

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

PRINTED: 02/10/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185311	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/29/2015
NAME OF PROVIDER OR SUPPLIER ROCKFORD HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4700 QUINN DR. LOUISVILLE, KY 40216	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
F 253 SS=E	<p>A Recertification Survey was initiated on 01/27/15 and concluded on 01/29/15. The facility was found not meeting the minimum requirements for recertification with deficiencies cited at the highest scope and severity of an "F".</p> <p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to make repairs to resident sinks, faucets and countertops for seven (7) of sixty-four (64) residents' rooms, Rooms B2, B5, B12 and B16, Rooms C6 and C12 and Room D8.</p> <p>Observations revealed brown stains around faucets and sinks, lime build-up around the faucets, leaking faucets, cracks around sink bowls and in the countertops and broken caulking around the sink causing that sink to move freely in the cut-out area of the countertop.</p> <p>The findings include:</p> <p>Observation of four (4) of sixteen (16) rooms on Unit B, on 01/27/15, during the entrance tour of the facility at approximately 8:40 am, revealed Room B2 with brown stains and a gray, grainy buildup around the faucet and sink. Room B5 had caulk around the sink that had turned brown in</p>	F 253	<p>The preparation 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. This Plan of Correction is prepared and solely because it is required by Federal and State Law.</p> <p>The sinks and faucets in rooms, B2, B5, B12, B16, C6, C12 and D8 were repaired by the Assistant Maintenance Director on February 3, 2015.</p> <p>An audit of all resident rooms was completed on February 2, 2015, by the Maintenance Director, to check for needed repairs to any sinks, faucets or countertops. The identified repairs will be completed by March 12, 2015 by the Maintenance Director, Maintenance Assistant, Floor Tech or Housekeeping Supervisor.</p> <p>A facility audit will be completed by the Maintenance Director or Assistant Maintenance Director monthly for 3 months and then quarterly for one year to check all resident rooms for needed repairs to faucets, sinks and countertops. Director of Nursing reviewed in In-service, on February 12, 2015, that any identified need for repairs to faucets, sinks or countertops is to be added to the Maintenance Log at the Nurses Station.</p>	March 13, 2015

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

[Handwritten Signature]

TITLE

Administrator Feb 18, 2015

(X6) DATE

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 required to continued program participation.

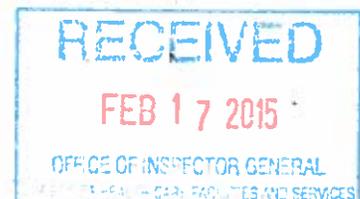
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If continuation sheet Page 1 of 12
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE REGULATION SERVICES

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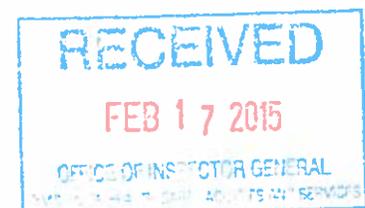
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F 253	<p>Continued From page 1</p> <p>color and the faucet was dripping in a steady stream. Room B12 had cracks around the sink bowl and chunks of countertop missing. Room B16 had broken caulking around the sink, causing the sink to move freely within the countertop.</p> <p>Observation of two (2) of sixteen (16) rooms on Unit C, on 01/27/15 during the entrance tour of the facility at approximately 8:40 AM, revealed Room C6 had broken caulk around the sink, and Room 12 had caulking missing around the sink.</p> <p>Observation of one (1) of sixteen (16) rooms on Unit D, on 1/29/15 at 1:32 PM, revealed the faucet was dripping in a steady stream.</p> <p>Interview with the Maintenance Director, on 01/29/15 at 01:49 PM, revealed he does a walk through of each room at least once monthly with the Corporate Maintenance person. At that time he looks for issues such as broken or missing caulking; build-up around faucets usually indicating a lime build-up; and, performs maintenance work at that time. He also stated there was a maintenance log at each nurse's station where staff writes down any problems they are having with resident rooms, storage areas, etc., and this log is checked weekly by the Maintenance Department and repairs are then made. He also stated if the repair was emergent, the repair would be made immediately if possible.</p> <p>Interview with State Registered Nursing Assistant (SRNA) #3, on 01/29/15 at 4:05 PM, revealed when a maintenance issue is discovered, she was to fill out a request on the Maintenance Log located at the Nurse's station which had the room number, resident's name and what the problem</p>	F 253	<p>Maintenance Director will review Maintenance Log monthly for 3 months then quarterly to see that in room repairs are being logged. Maintenance Director will report finding of audits from in room checks and Maintenance Log reviews to the QA committee for review monthly for the first 3 months and then quarterly.</p>		



