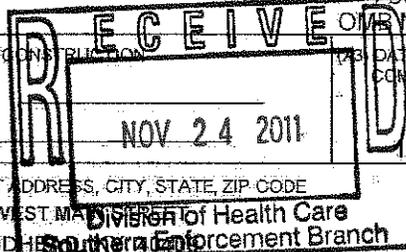


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2011  
FORM APPROVED  
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185246	(X2) MULTIPLE CONSTITUTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED  11/02/2011
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NAME OF PROVIDER OR SUPPLIER  ROCKCASTLE HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 371 WEST MAIN BROOKS DIVISION of Health Care Southern Enforcement Branch
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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 standard health survey was conducted on 10/31/11 through 11/02/11. Deficient practice was identified with the highest scope and severity at "D" level.  An abbreviated standard survey (KY16983, KY17125, KY17217) was also conducted at this time. KY16983 and KY17125 were unsubstantiated with no related deficient practice. KY17217 was substantiated with no related deficient practice.	F 000	Rockcastle Health and Rehabilitation does not believe and does not admit that any deficiencies existed, before, during or after the survey. The Facility reserves the right to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the Facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality Assurance or self critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions	F 441		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>David Dikora</i>	TITLE Administrator	(X6) DATE 11/24/11
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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.

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NAME OF PROVIDER OR SUPPLIER  ROCKCASTLE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 371 WEST MAIN STREET BRODHEAD, KY 40409		
(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 1</p> <p>from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(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> <p>This REQUIREMENT is not met as evidenced by. Based on observation, interview, record review, and a review of facility policy, it was determined the facility failed to maintain an infection control program to ensure a safe, sanitary environment and to help prevent the development and transmission of disease and infection for one of nineteen sampled residents (Resident #12). Resident #12 had physician's orders for contact isolation. Observation revealed facility staff failed to utilize Personal Protective Equipment when delivering a food tray to the resident. Observation also revealed no evidence of signage to notify staff/visitors of isolation precautions, and interview with staff members revealed they were unaware of what type of isolation precautions should be utilized when care was provided for Resident #12. In addition, observation on 10/31/11, during the noon meal on the East Wing, revealed facility staff failed to wash/sanitize their hands properly before handling a resident's food tray, before/after the provision of care for the</p>	F 441	<p><b>F 441 483.65 Infection Control/Prevent Spread, Linens</b></p> <p><u>Address what corrective action will be accomplished for those residents found to be affected by the deficient practice/specific corrective action.</u></p> <p>The physician was notified on 11-2-22 by the charge nurse of the sputum culture results for resident #12. Contact isolation precautions were discontinued on 11-2-11 per physician orders. Resident #12 was notified by the charge nurse that all isolation precautions were discontinued. All present staff were educated by the charge nurse that resident #12 was no longer in isolation precautions. Isolation precautions were discontinued from the care plan, the c.n.a. care plan and added on the 24 hour report to alert the oncoming staff by the charge nurse.</p> <p><u>Address how the facility will identify other residents having the potential to be affected by the same deficient practice.</u></p>		

