

ACTS Complaint/Incident Investigation Report

PROVIDER INFORMATION

Name: ROCKFORD HEALTH AND REHABILITATION CENTE License #: 100453
Address: 4700 QUINN DR. Type: SNF/NF
City/State/Zip/County: LOUISVILLE, KY, 40216, JEFFERSON Medicaid #: 12504981
Telephone: (502) 448-5850 Administrator: MARY CAMPBELL, ADM.

INTAKE INFORMATION

Taken by - Staff: MAYO, JERRY Received Start: 05/02/2012 At 10:30
Location Received: REGION B LONG TERM CARE Received End: 05/02/2012 At 10:30
Intake Type: Complaint Received by: Telephone
Intake Subtype: Federal COPs, CFCs, RFPs, EMTALA, CLIA State Complaint ID:
External Control #: CIS Number:
SA Contact: SIMPSON, AMY
RO Contact:
Responsible Team: REGION B LONG TERM CARE
Source: Ombudsman

COMPLAINANTS

Name	Address	Home Phone	Work Phone	Link ID
SYLVIA RHODES (Primary)			(502) 585-9949	087K0K

RESIDENTS/PATIENTS/CLIENTS

Name	Admitted	Location	Room	Discharged	Link ID
BARBARA TAYLOR					6131766
JERRY MCFALL					6131767
CARL WILSON					6131768

ALLEGED PERPETRATORS - No Data

INTAKE DETAIL

Date of Alleged: Time: Shift:
Standard Notes:
Extended RO Notes:
Extended CO Notes:

ALLEGATIONS

Category: Physical Environment
Subcategory: Other
Seriousness:

Findings: Substantiated:No deficiencies related to the alleg are cited

Tags: F0241-DIGNITY AND RESPECT OF INDIVIDUALITY (483.15(a))	S/S: E
F0353-SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS (483.15(a))	S/S: F

Details: The facility failed to maintain a sanitary environment free from pests. The LTC Ombudsman representative Sylvia Rhodes reported concerns brought to her from several residents in the home. It was reported that the facility has mice and residents have seen them in resident rooms and in common areas of the facility such as the dining room. The Ombudsman reported that residents Jerry McFall and Carl Wilson reported seeing mice in the facility. The residents are roommates and live in room 12. The Ombudsman reported no physical nor emotional harm related to the complaint. The facility was reported to have placed out "sticky tape" to catch the mice.

Findings Text:

Based on observation, interview, and record review, it was determined the facility failed to maintain dignity and

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respect for three (3) of five (5) sampled residents and for one (1) un-sampled resident. Staff members did not respond to Resident #1, #2, #3 and Un-sampled Resident A 's requests for assistance with brief changes in a timely manner.

The findings include:

Clinical record review revealed the facility admitted Resident #1 on 12/16/11 with a diagnosis of Chronic Kidney Disease and the resident was prescribed Lasix (a medication for fluid retention).

Observation, on 05/25/12 at 8:30 AM, revealed Resident #1 was sitting on the side of the bed dressed in a hospital gown, waiting for the CNA to come into the resident's room to assist with a brief change. The Resident showed the surveyor the heavily soaked brief.

Observation, on 05/25/12 at 9:05 AM and 9:45 AM, revealed Resident #1 was still wearing the urine soaked brief and the hospital gown.

Interview with Resident #1, on 05/24/12 at 3:45 PM, revealed the resident often wakes up in a urine soaked brief that is dripping with urine so much, the bed linens have to be changed.

Interview with Resident #1, on 05/25/12 at 9:45 AM, revealed the resident had awakened at about 8:30 AM in a urine soaked brief and had put on the call light at 9:05 AM to request a brief change. A CNA came into the resident's room a few minutes later, turned off the call light, and told the resident the facility was short staffed and someone would be back soon to help. The resident revealed there usually was at least a thirty (30) minute wait to get assistance, because the facility was short staffed, and so many residents need assistance in the early morning. The resident said the wait today was longer than usual, and there was a burning feeling in the area where the wet brief was. The resident revealed the CNA's often tell the residents the facility was short staffed, therefore the resident tried to be patient.

Review of the clinical record for Resident #2 revealed the facility admitted the resident on 10/20/10 with a diagnoses of Dysphasia (difficulty talking), Convulsions, and History of Stroke.