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F 253	Continued From page 2 was. She further stated this was discussed when she was oriented and also at different in-services. Interview with SRNA #2, on 01/29/15 at 4:10 PM, revealed she was told in orientation that if she found a problem with a resident's room or equipment, she was to write down the problem in the Maintenance Log at the Nurse's station and to be sure to write down the resident's name and room number. she further stated any issue with a room was to be put in that log. Interview with SRNA #4, on 01/29/15 at 4:15 PM, revealed she would put any problem she found with a resident's room, equipment or property, on the Maintenance Log hanging at the Nurse's station. She stated the room number and resident's name should also be put in there so the maintenance man could find the problem. She stated she would also tell her supervisor. She further stated this was told to her in her orientation and there had been in-services on this. Interview with the Director of Nursing (DON), on 01/29/15 at 4:20 PM, revealed it was the responsibility of the staff to make sure any issues with maintenance problems or housekeeping concerns were written in the Maintenance Log at each nurse's station with the nature of the problem/issue; the resident's name and room number; and, the date the issue was discovered. The DON further stated it was the responsibility of the Maintenance Director to check this log frequently to make sure the issues/concerns were addressed.	F 253			
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	F 281			



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F 281	Continued From page 3 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 a review of the facility's Policy and Procedure, it was determined the facility failed to ensure nursing staff checked for the correct tube feeding rate for one (1) of twenty (20) sampled residents (Resident #3). The facility reported seven (7) residents with tube feedings. In addition, the facility failed to ensure nursing staff disposed of medications for residents who refused or were unavailable during medication pass for five (5) of six (6) unsampled residents (Unsampled Resident B, C, D, E, and F) when the nurse left loose pills in the cups in a locked drawer of the medication cart. The findings include: Interview with Licensed Practical Nurse (LPN) #8, on 01/29/15 at 3:45 PM, revealed the facility followed Perry and Potter's Clinical Nursing Skills and Techniques for standards of care. According to these standards the facility nursing staff was to administer medications per physicians order. Review of the Kentucky Board of Nursing KRS 314.021(2), revised October 2010, revealed nurses are held individually responsible and accountable for rendering safe, effective nursing care to clients and for judgments exercised and actions taken in the course of providing care. 1. Review of the clinical record for Resident #3	F 281	Residents identified in deficient practice B, C,D,E,F and L received their medication by Nurse #2. All medication left in medication cart and not administered was removed from the medication cart by Nurse #2 and delivered to the Director of Nursing. Nurse #2 was re-educated on proper procedure on January 29, 2015 by the Director of Nursing. All medication carts were audited for medication left in cart and not administered by the Unit Managers or Assistant Director of Nursing. No other medication cups were found with medication in locked drawers on January 29,2015. In-services started on January 28,2015 on Medication Administration and will be completed by February 28,2015 by the Assistant Director of Nursing, Unit Manager or Nurse Supervisor. New hire employees will receive training during orientation and In-service will be repeated no less than annually Assistant Director of Nursing or Unit Manager or Nurse Supervisor will inspect medication cart for medication left in medication cart and not administered daily for one week, weekly x3, then monthly x3. Quarterly medication cart will be inspected by the facility pharmacy. All new hired employees will receive education during orientation. In-service will be repeated at least annually. All findings will be reviewed in monthly Quality Assurance Meeting. Resident identified in deficient practice for resident #3 tube feeding rate was corrected by Nurse #3 on January 29, 2015. \	March 1, 2015	