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NAME OF PROVIDER OR SUPPLIER  ROCKCASTLE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 371 WEST MAIN STREET BRODHEAD, KY 40409		
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F 441	<p>Continued From page 2</p> <p>residents, and when they handled objects the residents had come into contact with.</p> <p>The findings include:</p> <p>A review of the infection control policy (dated 2001 and revised August 2007) revealed the facility had established guidelines for implementing isolation precautions, and would maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general public. According to the policy gloves, masks, gowns, eye protection, and face shields were to be used for resident care that may generate splashes or sprays of blood, body fluids, and secretions. In addition, a review of the policy revealed signage was to be prominently displayed related to isolation.</p> <p>A review of the handwashing policy (effective 12/2010) revealed staff was to wash hands before handling a resident's food tray, before/after caring for each resident, and "before/after they handled anything the resident has touched."</p> <p>A review of the medical record for Resident #12 revealed on 09/07/11, Resident #12 was diagnosed with Right Lower Lobe Pneumonia, had bacterial Extended Spectrum Beta Lactamase (ESBL) in his/her sputum, and was in contact isolation. Resident #12 was in a room by him/her self and the physician had requested for the resident to wear a mask when outside of his/her room. Documentation revealed the resident had been instructed to wash his/her hands and to wear a mask over his/her nose and mouth when the resident was near other</p>	F 441	<p>All other residents on isolation precautions were reviewed to ensure that the correct isolation precautions and signage were in place. The staff was educated on proper isolation precautions by the charge nurse and the isolation precautions were added to the 24 hour shift report.</p> <p><u>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.</u></p> <ol style="list-style-type: none"> <li>1. The charge nurse will determine the need for isolation precautions and type of precautions to be used based on resident diagnosis per the CDC guidelines.</li> <li>2. The charge nurse will contact the housekeeping department who will bring up isolation carts, biohazard barrels and notification signage for staff and visitors.</li> <li>3. The charge nurse will update the communication board to include room number and type of isolation precautions to be used.</li> </ol>		

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F 441	<p>Continued From page 3 residents. A review of documentation revealed Resident #12 was compliant with hand washing and wearing the mask.</p> <p>A care plan dated 09/07/11, revealed contact precautions had been recommended for Resident #12 related to the ESBL organism in the sputum. A review of the State Registered Nursing Assistant (SRNA) care plan dated November 2011 for Resident #12 revealed staff was instructed to have the resident wear a mask when outside of his/her room and to remain in isolation until further orders. The orders to remain in isolation were discontinued on 11/02/11. Continued review of Resident #12's physician's orders written on 11/02/11, revealed a sputum culture had been obtained on 10/31/11, and revealed a growth of bacteria Escherichia coli (E-coli). The physician was contacted and there were no additional orders received related to isolation precautions.</p> <p>Observation on 10/31/11, at 11:30 AM, revealed SRNA #1 entered Resident #12's room to deliver a meal tray and did not wash her hands or apply gloves/gown/mask. The SRNA arranged Resident #12's tray on a bedside table and exited Resident #12's room without washing/sanitizing her hands.</p> <p>Continued observation conducted on 10/31/11, at 11:30 AM; 11/01/11, at 9:00 AM; and 11/02/11, at 9:00 AM, revealed a red barrel that contained soiled linens and a container with masks, gowns, and gloves located outside of the resident's room. There was no signage outside of Resident #12's room related to isolation.</p>	F 441	<p>4. The charge nurse will be responsible to ensure that signage is on the residents' door to alert visitors and staff and that isolation carts/barrels are available and stocked. Nurse will utilize check sheet to ensure all steps have been followed. This will be turned into the DON/ADON upon completion.</p> <p>5. All staff will be educated by the DON/ADON and staff development coordinator on the isolation precaution process to include the use of communication board, type of precautions and use of PPE.</p> <p>6. To ensure that all staff is aware of what PPE to use for each type of isolation precaution, a color coding system has been established to identify the type of PPE will be used. Color coded precautions with the needed PPE will be available with ALL isolation carts and at the nurses' station for easy staff accessibility. All Staff will be educated by the ADON/DON or staff development coordinator on the color coded isolation precaution system.</p> <p>7. The color coded isolation system will be added to the new employee orientation process by the staff development coordinator.</p>		

