

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

OFFICE OF INSPECTOR GENERAL

PRINTED: 01/07/2013
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 C 01/03/2013
--	--	--	---

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

An abbreviated survey was initiated on 01/02/13 concluded on 01/03/13 to investigate KY19551. The Division of Health Care substantiated the allegations as verified by the evidence with deficiencies cited.

F 176 SS=D 483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE

An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.

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 assess two (2) of the four (4) sampled residents in order to allow them to self administer medications. Resident #1 and #3.

The findings include:

Review of the facility's Medication Administration Policy, dated August 2000, revealed the policy did not address the ability of the resident to self administer their medications.

Review of the Pharmacy's policy regarding Evaluation of Resident's ability To Safely self-Administer Drugs, revealed in order to self-administer medications, the resident must (1) have knowledge of the medication action, (2) know the correct times to take the medication, and (3) able to read the medication label.

F 000

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 executed solely because it is required by Federal and State Law.

F 176

1. Resident #1 has not been assessed as able to self-administer medications and upon interview by DON resident does not want to self-administer medications. Resident #3 has not been assessed as able to self-administer medications and upon interview with DON resident does not want to self-administer medications.

Director of Nursing checked to see if any resident in the facility had been assessed as able to self administer medication and none have.

1-20-13

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

TITLE

(X6) DATE

[Signature]

[Signature]

1-24-13

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.

= 176

Nurses immediately re-
educated on not leaving
medications at the bedside for
any resident in the facility by
DON on 1-3-13.

Nurses did identify one resident
who has requested to administer
her own eye drops, but not to
keep them at bedside. DON will
determine resident competency
in administering the eye drop
and give permission for same.

2. Director of Nursing made
rounds during med pass times
on 1-5-13, 1-7-13 and 1-9-13 to
ensure no meds were left for a
resident to self administer.

3. Director of Staff
Development and DON
reviewed facility policy on self
administration of medications
and the assessment for self
administration of medication
with nurses. This was completed
on 1-3-13 A questionnaire based
on the policy will be completed
by nurses by 1-19-13 to ensure
they understood the policy. All
newly hired nurses will be
educated on the facility policy
during orientation provided by
Staff Development.

RECEIVED
JAN 24 2013
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITY REGULATION

F170

4. Director of Staff Development or Pharmacy Consultant to observe each nurse do a med pass within the next quarter then no less than annually to ensure appropriate med pass procedures are followed. Med pass observations will be a required part of the licensed employee annual training. Director of Nursing and Staff Development to make rounds during med pass weekly on all 3 shifts for 4 weeks then monthly on all 3 shifts to ensure no meds are left at the bedside for resident to self administer. Director of Nursing will report on rounds to Quality Assurance Committee who will monitor compliance with POC for one year.

RECEIVED
JAN 24 2013
OFFICE OF ASPECTOR GENERAL
DIVISION OF HEALTH CARE ACQUISITION SERVICES

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

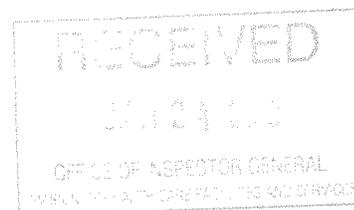
PRINTED: 01/07/2013
FORM APPROVED
OMB NO. 0938-0391

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 C 01/03/2013
--	---	--	---

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 176	<p>Continued From page 1</p> <p>Interview with the Registered Nurse (RN), on 01/03/13 at 12:00 PM, revealed she was knowledgeable of the policy requirements; however, had in the past left medications with a resident without administering the medication or ensuring the resident ingested them.</p> <p>Record review for Resident #1 revealed the facility admitted the resident on 08/13/12 and assessed the resident as cognitively intact. The record did not reveal any assessments or careplan to address the self administration of medications.</p> <p>Interview with Resident #1, on 01/03/13 at 1:05 PM, revealed the nurse had in the past left medications on the bedside table, without the nurse administrating the medications.</p> <p>Interview with the Daughter of Resident #1, on 01/03/13 at 1:10 PM, revealed she had come to the facility to visit Resident #1 and seen a small cup with pills in it sitting on the resident's bed side table. The resident admitted to her that they were his/her pills.</p> <p>Record review for Resident #3 revealed the facility admitted the resident on 10/18/05 and assessed the resident as cognitively intact. In addition, the record revealed there was no assessment or careplan for self administration of medications.</p> <p>Interview with Resident #3, on 01/03/13 at 2:35 PM, revealed the same nurse had also left medications at the bedside without ensuring the resident had taken the medications.</p>	F 176		
-------	---	-------	--	--



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

PRINTED: 01/07/2013
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 C 01/03/2013
--	--	--	---

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 176 Continued From page 2
Interview with the Director of Nursing (DON) on 01/03/13 at 2:25 PM, revealed nursing staff are in-serviced to always ensure the resident takes their medication(s).

