM and 2:30 PM, with the Maintenance Director revealed the sprinkler heads located in the East Hall Supply Closet, and the closet in room #45, had paint on the sprinkler heads decreasing their ability to react as intended.</p> <p>Interview, on 07/18/12 between 1:00 PM and 2:30 PM, with the Maintenance Director revealed they were not aware that the sprinklers heads had been painted.</p> <p>Reference: NFPA 13 (1999 Edition)</p> <p>5-5.5.2* Obstructions to Sprinkler Discharge Pattern Development. 5-5.5.2.1 Continuous or noncontiguous obstructions less than or equal to 18 in. (457 mm) below the sprinkler deflector that prevent the pattern from fully developing shall comply with 5-5.5.2.</p> <p>2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper</p>	K 062		



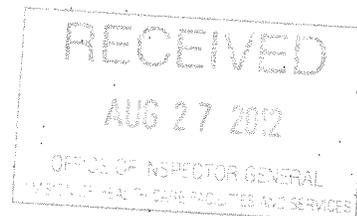
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/01/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  125342	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  07/19/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  COLONIAL HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 706 BARTLEY AVENUE BARDSTOWN, KY 40004
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 062	Continued From page 10 orientation. hydraulic design basis, the system area of operation shall be permitted to be reduced without revising the density as indicated in Figure 7-2.3.2.4 when all of the following conditions are satisfied: (1) Wet pipe system (2) Light hazard or ordinary hazard occupancy (3) 20-ft (6.1-m) maximum ceiling height The number of sprinklers in the design area shall never be less than five. Where quick-response sprinklers are used on a sloped ceiling, the maximum ceiling height shall be used for determining the percent reduction in design area. Where quick-response sprinklers are installed, all sprinklers within a compartment shall be of the quick response type. Exception: Where circumstances require the use of other than ordinary temperature-rated sprinklers, standard response sprinklers shall be permitted to be used.	K 062		
K 066 SS=D	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.	K 066	K066  The unapproved ashtray was removed for the front porch, on July 19, 2012, by the Maintenance Director. There were no other unapproved ashtrays on the premises, on July 19, 2012. Maintenance Director was re-educated on approved ashtrays on July 19, 2012, by the Administrator.	



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

PRINTED: 08/01/2012  
FORM APPROVED  
CMB NO. 0936-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185342	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  07/18/2012
--	--	--	--

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 066	<p>Continued From page 11</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(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</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was 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 one (1) of six (6) smoke compartments, residents, staff and visitors. The facility has sixty five (65) certified beds with a census of sixty five (65) on the day of the survey.</p>	K 066	<p><b>K066 (continued)</b></p> <p>As part of the monthly fire drill, the Maintenance Director will monitor ashtrays to ensure they are all of the approved type. Reports from environmental audits are kept in the Preventative Maintenance Binder and will be reviewed by the Regional Maintenance Director quarterly. The Maintenance Director will submit a quarterly report to the Quality Assurance Committee for review, to ensure continued compliance.</p>	August 24, 2012
	<p>The findings include:</p> <p>Observation, on 07/18/12 at 2:13 PM, with the Maintenance Director revealed the ashtrays located on the front porch were not of the unapproved type. They did not have a metal container with a self-closing lid.</p> <p>Interview, on 07/19/12 at 2:13 PM, with the</p>			

RECEIVED  
AUG 27 2012  
OFFICE OF INSPECTOR GENERAL  
DIVISION OF HEALTH CARE SERVICES

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

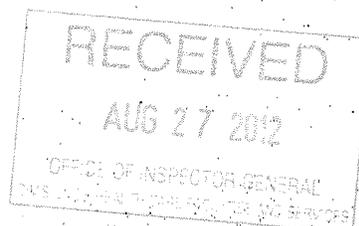
PRINTED: 08/01/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185342	(X2) MULTIPLE CONSTRUCTION A. BUILDING G1 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  07/18/2012
--	--	--	--

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

K 066	<p>Continued From page 12</p> <p>Maintenance Director revealed he was not aware of the requirement for self-closing ashtrays.</p> <p>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 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.</p>	K 066		
	<p>(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.</p>			



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

PRINTED: 08/01/2012  
FORM APPROVED  
OMB NO. 0938-0301

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185342	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  07/18/2012
--	--	--	--

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

K 072  
SS=E

**NFPA 101 LIFE SAFETY CODE STANDARD**

Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10

This STANDARD is not met as evidenced by:  
Based on observation and interview, it was determined the facility failed to maintain exit access in accordance with NFPA standards. The deficiency had the potential to affect three (3) of six (6) smoke compartments, residents, staff and visitors. The facility has sixty five (65) certified beds with a census of sixty five (65) on the day of the survey.