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NAME OF PROVIDER OR SUPPLIER  ROCKCASTLE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 371 WEST MAIN STREET BRODHEAD, KY 40409		
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F 441	<p>Continued From page 4</p> <p>On 11/02/11, at 1:00 PM, Resident #12 was observed to be in the facility dining room, in the presence of other residents/staff. Observation revealed the resident was not wearing a mask as required by physician's orders. Observations further revealed on 11/02/11, the Personal Protective Equipment (PPE) and the red barrel had been removed from outside of the resident's room. Interview with Resident #12 on 11/02/11, at 1:00 PM, revealed the physician had discontinued the mask and isolation on 10/26/11.</p> <p>Interview with SRNA #1 on 10/31/11, revealed the SRNA was unsure of the PPE required to care for Resident #12. The SRNA knew the resident was to wear a mask when the resident came out of his/her bedroom and stated staff was to wear a mask when in Resident #12's room. The SRNA stated, "I did not wear a mask to just set up the lunch tray." Further interview revealed the SRNA did not know to wash/sanitize hands before and after assisting residents with setting up meal trays and touching items in residents' rooms.</p> <p>Interview with SRNA #2 on 10/31/11, at 11:40 AM, revealed to her knowledge Resident #12 was not in isolation and could be outside of his/her room if the resident wore a mask. The SRNA reportedly thought Resident #12 had Methicillin Resistant Staphylococcus Aureus (MRSA) in his/her nose. The SRNA stated, "I wear gloves when I go into the room, and wear a mask when I give [him/her] a shower."</p> <p>Interview with LPN #3 on 10/31/11, at 11:45 AM, revealed Resident #12 was in contact isolation related to a growth of ESBL in sputum. LPN #3 stated the mask was discontinued by the doctor</p>	F 441	<p>8. All staff will be re-educated by the DON/ADON or staff development coordinator on hand washing between resident care duties and delivering meal service to residents. This will also include re-education on hand washing upon leaving a room with isolation precautions.</p> <p>9. SRNA #1 was educated on 11-3-11 by the DON on the infection control and hand washing policies verbally with no written documentation noted and resigned from the position without notice. SRNA #2 was educated on 11-3-11 by the DON on the infection control and hand washing policies with written education.</p> <p><u>Indicate how the facility plans to monitor its performance to ensure that solutions are sustained.</u></p> <p>1. All nursing staff will be observed and checked off on hand washing competency and proper technique by the DON/ADON or Staff Development Coordinator.</p>		

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NAME OF PROVIDER OR SUPPLIER  ROCKCASTLE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 371 WEST MAIN STREET BRODHEAD, KY 40409		
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F 441	<p>Continued From page 5</p> <p>on 10/26/11; however, the resident was still on antibiotics and the facility continued the mask for the resident when he/she was outside of the room until a culture came back negative for ESBL. LPN #3 stated staff should wear masks/gowns and gloves when entering Resident #12's room. LPN #3 was not aware of any signage utilized by the facility to notify the staff or the public of isolation precautions.</p> <p>Interview with RN #1 on 10/31/11, at 12:30 PM, revealed Resident #12 had the organism ESBL in the sputum and was on contact isolation. The RN stated the resident was required to wear a mask when outside of the room.</p> <p>An interview with the Director of Nursing on 11/02/11, at 3:30 PM, revealed Resident #12 was on contact precautions and should have also have been on droplet precautions due to the growth of ESBL in the resident's sputum. According to the DON, signage was on the resident's door until 10/26/11 (that stated for visitors to notify Nursing prior to entering the room), at which time the resident went to the physician and the mask was ordered to be discontinued. Further interview with the DON revealed all staff/SRNAs had been trained to wash/sanitize hands before and after setting up residents' meal trays and touching items in resident rooms.</p>	F 441	<p>2. An audit will be completed weekly for 3 months by the DON or ADON on all residents that are on isolation precautions to ensure that proper procedures are in place and that staff are using appropriate PPE.</p> <p>3. Audits will be completed 3 x a week on different shifts for 3 months by the DON/ADON or Staff Development Coordinator to ensure proper hand washing to prevent the spread of infection is occurring.</p> <p>4. All of the above stated audits will be reviewed by the Quality Assurance committee monthly for 3 months and continued only at the discretion of the Quality Assurance committee.</p>		