F 176

F 315 483.25(d) NO CATHETER, PREVENT UTI, SS=D RESTORE BLADDER

F 315

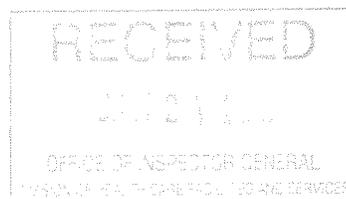
Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary, and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

This REQUIREMENT is not met as evidenced by:
Based on interviews, record review and review of the facility's policy, it was determined the facility failed to institute a urinary/bowel training program for one (1) of four (4) sampled residents. The facility assessed Resident #1 as occasionally incontinent and failed to initiate a bowel/bladder training program to ensure the resident improved bladder control or maintained bowel control.

The findings include:
Review of the facility's Bowel and Bladder Policy, dated 01/01/09, revealed it was the practice of the facility to assess residents for normal bowel and bladder function. Any resident that was assessed as having incontinence of bladder and/or bowel would be evaluated for appropriate

1. Current Bowel and Bladder Assessment and quarterly reviews for Resident #1 reviewed by Director of Nursing on 1-4-13. Staff initiated a 3 day voiding diary for resident #1 and from that diary a toileting program was established. Resident has been non-compliant with the implementation of the toileting plan and is now on a check and change program every 2 hours. The resident care plan and nurse aide assignment sheets were revised to reflect the current plan related to incontinence for Resident #1.

1-20-13



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

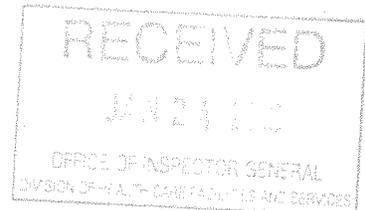
PRINTED: 01/07/2013
FORM APPROVED
OMB NO. 0938-0391

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 C 01/03/2013
--	--	--	---

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 315	<p>Continued From page 3</p> <p>services to restore or maintain as much normal function as possible.</p> <p>Review of Resident #1's initial Care Plan, dated 08/13/12, revealed the resident was care planned for incontinence of bladder occasionally. Review of the admission bowel/bladder tool, also dated 08/13/12, revealed there had been no further bowel and bladder assessment since admission in August 2012. Review of the Minimum Data Set (MDS), dated 08/20/13, revealed the facility had assessed the resident as occasionally incontinent of bladder and continent of bowel. The MDS, dated 11/20/13, revealed a decline in bowel control.</p> <p>Interview with Daughter #1, on 01/03/13 at 1:05 PM, revealed Resident #1 had been a resident since August of 2012. The facility admitted Resident #1 for therapy and could on admission go to the bathroom with assistance. Resident #1 at this time could not go to the bathroom anymore and wore pull-ups at first to make the resident more comfortable and then became a staff convenience. To her knowledge the staff did not check the resident routinely.</p> <p>Interview with Daughter #2, on 01/03/13 at 3:20 PM, revealed she felt if Resident #1 had been taken to the bathroom routinely, he/she would not be incontinent. He/she has had an urinary infection in the past and she attributed that to not being routinely toileted.</p> <p>Interviews, on 01/03/13 at 1:05 PM, with Resident #1 and at 2:20 PM, with #4 revealed the staff was slow to answer call lights which resulted in incontinent episodes for both of them.</p>	F 315	<p>2. Care Plan team reviewed Bowel and Bladder Assessments and current quarterly review to ensure they accurately reflected the current care needs of each resident. If indicated a new assessment was initiated, a 3 day voiding diary was started and based on that 3 day voiding diary an individualized Bowel and Bladder program will be established. Resident care plans and nurse aide assignment sheets were reviewed to ensure they accurately reflected the current plan for each resident and that they were consistent. This will be completed by 1-19-13.</p>	
-------	--	-------	---	--



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

PRINTED: 01/07/2013
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 C 01/03/2013
--	--	--	---

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 315 Continued From page 4

Interview with the Director of Nursing (DON), on 01/03/13 at 2:00 PM, revealed a bowel and bladder assessment was done on all newly admitted residents, on re-admission, and annually. The assessment was reviewed annually and if there was a significant change in the resident's health status. Resident #1 did have a change in his/her bowel pattern and the resident was not on a bowel/bladder training program. In addition, the resident had not been re-assessed to identify the possible cause of the elimination changes.

F 315

3. Corporate Consultant provided education for the Staff Development and the nurse responsible for oversight of the Bowel and Bladder Program. Included in the education were the facility policy, the assessment, the reviews, care planning, the 3 day diary, and establishing a toileting program this was completed on 1-17-13. Corporate Nurse Consultant evaluated understanding by means of a post test administered on 1-17-13.
4. Corporate Consultant to audit 25% of Bowel and Bladder Assessments completed monthly for 3 months then will audit 10% monthly for 9 months. The results of these audits will be used to provide feedback to the Director of Nursing regarding accuracy and appropriate follow up with a 3 day diary and implementation of a toileting program to improve or maintain bladder/bowel control. If indicated the DON will direct that re-visions be made and re-education be provided. Audits will be reported no less than quarterly to the facility QA Committee for one year.