Interview with Resident #2 in Room C12-B, on 05/25/12 at 5:35 PM, revealed the Resident had put on the call light at 8:45 AM that morning to request a brief change. Someone came into the resident's room within a few minutes and told the resident the facility was very short staffed and someone would be back as soon as they could. The resident said someone finally came back to help at 10:45 AM. This long wait had caused the resident's groin to hurt with a burning sensation.

Interview with Resident #3 in Room C12-A, on 05/25/12 at 5:50 PM, revealed the same incident as described above had occurred that morning when he/she had requested assistance. When asked how this made him/her feel. The resident wrote "makes me feel helpless".

Interview, on 05/25/12 at 7:30 PM, with un-sampled Resident A revealed she/he was scheduled to have a shower on Tuesday, 5/22/12, but was told the facility was short staffed, and would not be able to assist the resident with a bath that day. About three (3) to four (4) weeks ago the resident had an episode of diarrhea and put on her/his call light to request assistance. About an hour later no one had come to help the resident. Therefore, she/he self propelled in a wheelchair to the Nurses' Station to request help. The nurse got someone to help the resident. The resident revealed this made her/him feel nasty and uncomfortable. The resident revealed the skin was burning around her/his tail bone.

Interview with CNA #5, on 05/24/12 at 2:35 PM, revealed she/he cared for Resident #1 often on the first shift. There had never been a day she had come into the facility, that the resident had not been saturated in urine, requiring the entire bed to be stripped, and the mattress to be wiped down.

Interviews with CNA #3 and #4, on 05/25/12 at 9:45 AM, revealed neither CNA had changed resident #1's brief. CNA #4 admitted she had gone into the resident's room at 9:05 AM, turned off the call light, told the resident the facility was short staff, and someone who return as soon as possible. CNA #3 and #4 both confirmed the facility was short staffed this morning, and there was a period of time that no one was covering the back-right portion of the C-Hall. CNA #4 revealed, she had gone to the House Supervisor to inform her of the situation. CNA #3 and #4 confirmed the facility had a staffing problem. Residents should not have to wait forty-five (45) minutes or longer for assistance. Both CNA's agreed this could be very uncomfortable for the residents, and could cause skin breakdown.

Interview, on 05/25/12 at 10:40 AM, with LPN #1 revealed the facility was short staffed two (2) to three (3) times per week because CNA's and Nurses often call in. LPN #1 commented that it was understandable the residents may have to wait longer to get help when the facility was short staffed.

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Interview with the House Supervisor, on 05/25/12 at 1:00 PM, confirmed that a resident sitting in a wet brief for an extended period of time could cause skin breakdown as well as infection and make a resident very uncomfortable.

Interview with the Director of Nursing (DON), on 05/25/12 at 10:20 AM, revealed Resident #1, #2, #3, and un-sampled Resident A, should not have to sit in a soiled brief for an extended period of time. This would be very uncomfortable and could cause skin breakdown.

Based on observation, interview, record review, and review of the facility's staffing schedule, it was determined the facility failed to provide sufficient staff to meet the residents' needs including answering call lights promptly, and providing incontinent care promptly, for three (3) of five (5) sampled residents and one (1) un-sampled resident. Residents #1, #2, #3 and un-sampled Resident A's call lights were not answered timely and were left in soiled briefs for extended periods of time.

The findings include:

Observation, on 05/25/12 at 8:30 AM, revealed Resident #1 was sitting on the side of the bed dressed in a hospital gown, waiting for the CNA to come into the room to assist with a brief change. The Resident showed the surveyor the heavily soaked brief.

Observation, on 05/25/12 at 9:05 AM and 9:45 AM, revealed Resident #1 was still wearing the urine soaked brief and the hospital gown.

Interview with Resident #1, on 05/24/12 at 3:45 PM, revealed the resident often wakes up in a urine soaked brief that was dripping with so much urine, the bed linens had to be changed.

Interview with Resident #1, on 05/25/12 at 9:45 AM, revealed the resident had awakened at about 8:30 AM in a urine soaked brief and had put on the call light at 9:05 AM to request a brief change. A CNA came into the resident's room and said the facility was short staffed and someone would be back soon to help. The Resident revealed that usually in the morning there was a thirty (30) minute wait to get assistance, because the facility was short staffed and so many residents needed assistance in the early morning. The resident said today was a longer wait than usual. The resident revealed the CNA's often tell the residents the facility was short staffed. Therefore, the resident tried to be patient.

Interview with Resident #2 in Room C12-B, on 05/25/12 at 5:35 PM, revealed the resident had put on the call light at 8:45 AM that morning to request a brief change. Someone came into the resident's room within a few minutes and told the resident the facility was very short staffed and someone would be back as soon as they could. The Resident said someone finally came back to help at 10:45 AM.

Interview with Resident #3 in Room C12-A, on 05/25/12 at 5:50 PM, revealed the same incident as described above had occurred that morning when he/she had requested assistance.

Interview with un-sampled Resident A, on 05/25/12 at 7:30 PM, revealed she/he was scheduled to have a shower on Tuesday, 5/22/12, but was told the facility was short staffed, and would not be able to assist the resident with a bath that day. Additionally, about three (3) to four (4) weeks ago the resident had an episode of diarrhea, put on her/his call light, and requested help. About an hour later no one had come to help the resident. She/he self propelled in a wheelchair to the Nurses' Station to request help.

Interview with CNA #5, on 05/24/12 at 2:35 PM, revealed she/he cared for Resident #1 often on first shift. There had never been a day she had come into the facility the resident had not been saturated in urine, requiring the entire bed to be stripped, and the mattress to be wiped down.

Interview with CNA #3 and #4, on 05/25/12 at 9:45 AM, revealed they had not changed Resident #1's brief. CNA #4 admitted she had gone into the resident's room at 9:05 AM, turned off the call light, told the resident the facility was short staff, and someone who return as soon as possible. CNA #3 and #4 both confirmed the facility was short staffed this morning, and there was a period of time that no one was covering the back-right portion of the C-Hall. CNA #4 revealed she had gone to the House Supervisor to inform her of the situation. CNA #3 and

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#4 confirmed the facility had a staffing problem. The residents should not have to wait forty-five (45) minutes or longer for assistance.

Interview, on 05/25/12 at 10:40 AM, with LPN #1 revealed the facility was short staffed at least two (2) to three (3) times per week because CNA's and Nurses often call in. LPN #1 commented it was understandable the residents may have to wait longer to get help when the facility was short staffed.

Interview with the House Supervisor, on 05/25/12 at 1:00 PM, confirmed the facility had three (3) CNA's and one (1) nurse call in that morning and there were not sufficient as needed (PRN) staff to fill the positions. There was a period of time that Hall-C was not covered by the CNA staff. Therefore, nurses and a restorative aid were pulled to cover. A staff member from Dietary was pulled to cover the Restorative Aid position.

Telephone Interview with the Staffing Coordinator, on 05/25/12 at 6:15 PM, revealed she was aware of the staffing problem. The Staffing Coordinator revealed there was not enough staff to cover if a staff member took off for sick or annual leave. The facility was short staffed at least two (2) to three (3) shifts per week. The Staffing Coordinator revealed there was not a pool of PRN CNA's for first shift at this time. She calls CNA's and Nurses to take on an extra shift when she realized the facility was short staffed. Nurses fill in for CNA's and the Dietary Staff even help out.

Interview with the Director of Nursing (DON), on 05/25/12 at 10:20 AM, revealed she was aware the facility was short staffed and the facility did not have enough regular or PRN staff to cover. The DON stated this was something they need to get solved.

Interview with the Administrator, on 05/25/12 at 7:00 PM, revealed she was out of the facility for a period of time for Emergency Surgery in the early part of the year and realized that the staffing quota had gotten low.

Category: Quality of Care/Treatment

Subcategory: Resident Left Wet For Extended Periods

Seriousness:

Findings: Substantiated:Federal deficiencies related to alleg are cited

Details: The facility failed to provide quality of care and treatment. The LTC Ombudsman representative Sylvia Rhodes reported concerns brought to her from residents in the home. It was reported that resident Barbara Taylor in room 16 said the facility only allows five briefs per day per resident. The Ombudsman reported she was told that staff have to borrow other briefs if Ms. Taylor needs them. The resident has reported she has not gone without being changed or receiving a brief, however, it takes longer to get changed if staff have to go borrow briefs. The Ombudsman and resident reported no physical injures nor emotional harm.

Findings Text:

SURVEY INFORMATION

<u>Event ID</u>	<u>Start Date</u>	<u>Exit Date</u>	<u>Team Members</u>	<u>Staff ID</u>
GIL911	05/23/12	05/25/12	Miles, Jacqueline	29816

Intakes Investigated: KY00018187(Received: 04/13/2012); KY00018301(Received: 05/02/2012)

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Event ID	Exit Date	Tag	SUMMARY OF CITATIONS:	S/S
GIL911	05/25/2012		Federal - Link to This Intake	
			F0241-DIGNITY AND RESPECT OF INDIVIDUALITY	E
			F0353-SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS	F
			Federal - Not Related to any Intakes	
			F0000-INITIAL COMMENTS	NOT SPECIFIED
			State - Not Related to any Intakes	
			N0000-INITIAL COMMENTS	NOT SPECIFIED
			N0239-Section 9. Nursing Services	NOT SPECIFIED
			N0113-Section 6. Quality Of Life	NOT SPECIFIED
GIL912	07/05/2012		Federal - Link to This Intake	
			F0241-DIGNITY AND RESPECT OF INDIVIDUALITY	E
			F0353-SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS	F
			Federal - Not Related to any Intakes	
			F0000-INITIAL COMMENTS	NOT SPECIFIED
			State - Not Related to any Intakes	
			N0239-Section 9. Nursing Services	NOT SPECIFIED
			N0113-Section 6. Quality Of Life	NOT SPECIFIED
			N0000-INITIAL COMMENTS	NOT SPECIFIED

EMTALA INFORMATION - No Data

ACTIVITIES

<u>Type</u>	<u>Assigned</u>	<u>Due</u>	<u>Completed</u>	<u>Responsible Staff Member</u>
Schedule Onsite Visit	05/23/2012	05/23/2012	05/23/2012	MILES, JACQUELINE

INVESTIGATIVE NOTES - No Data

CONTACTS - No Data

AGENCY REFERRAL - No Data

LINKED COMPLAINTS - No Data

DEATH ASSOCIATED WITH THE USE OF RESTRAINTS/SECLUSION - No Data

NOTICES

PROPOSED ACTIONS

<u>Proposed Action</u>	<u>Proposed Date</u>	<u>Imposed Date</u>	<u>Type</u>
Enforcement Action	05/25/2012	05/25/2012	Federal

END OF COMPLAINT INVESTIGATION INFORMATION

JM

SURVEYOR NOTES WORKSHEET

Facility Name: Rockford Health & Rehabilitation Center **Surveyor Name:** Jacqueline Miles
Provider Number: 18531 **Surveyor Number:** 29816 **Discipline:** NCI
Observation Dates: From 05/23/12 To 05/24/12

TAG/CONCERNS	DOCUMENTATION
	Complaint Investigative Plan KY # 18301
Allegations Category: Physical Environment	<i>/ Resident Rights JM</i>
Reg Tag:	F469, F465
History of deficiencies R/T allegation: NA (detail dates, reg, s/s if applicable)	
Last survey highest s/s:	E
Is the facility currently in compliance:	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
If no, detail tags out of compliance:	
Contacts Made: (Name, Date, Time)	
Complainant	Omsbudmans reported, Sylvia Rhodes, phone 502-637-9786
Ombudsman	Sylvia Rhodes, emailed 05/23/12, 9:20 AM
DCBS	Tood Meade, emailed 05/23/12, 9:20 AM
Other	
Observations to make pertinent to allegation: (detail partial tour)	Partial Tour of Facility to include Room 12 and the Dining Room
Interviews to Get: (Name, Title, detail order & who may validate allegation)	
	Alleged Victims <i>Carl Wilson, Jerry McFall</i>
	Interviewable residents
	Dining Room Staff
	Maintenance Director
	Housekeeping Director
	Nursing Staff
	Complaintant

