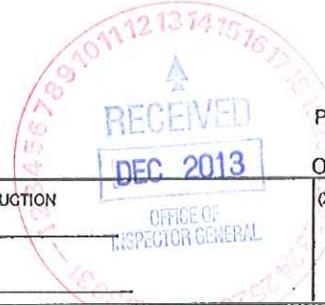


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/09/2013
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/21/2013
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NAME OF PROVIDER OR SUPPLIER COLONIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2366 NASHVILLE ROAD BOWLING GREEN, KY 42101
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS A Recertification Survey was conducted 11/19/13 through 11/21/13 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with the highest scope and severity of a "E".	F 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Colonial Center does not admit that the deficiency listed on this form exists, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET 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 and facility policy and procedure review it was determined the facility failed to ensure physician's orders were carried out related to oxygen (O2)therapy for one (1) of twelve sampled residents (Resident #4). Observations on two consecutive days revealed Resident #4 was receiving O2 therapy at 3.5/liters (L) instead of 2/L as per the physician's order. The findings include: Review of a facility policy, titled "Oxygen Concentrator", dated 12/01/06, revealed to verify the physician's order. Record review revealed the facility admitted Resident #4 on 01/14/13 with diagnoses to include Coronary Artery Disease, Congestive Heart Failure, Chronic Anemia and Cerebral Vascular Disease.	F 281	F281 Professional Standards Resident #4 was assessed by the Director of Nursing on 11/20/2013. Resident #4's physician was notified on 11/20/2013 by a Licensed Nurse with new orders received. On 11/20/2013 Physician orders were updated with new order. Current Medication/Treatment Administration Records were reviewed by the Director of Nursing Services on 11/20/2013. Physician orders were reviewed for current resident's that receive oxygen services on 11/20/2013 by the Director of Nursing Services. No other issues were identified in the review.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Chris Swihart TITLE: Administrator (X5) DATE: 12/12/13

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

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NAME OF PROVIDER OR SUPPLIER COLONIAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2365 NASHVILLE ROAD BOWLING GREEN, KY 42101	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 1 Review of a significant change Minimum Data Set (MDS) assessment, dated 10/24/13, revealed the facility assessed Resident #4 to require extensive assistance with most activities of daily living. Review of a Physician's Order, dated 11/14/13, revealed Resident #4 was to have O2 at 2/L via nasal cannula (NC) to maintain O2 saturation of 90% or greater. Observations on 11/19/13 at 10:50 AM, 12:30 PM, and 2:15 PM and on 11/20/13 at 7:35 AM and 8:30 AM revealed Resident #4 was receiving O2 per NC at 3.5L. Further observation with Licensed Practical Nurse #4, at 9:10 AM, revealed the O2 was being administered at 3.5/L instead of 2/L. LPN #4 stated each nurse is responsible to check O2 administration to ensure it was being administered correctly as prescribed.	F 281	The Director of Nursing Services provided re-education to licensed nursing staff on policy and procedure for Medication Administration to include oxygen along with policy and procedure for following physician orders completed on 12/9/2013. The Director of Nursing/Assistant Director of Nursing will conduct Oxygen Medication Administration reviews and Oxygen Physician Orders three times a week for the next four weeks, then three times a month for two months. The Director of Nursing will report the findings to the Performance Improvement Committee for the next three months for further recommendations. Completion Date:	12/11/13
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	F 282		

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NAME OF PROVIDER OR SUPPLIER COLONIAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2365 NASHVILLE ROAD BOWLING GREEN, KY 42101		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 282	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy and procedure review it was determined the facility failed to ensure correct implementation of the care plan for one (1) of twelve (12) sampled residents (Resident #4). Resident #4 was care planned for 2/Liters (L) of oxygen (O2)per nasal cannula (NC) however, Resident #4 was observed being administered 3.5/L of O2 on two (2)consecutive days. The findings include:	F 282	F282 Care Plan Resident #4 was assessed by the Director of Nursing on 11/20/2013. Resident #4's physician was notified on 11/20/2013 with new orders received and care plan updated with new physician order by a Licensed Nurse. Current Care Plans were reviewed by the Director of Nursing on 11/20/2013for resident's receiving oxygen services. No issues were identified in this review.		
	Review of a facility policy titled, "Care Plan", dated effective 01/08, revealed the IDT (Interdisciplinary Team) educated the resident/responsible party to the care plan and implements the care plan. Record review revealed the facility admitted Resident #4 on 01/14/13 with diagnoses to include Coronary Artery Disease, Congestive Heart Failure, Chronic Anemia and Cerebral Vascular Disease. Review a Minimum Data Set (MDS) significant change assessment dated 10/24/13, revealed the facility assessed Resident #4 to require extensive assistance with most activities of daily living. Review of a care plan for "Potential for Alteration In Cardiac/Pulmonary Status", initiated on 11/14/13, revealed "Administer oxygen per orders at 2/L via nasal cannula to maintain oxygen saturation at 90% or greater". Observations on 11/19/13 at 10:50 AM, 12:30 PM		The Director of Nursing Services provided re-education to licensed nursing staff on policy and procedure for following plan of care to include oxygen completed on 12/9/2013. The Director of Nursing/Assistant Director of Nursing will conduct Oxygen Medication Administration reviews and review care plans for implementation of the care plans three times a week for the next four weeks, then three times a month for two months. The Director of Nursing will report the findings to the Performance Improvement Committee for the next three months for further recommendations. Completion Date:		12/11/13