The findings include:

Observation, on 07/18/12 between 1:00 PM and 2:30 PM, with the Maintenance Director revealed storage of an oxygen concentrator in the corridor outside room #20, also Med Carts stored in the East Hall.

Interview, on 07/18/12 between 1:00 PM and 2:30 PM, with the Maintenance Director revealed the facility routinely stored items in these areas. Further interview revealed the oxygen concentrator was being stored in the corridor outside room #20 due to it causing excessive heat in the residents' room.

Reference: NFPA 101 (2000 Edition)

K 072

**K072**

The oxygen concentrator belonging to resident #20 was placed inside of the room on July 19, 2012. Upon tour of the facility on July 19, 2012 there were no other oxygen concentrators in the hallway. The Director of Nursing addressed this concern with Resident #20 and nursing staff on July 19, 2012. Carts are not to be stored in the hallway when not in use. Nurses to receive re-education regarding Fire Safety and means of egress, beginning August 10, 2012 by the Administrator, Director of Nursing, Administrative Nurse or Nursing Manager. To monitor effectiveness and ensure continued compliance, the Nursing Supervisor will monitor the hallways daily for one week, weekly for four weeks, and monthly thereafter, beginning August 13, 2012. These reports will be submitted to the Director of Nursing upon completion and any concerns will be reported to the Quality Assurance Committee quarterly.

August 24, 2012

RECEIVED  
AUG 27 2012  
OFFICE OF DIRECTOR GENERAL  
DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/01/2012  
FORM APPROVED  
OMB NO. 5958-0391

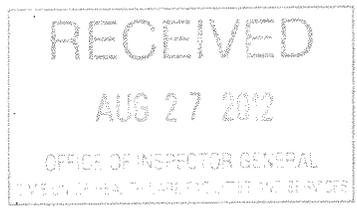
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
ENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES & PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  136342	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  07/18/2012
---	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------------	--	---------------------	--	----------------------------

K 072	Continued From page 14 Means of Egress Reliability 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.	K 072		
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  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 two (2) of six (6) smoke compartments, residents, staff, and visitors. The facility has sixty five (65) certified beds with a census of sixty five (65) on the day of the survey.  The findings include:  Observations, on 07/18/12 between 1:00 PM and 2:30 PM, with the Maintenance Director revealed:  1) The hydrocollator located in the Therapy Room was not plugged into a ground fault protected outlet.  2) A power strip was plugged into another power strip located in the Bookkeeping Office.  Interview, on 07/18/12 between 1:00 PM and 2:30 PM, with the Maintenance Director revealed he	K 147	<b>K147</b>  The hydrocollator in therapy was plugged into a ground fault July 19, 2012, by the Maintenance Director. The power strip in the Bookkeeping Office was plugged into a ground fault on July 19, 2012, by the Maintenance Director. A complete tour of the facility was conducted by the Maintenance Director on July 19, 2012 and not other electrical safety concerns were identified. All staff will be re-educated on electrical safety beginning August 10, 2012 by the Administrator, Director of Nursing, Administrative Nurse or Nursing Supervisor. Maintenance will conduct monthly environmental audits for electrical safety to ensure that this practice does not reoccur. The Maintenance Director will submit the reports from the electrical safety audits to the quality Assurance Committee quarterly for review.	August 24, 2012



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

PRINTED: 08/01/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  195342	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  07/18/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  COLONIAL HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 706 BARTLEY AVENUE BARDSTOWN, KY 40004
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 147	<p>Continued From page 15</p> <p>was not aware of the misuse of power strips, or the hydrocollator not plugged into a ground fault protected outlet.</p> <p>Reference: NFPA 99 (1999 edition) 3-3.2.1.2 D</p> <p>Minimum Number of Receptacles. The number 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.</p>	K 147		

RECEIVED  
AUG 27 2012  
OFFICE OF INSPECTOR GENERAL  
U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES