

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 04/24/2026
NAME OF PROVIDER OR SUPPLIER Colonial Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2365 Nashville Road Bowling Green, KY 42101	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on facility policy review, record review, and interview, the facility failed to provide adequate assistance to prevent falls for 1 of 3 residents sampled for falls (Resident (R) 14). The findings include: Review of a facility policy titled, Falls Policy, last reviewed on 12/22/2025, revealed, The intent of this policy was to ensure the facility provides an environment that was as free from accident hazards as possible, over which the facility has control to prevent avoidable falls/accidents. The policy revealed, 2. A Care Plan would be implemented based on the resident's risk for falls with an individual goal and interventions specific to each resident to attempt to reduce the risk of avoidable falls, to the extent possible. Review of R14's admission Record revealed the facility admitted R14 on 05/06/2022. According to the admission Record, the resident had a medical history that included diagnoses of morbid obesity, left foot drop (difficulty in lifting the front part of the foot), and right foot drop. Review of an annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/27/2026, revealed R14 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated that the resident required supervision or touching assistance for rolling left and right on a bed. Review of R14's Care Plan Report, included a focus area initiated 01/30/2026, that indicated the resident expressed emotional distress, embarrassment, and discomfort related to body image and the need for a two-person assist with bed mobility and in-bed care. Intervention indicated that the resident required assistance from two staff with bed mobility and in-bed care related to bariatric status to ensure resident and staff safety (initiated 01/30/2026). R14's Care Plan Report included a focus area initiated 05/19/2022, that indicated the resident required assistance for activity of daily living (ADL) care related to impaired balance, morbid obesity incontinence, weakness with decreased endurance, and drop foot to bilateral feet. Interventions directed staff to provide the resident with assistance from two staff for bed mobility as the resident required/would allow (initiated 04/26/2023) and to provide the resident with total assistance for incontinence care (initiated 04/26/2023). Review of R14's Acute Change in Condition Assessment, dated 04/15/2026 at 10:43 AM and completed by Licensed Practical Nurse (LPN) 1, revealed R14 slid off of the edge of their bed, to the floor, and onto their knees during perineal care. The Acute Change in Condition Assessment indicated that R14 had abrasions and skin discoloration upon assessment from LPN1. During an interview on 04/20/2026 at 9:22 AM, R14 stated that they fell out of bed the previous week but was feeling fine. R14 stated that a staff member rolled them out of bed during incontinence care. During an interview on 04/21/2026 at 9:45 AM, R14 stated that on 04/15/2026, State Registered Nurse Aide (SRNA) 6 was their assigned SRNA and provided incontinence care by herself. R14 stated that the facility sometimes used two staff members to help perform incontinence care, but SRNA7 was busy in another room and unable to assist. R14 stated they were able to assist with rolling from right to left in the bed by using the assist bars on either side of the bed. R14 stated that while rolling to the right side of the bed, they rolled too far and slid off the edge of the bed. Per R14, SRNA6 was standing on the opposite side of the bed. R14 stated that their lower body was on the floor and their upper body was leaning on the nightstand next to the bed. R14 stated that SRNA 6 yelled into the hallway for assistance, and several staff members used the (continued on next page)</p>		

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.

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

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 04/24/2026
NAME OF PROVIDER OR SUPPLIER Colonial Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2365 Nashville Road Bowling Green, KY 42101	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>full body lift to get them back into bed. R14 stated that they were not hurt as a result of the fall and only had minor bruises and abrasions. During an interview on 04/22/2026 at 2:32 PM, SRNA6 stated that if a resident required the assistance of two staff members, the other SRNA in the hall, as well as the nurse, were available to help. SRNA 6 stated that on 04/15/2026, she was assigned to R14, and she normally completed incontinence care for the resident without difficulty since R14 could use the assist bars to turn in the bed. SRNA6 stated that the resident put the head of the bed down, but the resident's knees were slightly elevated at the time she assisted the resident with incontinence care. SRNA6 stated that during the incontinence care for R14, the resident rolled onto their side and threw their leg over the edge of the bed, causing them to slip onto the floor. SRNA6 stated she ran out of the room to get help from LPN1, and several other staff assisted with a full body lift to get the resident back into bed. SRNA6 stated that having another SRNA in the room to assist with the incontinence care could have prevented the incident. During an interview on 04/24/2026 at 11:12 AM, SRNA6 stated that she did not ask any other staff member for assistance on 04/15/2026 to assist with R14's incontinence care because she was used to performing the care by herself. SRNA 6 stated she was the only one who performed the incontinence care at the time of the fall. During an interview on 04/22/2026 at 2:47 PM, SRNA 7 stated she was familiar with R14's care needs. SRNA 7 stated that R14 was able to turn to their left side using the assist bars on their bed but required more assistance when turning to the right. SRNA7 stated she was assisting another resident when she heard something happened and went to R14's room. SRNA7 stated she observed R14 on the floor with their knees close to the window next to the bed. SRNA7 stated she grabbed a mechanical lift, and several staff members assisted R14 back into bed. SRNA7 stated that when Resident #14 was being turned by SRNA6, the resident's leg swung too far, and the resident ended up falling out of the bed. During an interview on 04/21/2026 at 1:51 PM, LPN1 stated that R14 required two-person assistance with incontinence care and the resident was incontinent of bowel and bladder. LPN1 stated that on 04/15/2026, she was assisting another resident, when she heard someone calling for help. LPN1 stated that she entered R14's room and observed the resident on the floor near the right side of the resident's bed. LPN1 stated that the resident rolled off of the edge of the bed with their knees on the ground and hands grabbing the nightstand and assist bar on the bed. LPN1 stated she assisted other staff in getting Resident14 back into bed after assessing the resident. LPN1 stated that the foot of the resident's bed was elevated, which caused an incline and the resident slipped out of the bed. During an interview on 04/22/2026 at 2:55 PM, the Assistant Director of Nursing (ADON) stated SRNA6 should have utilized two staff members to assist with R14's incontinence care. During an interview on 04/22/2026 at 3:19 PM, the Director of Nursing (DON) stated that R14 could assist with turning and repositioning themselves during incontinence care using the assist rails on their bed. The DON stated that the resident could be sensitive at times with using two staff to assist with incontinence care, so the resident was a two-person assist as the resident allowed. The DON stated that on 04/15/2026, SRNA6 was assisting Resident14 with incontinence care and the resident rolled themselves out of the bed and onto the floor. The DON stated that SRN6 should have used another staff member to assist R14 at the time of the fall and should have waited for assistance.</p>		

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 04/24/2026
NAME OF PROVIDER OR SUPPLIER Colonial Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2365 Nashville Road Bowling Green, KY 42101	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>Based on observation, interview, record review and review of a manufacturer's instructions, the facility failed to ensure licensed nursing staff demonstrated competencies and skill set necessary to administer insulin via insulin injector pen for one (Licensed Practical Nurse (LPN) of two licensed nurses observed during the medication administration task for one of 11 residents observed during medication administration (Resident (R) 50). The findings include: Review of LPN1's Competency Assessment Insulin Administration document, dated 04/16/2026, revealed, A) Purpose revealed, To provide guidelines for the safe administration of insulin to residents with diabetes. The document revealed, B) Preparation included 5. The nursing staff would have access to specific instructions (from the manufacturer if appropriate) on all forms of insulin delivery system(s) prior to their use. The document indicated that the Director of Nursing (DON) assessed LPN1's ability to administer insulin via syringe but did not indicate the DON assessed the LPN's ability to administer insulin via a pen injector. Review of NovoLog (insulin aspart) 100 units per milliliter (mL) injection pen's Instructions for Use, revised 02/2023 revealed, Before each injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing; E. Turn the dose selector to select 2 units; F. Hold your NovoLog FlexPen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge; and G. Keep the needle pointing upwards, press the push-button all the way in [reference to photographic material in instructions]. The dose selector returns to 0. A drop of insulin should appear at the needle tip. If not, change the needle and repeat the procedure no more than 6 times. Review of R50's admission Record revealed the facility admitted R50 on 04/15/2026. According to the admission Record, the resident had a medical history that included a diagnosis of type 2 diabetes mellitus with hyperglycemia (a medical condition where a person's blood sugar elevates to potentially dangerous levels). Review of R50's Order Summary Report, with active orders as of 04/22/2026, contained an order, dated 04/16/2026 for, NovoLog FlexPen subcutaneous solution pen injector 100 units per milliliter (mL) as per a sliding scale. The order specified that if blood glucose was 150 to 200, inject 2 units; 201 to 250, inject 4 units; 251 to 300, inject 6 units; 301 to 350, inject 8 units; 351 to 400, inject 10 units subcutaneously before meals and at bedtime for diabetes. The order specified to contact the physician if their blood glucose level was above 401. Resident 50's Order Summary Report contained another order, dated 04/16/2026 for NovoLog FlexPen subcutaneous solution pen injector 100 units per mL, with instructions to inject 16 units subcutaneously before meals for diabetes. During an observation of medication administration on 04/22/2026 at 10:16 AM, LPN1 assessed R50's blood glucose level using a glucometer, which resulted in a reading of 409. LPN1 returned to the medication cart and gathered R50's NovoLog FlexPen, an insulin needle, and alcohol pads and entered R50's room. LPN1 applied the needle to the tip of the pen injector and dialed the dose selector to 16 units. LPN1 did not prime the insulin needle with insulin prior to dialing the dose selector to 16 units. LPN1 performed hand hygiene, donned clean gloves, and administered the insulin to R50. LPN1 removed her gloves, performed hand hygiene, and exited the resident's room. LPN1 stated that she needed to notify R50's physician regarding the resident's blood glucose reading of 409 to check for any additional instructions or orders. LPN1 went to the unit nurses' station and contacted R50's physician via telephone. During an observation of medication administration on 04/22/2026 at 10:28 AM, LPN1 returned to the medication cart and reviewed Resident #50's insulin aspart per sliding scale order and verified the resident was to receive 10 units. LPN1 gathered R50's insulin aspart pen injector, an insulin needle, and alcohol pads and entered Resident #50's room. LPN1 applied the needle to the tip of the NovoLog FlexPen and dialed the dose selector to 10 units. LPN1 did not prime the insulin needle prior to dialing the dose selector to 10 units. LPN1 performed hand hygiene, donned clean gloves, and administered the insulin to R50. LPN1 removed her gloves, performed hand hygiene, and (continued on next page)</p>		

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 04/24/2026
NAME OF PROVIDER OR SUPPLIER Colonial Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2365 Nashville Road Bowling Green, KY 42101	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>exited the resident's room. During an interview on 04/22/2026 at 10:31 AM, LPN1 stated that she was not aware that the insulin needle on a pen injector needed to be primed prior to administering insulin to a resident. She stated that she had competency training related to insulin administration, but she was not sure if she had education related to the use of insulin pen injectors. During an interview on 04/22/2026 at 11:53 AM, the DON stated that during medication administration competency training, they reviewed insulin administration via an insulin syringe, but they did not conduct training on the use of insulin pen injectors. During an interview on 04/22/2026 at 4:03 PM, the Administrator stated that she expected nursing staff to follow best practices and manufacturer guidelines on the use of insulin pen injectors. She also stated that the facility had not provided competency training related to insulin pens.</p>		