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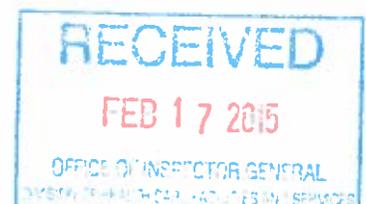
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F 281	<p>Continued From page 4</p> <p>revealed the facility admitted the resident on 05/12/11 with diagnoses of Cerebrovascular Accident, Hemiplegia, Senile Dementia, and Gastro-Esophageal Reflux. Review of the quarterly Minimum Data Set (MDS) assessment, dated 11/13/14, revealed the facility assessed Resident #3's cognition as moderately impaired with a Brief Interview for Mental Status (BIMS) score of 8. Further review of the MDS assessment revealed the facility assessed the resident to be an extensive assist with eating requiring assistance of one person. As well as the use of a feeding tube for nutrition.</p> <p>Review of the Comprehensive Physician's Order Sheet, dated 12/30/14, revealed Resident #3 was to have Jevity (enteral nutrition/tube feeding) 1.5 @ 65 cubic centimeter/hour (cc/hr) for twenty-two (22) hours per day, to be off at 3:00 PM and back on at 5:00 PM.</p> <p>Observation of Resident #3, on 01/27/15 at 1:12 PM and 2:05 PM, revealed the resident was sitting up in the Geri chair with Jevity 1.5 infusing at 60 cc/hr.</p> <p>Interview with LPN #7, on 01/29/15 at 2:30 PM, revealed she was responsible for changing Resident #3's tube feeding bottle and tubing on the night of 01/27/15. She was unable to recall the resident's tube feeding rate. The LPN stated she was trained to check the MAR for the tube feeding rate and check for to make sure the rate was correct.</p> <p>Further observations, on 01/28/15 at 8:27 AM and 2:45 PM, revealed the resident's Jevity 1.5 was running at 60 cc/hr.</p>	F 281	<p>All residents with Tube Feedings rate checked with Physician orders by Assistant Director of Nursing or Unit Managers on January 29, 2015</p> <p>In-service was started on January 29, 2015 on medication administration via tube feeding which includes to check the rate with each medication administration, every shift change and when changing out tube feeding and will be completed by February 28, 2015 by the Assistant Director of Nursing or the Nurse Supervisor. All new hired employees will receive education during orientation. In-service will be repeated no less than annually.</p> <p>Assistant Director of Nursing, Unit Manager or Nurse Supervisor will observe the tube feed rate with the physician orders daily for 2 weeks, weekly x3, then monthly x3, then quarterly and will reeducate as needed. All finding will be reviewed in monthly QA by the Director of Nursing.</p>		

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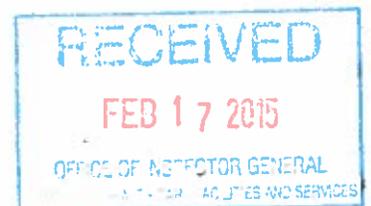
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F 281	<p>Continued From page 5</p> <p>Interview with LPN #9, on 01/28/15 at 2:55 PM, revealed Resident #3's tube feeding, Jevity, should be running at 65 cc/hr. The LPN revealed she had not checked the resident's tube feeding rate during her shift.</p> <p>Interview with LPN #6, on 01/29/15 at 9:55 AM, revealed she was responsible for checking Resident #3's tube feeding rate during her shift. The LPN stated she had not checked the rate.</p> <p>Interview with the Director of Nursing (DON), on 01/29/15 at 2:10 PM, revealed the facility had a two part checking system. The first check was completed by the night shift nurse that changed the tube feeding bottle and tubing. The second check was done by the nurse on the next shifts to ensure the tube feeding was infusing correctly.</p> <p>2. Review of the facility's policy and procedure Preparation and General Guidelines, revised 12/18/12, revealed medications were to be administered as prescribed in accordance with good nursing principles and practices. Medications were to be administered at the time they were prepared and were not pre-poured (prepared in advance). In addition, when residents who were not in their rooms or were otherwise unavailable to receive medications during the medication pass, the Medication Administration Record (MAR) was to be flagged and after completing the medication pass, the nurse was to return to the missed resident to administer the medication.</p> <p>Observation of the D Unit medication cart, on</p>	F 281			



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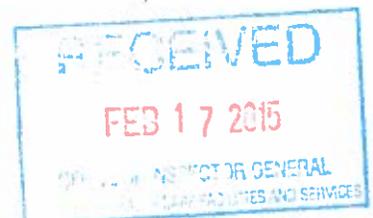
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F 281	Continued From page 6 01/29/15 at 9:45 AM, revealed five (5) medication cups in a locked drawer containing loose pills and the resident's names on the cups for Unsampled Residents B, C, D, E, and F. Interview with the Licensed Practical Nurse (LPN) #2, on 01/29/15 at 9:48 AM, revealed after a resident refused or was unavailable for their medication at the time it was prepared, the medications that were prepared should have been immediately discarded in the sharps container. Interview with the DON, on 01/29/15 at 1:55 PM, revealed LPN #2 should have immediately disposed of the medications per the policy and procedure that stated medications prepared and not immediately administered due to resident refusal or unavailability should be discarded in a sharps container.	F 281		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident's clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating	F 322	Resident B was monitored by review of nurses notes and vital signs for 5 days by the Unit Manager and Director of Nursing and did not have sign or symptom of aspiration, pneumonia, diarrhea, vomiting, dehydration, or metabolic abnormality related to the deficient practice. Nurse #3 was educated by the Director of Nursing on January 29, 2015. Nurse #3 staffing agency was notified of the deficient practice on January 29, 2015 by the Director of Nursing. Director of Nursing reviewed all physician telephone orders, nurses notes and vital signs written for any resident with tube feeding for 5 days starting on January 29, 2015 for any signs or symptoms of aspiration, pneumonia, diarrhea, vomiting, dehydration, or metabolic abnormality related to the deficient practice. No signs or symptoms were noted.	March 12, 2015