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NAME OF PROVIDER OR SUPPLIER  ROCKCASTLE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 371 WEST MAIN STREET BRODHEAD, KY 40303 Division of Health Care Southern Enforcement Branch	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROBABLE PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	<p>INITIAL COMMENTS</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1985</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One story, Type III (000)</p> <p>SMOKE COMPARTMENTS: Six</p> <p>COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM</p> <p>FULLY SPRINKLED, SUPERVISED (DRY SYSTEM)</p> <p>EMERGENCY POWER: Type II diesel generator and Type II propane generator</p> <p>A life safety code survey was initiated and concluded on 11/01/11. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not in substantial compliance with the Requirements for Participation for Medicare and Medicaid.</p> <p>Deficiencies were cited with the highest deficiency identified at "E" level.</p>	K 000	<p>Rockcastle Health and Rehabilitation does not believe and does not admit that any deficiencies existed, before, during or after the survey. The Facility reserves the right to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the Facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality Assurance or self critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.</p>	
K 062 SS-E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating</p>	K 062		11/17/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *David Dickson* TITLE: Administrator (X6) DATE: 11/17/11

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NAME OF PROVIDER OR SUPPLIER  <b>ROCKCASTLE HEALTH &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>371 WEST MAIN STREET BRODHEAD, KY 40409</b>	
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K 062	<p>Continued From page 1 condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure the sprinkler system was maintained according to NFPA standards. This deficient practice affected four of six smoke compartments, staff, and approximately sixty residents. The facility has the capacity for 104 beds with a census of 93 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code survey on 08/23/11, at 11:20 AM, with the Director of Maintenance (DOM) a record review of the facility's sprinkler system revealed documentation that a full flow trip test had been performed. This test is performed to ensure the water in the sprinkler system reaches the hazard in a timely manner in a fire situation. The requirement is 60 seconds for the water to reach the test valve. The facility has three sprinkler systems. One of the sprinkler systems exceeded the 60-second time limit at 75 seconds. An interview with the DOM on 08/23/11, at 3:30 PM, revealed the DOM was not aware of the 60-second requirement of this type of testing.</p> <p>Reference: NFPA 13 (1999 Edition);</p> <p>4-2.3.1* Volume Limitations. Not more than 750 gal (2839 L) system capacity</p>	K 062	<p>K</p> <p><u>Address what corrective action will be accomplished for those residents found to be affected by the deficient practice/specific corrective action.</u></p> <ol style="list-style-type: none"> <li>1. Adding accelerator to sprinkler system. Accelerator on order with fire protection company.</li> </ol> <p><u>Address how the facility will identify other residents having the potential to be affected by the same deficient practice.</u></p> <ol style="list-style-type: none"> <li>2. All residents have the potential to be affected.</li> </ol> <p><u>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.</u></p> <ol style="list-style-type: none"> <li>3. Fire Protection company to do trip test quarterly for 6/mo to ensure compliance.</li> </ol>	

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NAME OF PROVIDER OR SUPPLIER  <b>ROCKCASTLE HEALTH &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>371 WEST MAIN STREET BRODHEAD, KY 40409</b>		
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K 062	Continued From page 2 shall be controlled by one dry pipe valve. Exception: Piping volume shall be permitted to exceed 750 gal (2839 L) for nongridded systems if the system design is such that water is delivered to the system test connection in not more than 60 seconds, starting at the normal air pressure on the system and at the time of fully opened inspection test connection.  A-4-2.3.1 The 60-second limit does not apply to dry systems with capacities of 500 gal (1893 L) or less, nor to dry systems with capacities of 750 gal (2839 L) or less if equipped with a quick-opening device.	K 062	<u>Indicate how the facility plans to monitor its performance to ensure that solutions are sustained.</u>  4. All of the above stated audits will be reviewed by the Quality Assurance committee monthly for 3 months and continued only at the discretion of the Quality Assurance committee.  5. <b>Completion date 12/17/11</b>		