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NAME OF PROVIDER OR SUPPLIER COLONIAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2365 NASHVILLE ROAD BOWLING GREEN, KY 42101	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 3 and 2:15 PM and on 11/20/13 at 7:35 AM, 8:30 AM and 9:10 AM revealed the resident was receiving O2 at 3.5/L per NC. Interview with the Director of Nursing (DON), on 11/20/13 at 9:30 AM, revealed the nurse was responsible to check and verify the O2 administration and she expected the nurses to implement the care plan correctly. The DON was aware of the resident receiving O2 at 3.5/L instead of 2/L care plan and stated she would be treating the incident as a medication error. Additional interview at 10:30 AM revealed there was the possibility of complications with the inaccurate administration of O2.	F 282		
F 371 SS=E	483.35(l) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and facility policy review it was determined the facility failed to ensure food was prepared and distributed under sanitary conditions. Observation of the kitchen revealed an improperly stored mop, broom and dust pan. The stove hood had an accumulation of dust and an opened and partly	F 371		

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NAME OF PROVIDER OR SUPPLIER COLONIAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2365 NASHVILLE ROAD BOWLING GREEN, KY 42101	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 4 consumed staff beverage was observed in the milk cooler. A review of the facility census and condition, dated 11/19/13, revealed a census of forty-eight (48) residents with one (1) resident receiving tube feedings. The findings include: Review of a facility policy titled, "Mops, Wet-Daily Cleaning", dated 2002, revealed after mopping to place mop head in designed covered container in soiled laundry area to be washed.	F 371	F371 Food Procure; Store/Prepare/Serve-Sanitary On 11/19/2013 broom and mop head were discarded and dust pan properly stored by Food Service Director. On 11/19/2013 the hood vent was cleaned by the Food Service Director. On 11/19/2013 the bottle of water was discarded from the milk cooler by Food Service Director. Sanitation review of the kitchen was completed on 11/22/2013 by the Food Services Director. No issues were identified in this review.	
	Review of a facility policy titled, "Dietary Hood Extinguishing Device Inspection", last revised 06/01/07, revealed during monthly inspection "Remove and clean the screen". Observation during the initial tour of the kitchen, on 11/19/13 starting at 11:15 AM revealed: 1. the stove hood had an accumulation of dust hanging from the hood vent located over the stove burners. 2. the milk cooler was observed with a bottle of water that was partly consumed and determined to belong to a staff member. 3. a mop was observed outside the building by the exit door of the kitchen hanging from a hanger with the head of the mop in contact with the dirt on the ground. The broom and dust pan were sitting directly on the ground. Interview with the Dietary Manager, on 11/19/13 during the time of the observations, revealed the		Re-education was completed on 12/9/2013 with all Dietary Staff by the Food Service Director; education included food prepared and distributed under sanitary conditions, including cleaning schedule of hood filter, storage of cleaning equipment and storage of personal items. Sanitation reviews will be completed three times a week for four weeks, then three times a month for two months by the Food Services Director or Administrator. The Food Services Director will report findings to the Performance Improvement Committee for the next three months for further recommendations. Completion Date	12/11/13

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NAME OF PROVIDER OR SUPPLIER COLONIAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2365 NASHVILLE ROAD BOWLING GREEN, KY 42101		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	<p>Continued From page 5</p> <p>stove hood was cleaned every three months by an outside contractor and was last cleaned on 08/13/13. She stated the partially consumed employee bottle of water should not have been in the resident milk cooler and the mop heads were usually taken to the laundry for cleaning, but the mop head touching the ground outside the kitchen was available for use.</p> <p>Interview with the Administrator and Director of Nursing (DON), on 11/21/13 at 11:00 AM, revealed the stove hood was cleaned every three months and if it was dirty before the three months time frame the facility should contact the contractor. They revealed there was a refrigerator available for staff use and the resident milk cooler should not be utilized for staff.</p>	F 371		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185048	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/20/2013
NAME OF PROVIDER OR SUPPLIER COLONIAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2365 NASHVILLE ROAD BOWLING GREEN, KY 42101	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01.</p> <p>PLAN APPROVAL: 1963.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (200).</p> <p>SMOKE COMPARTMENTS: Three (3) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1963, upgraded in 2012 with 18 smoke detectors and 75 heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system installed in 1973.</p> <p>GENERATOR: Type II generator installed in 2009. Fuel source is Natural Gas.</p> <p>A standard Life Safety Code survey was conducted on 11/20/13. Colonial Center was found in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for Forty-Eight (48) beds with a census of Forty-Eight (48) on the day of the survey.</p> <p>The findings that follow demonstrate compliance 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

Chris Swihart

TITLE

Administrator

(X6) DATE

12/12/13

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