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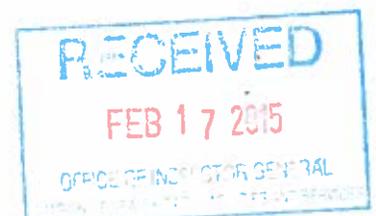
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F 322	Continued From page 7 skills. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy and procedure it was determined the facility failed to ensure the nurses flushed a gastrostomy tube before administration of medications and after each medication for one (1) of six (6) unsampled residents. (Unsampled Resident B) The facility reported seven (7) residents with tube feedings. The findings include: Review of the facility's policy and procedure Preparation and General Guidelines for Enteral Tube Medication Administration, revised 12/07/12, revealed to assure the safe and effective administration of enteral formulas and medications via enteral tubes, tubes were to be flushed with at least thirty (30) milliliters (ml) of water before administering medications and after all medications have been administered. The Policy did not address flushing the tube between each medication administered. Observation of a medication pass, on 01/29/15 at 10:05 AM, revealed Licensed Practical Nurse (LPN) #3 entered unsampled Resident B's room to administer medications via gastrostomy tube (G-tube). Further observation revealed LPN #3 administered the medication into Resident B's G-tube and did not flush with water before or after	F 322	Nurse in-service on Medication Administration via G tube started on February 12, 2015 and will be completed by February 22, 2015 by the Assistant Director of Nursing. Nurses will complete annual skills competency March 1, 2015- March 10, 2015, then annually by the Assistant Director of Nursing or Unit Manager, or Nurse Supervisor. New hired employees will complete skill competency during orientation then annually by the Assistant Director of Nursing. Observation of medication administration via G tube will be completed quarterly on 10% of Nurse staff x2 quarters, then annually and as needed. All findings will be reviewed in monthly QA.		



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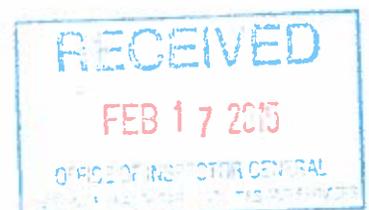
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F 322	Continued From page 8 the medication administration. Interview with LPN #3, on 01/29/15 at 10:17 AM, revealed she normally flushed the G-tube before and after administering medications and stated she was nervous and forgot. She further stated it was important to flush the G-tube before and after administration of medication to ensure all medications were administered and to prevent clogging of the G-tube. Interview with the Director of Nursing (DON), on 01/29/15 at 2:00 PM, revealed it was the facility's policy and procedure to flush the G-tube before and after administration of medications and it was her expectation for staff to follow the policy and procedure.	F 322			
F 514 SS=F	483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced	F 514	All orders identified in deficient practice for resident #1, 2, 4; 5, 6; 7, 8; 9; 10, 11; 12; 13; 14; 15; 16; 17; 18; 19; and 20 were reviewed on February 11, 2015 by the Director of Nursing or Unit Manager to ensure that each order was carried out. Assistant Director of Nursing or Director of Nursing audited physician telephone orders as well as nurses notes written for all residents on January 28-29, 2015 for date and time of order. Assistant Director of Nursing or Nurse Supervisor will in service all nurses how to write physician telephone orders, nurses will be instructed to include a date and time for each order either on the telephone order sheet or in the nurses notes related to the order.	Feb. 28, 2015	



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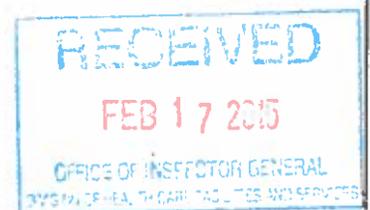
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NAME OF PROVIDER OR SUPPLIER ROCKFORD HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4700 QUINN DR. LOUISVILLE, KY 40216		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY 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 514	<p>Continued From page 9</p> <p>by: Based on interviews, record review, and facility policy review, it was determined the facility failed to ensure the medical record containing physician orders for the residents were accurate with the time the physician's verbal/telephone orders were received, written, and when noted (signed off) by the nurse for nineteen (19) of twenty (20) sampled residents. (Resident #1, #2, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19 and #20).</p> <p>The findings include:</p> <p>Review of the facility's Medication Orders Policy, not dated, revealed the nurse would document the time the verbal/telephone order was taken and the reason on the telephone order sheet or physician's order sheet as follows (time, date, nurses' name and title). When the orders are noted by the nurse (signed off) again the (time, date, nurses' name and title) were to be documented.</p> <p>Review of the physician verbal/telephone order sheets revealed the order form had three (3) areas for date and time. The first was the date and time it was ordered. The second was the name, date and time of the nurse receiving the order and the third was the name, date and time of the person transcribing the order.</p> <p>Review of Residents #1, #2, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, and #20's physician orders, revealed when staff had received the verbal/telephone orders the staff did not document the time of order. When the orders were transcribed by the nurse, the nurse did not document the time. In addition,</p>	F 514	<p>This was started on January 28, 2015. All new hired employees will receive education during orientation then annually. Each week, starting on January 28, 2015, the Assistant Director of Nursing will review physician telephone orders written for time and date weekly for 4 weeks, then no less than 30 orders monthly for 3 months, then no less than 50 orders quarterly. Re-education will be completed as needed by the Assistant Director of Nursing.</p> <p>Assistant Director of Nursing will review all physician telephone orders written for time and date weekly for 4 weeks, then no less than 30 orders monthly for 3 months, then no less than 50 orders quarterly. Re-education will be completed as needed by the Assistant Director of Nursing. All findings will be reviewed in monthly QA.</p>		



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

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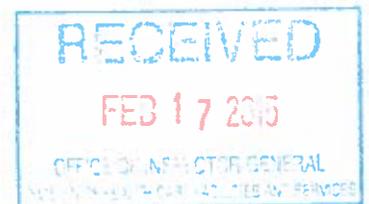
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185311	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/29/2015
NAME OF PROVIDER OR SUPPLIER ROCKFORD HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4700 QUINN DR. LOUISVILLE, KY 40216		
(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 514	<p>Continued From page 10</p> <p>Resident #17's order was not dated as to when it was received.</p> <p>Resident #1's order was written on 11/26/14; Resident #2's order was written on 01/06/15; Resident #4's order was written on 01/15/15; Resident #5's order was written on 01/27/15; Resident #6's order was written on 01/27/15; Resident #7's order was written on 01/20/15; Resident #8's order was written on 01/05/15; Resident #9's order was written on 09/22/14; Resident #10's order was written on 03/10/14; Resident #11's order was written on 01/21/15; Resident #12's order was written on 01/27/15; Resident #13's order was written on 01/28/15; Resident #14's order was written on 01/15/15; Resident #15's order was written on 01/26/15; Resident #16's order was written on 11/10/14; Resident #17's order was written on 12/18/14; Resident #18's order was written on 07/11/14; Resident #19's order was written on 09/12/14; and Resident #20's order was written on 11/07/14.</p> <p>Interview with Staff Development/LPN #8, on 01/29/15 at 3:10 PM, revealed during orientation the nursing staff was provided an example of how to write a telephone/verbal order.</p> <p>Review of the facility's orientation example of a verbal/telephone order revealed the telephone order was dated; however, the time was in the discontinue area. The example was a new order and not a discontinuance order. There was no time of when the order had been received or transcribed.</p> <p>Interview with Licensed Practical Nurse (LPN) #1,</p>	F 514		February 18, 2015	



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185311	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/29/2015
NAME OF PROVIDER OR SUPPLIER ROCKFORD HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4700 QUINN DR. LOUISVILLE, KY 40216		
(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 514	Continued From page 11 on 01/29/15 at 1:55 PM, revealed the nurses were to date and time all verbal/telephone orders when the order was written and again when the order was transcribed.	F 514			



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185311	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 01/27/2015
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NAME OF PROVIDER OR SUPPLIER ROCKFORD HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 4700 QUINN DR. LOUISVILLE, KY 40216
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1974</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: 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, 55 KW generator. Fuel source is Natural Gas.</p> <p>A Recertification Life Safety Code Survey was conducted on 01/27/15. The facility was found to be in compliance with the Requirements for Participation in Medicare and Medicaid in accordance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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.