SURVEYOR NOTES WORKSHEET

TAG/CONCERNS	DOCUMENTATION
Interviews - Continued	

Physical

SURVEYOR NOTES WORKSHEET

TAG/CONCERNS	DOCUMENTATION
Evidence that is basis for sub/unsub (Detail pert Int, Obs, Records that were deciding factors)	Complaint Ky 18301 was investigated in conjunction w/ Ky 18187 which had no regulatory violation
	<ol style="list-style-type: none"> 1. Observation of the Dining Room, Exercise Room, hallways, and residents' rooms revealed no mice or mice droppings present. The facility was clean and homelike. Observation of the outside foundation of the building revealed cracks had been filled and there were bait boxes in the (3) three patio areas and around the dumpsters. 2. Interactions between staff and residents were observed to be respectful and pleasant, no signs of abuse/neglect were observed. 3. Interview with Resident #2 and #3, the alleged victims revealed they had observed a mouse in their room a few weeks ago and had reported it to the nurse. Recently, the resident had not seen any mice or mice droppings in their rooms. Resident #5 reported she had seen mouse droppings in a drawer in her room, but had never seen a mouse. The resident report the Staff cleaned the drawer and checked for any signs of mice or openings in the baseboards in her room. 4. Interview with the Unit Manager revealed she had seen a mouse run under the door when she was using the staff rest room. The Unit Manager immediately reported it to the Maintenance Director. 5. Interview with CNA #5 revealed she had seen a mouse in the facility a few months ago in the hallway and had reported it to Maintenance. She had never seen a mouse in the Dining Room and had not recently seen any mice in the facility. 6. Interview with CNA's #1, 2, 3, and 4 revealed they had not every seen a mouse in the the facility. The CNA's commented they helped in the Dining Room and not seen any mice in the Dining Room. 7. Interview with the (DON), Director of Nursing, revealed she had seen mice in the facility on a few different occasions throughout the years she had worked at the facility. The DON said, when the ditch behind the building is mowed or there are heavy rains, sometimes mice come in the building. I have always called the Maintenance Department when this occurred. 8. Review of the resident council meeting minutes revealed there were no reports/discussions about rodents in the building 9. Review of the resident records revealed all residents interviewed, scored 15 on the BIMS and were noted as cognitively intact by the facility. 10. Review of the facility's Pest Control Service Agreement included control of rodents. 11. Interview with the Director of Maintenance revealed, rodents do at times come into the building when there are heavy rains or the ditch behind the facility is mowed. The City of Shively has recently treated the ditch for rodents, the foundation of the building has been inspected and repaired for any areas that rodents could enter the building. The Pest Control Company the facility has an agreement with maintains the bait boxes. Recently, there have not been any report of mice in the building. 12. Interview with the Housekeeping Director revealed she had seen a mouse in a trap in the Dining Room last week. The mice have come in because of the recent rains. The facility and the Pest Control Company is trying to control the mice.
	The complaint was substantiated and the facility was cited for F41 Dignity and F353 sufficient staffing to meet resident care needs
Findings: Allegation:	Substantiated <input checked="" type="checkbox"/> Unsubstantiated <input type="checkbox"/>
Deficiencies:	Yes <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/> error
If yes, detail Federal/State tags and s/s if applicable, SOC, IJ, 23 day term, 90 day Term, COPs	
Notifications:	Complainant: Sylvia Rhodes, Ombudsman Letter Sent: emailed, called, 5/29/12
Name, Date, Time	Facility: 05/25/12 @ 9:00 PM Mary Campbell Other: NA

JM

SURVEYOR NOTES WORKSHEET

Facility Name: Rockford Health & Rehabilitation Center

Surveyor Name: Jacqueline Miles

Provider Number: 18531

Surveyor Number: 29816 **Discipline:** NCI

Observation Dates: From 05/23/12 **To** 05/25/12

TAG/CONCERNS	DOCUMENTATION
	Complaint Investigative Plan KY # 18301
Allegations Category:	Quality of Care/Allowance of Briefs Per Day, Residents Left Wet for Extended Periods
Reg Tag:	F309
History of deficiencies R/T allegation:	NA
(detail dates, reg, s/s if applicable)	
Last survey highest s/s:	E
Is the facility currently in compliance:	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
If no, detail tags out of compliance:	
Contacts Made:	(Name, Date, Time)
Complainant	Omsbudmans reported, Sylvia Rhodes, phone 502-637-9786
Ombudsman	Sylvia Rhodes, emailed 05/23/12, 9:20 AM
DCBS	Tood Meade, emailed 05/23/12, 9:20 AM
Other	
Observations to make pertinent to allegation:	(detail partial tour)
	Partial Tour of Facility
	Observe Incontinent Residents for Supply of Briefs
	Alleged Victim
Interviews to Get:	(Name, Title, detail order & who may validate allegation)
	Alleged Victim, Barbara Taylor, if interviewable
	Interviewable residents using briefs
	Social Service Director
	CNA's
	Nursing Staff
	Complainant
	Abuse interview x5

SURVEYOR NOTES WORKSHEET

TAG/CONCERNS	DOCUMENTATION
Interviews - Continued	
Record Review:	(Clinical Rec documents, Policies, Audits, Documents from other facilities).
	Interview resident list
	List of resident using briefs
	Policy for resident quality of care
	Grievances
	Resident Records including MDS
Questions to be answered:	
	Is there a quota on how many briefs a resident can use per day? How long and where do Staff get
	briefs if a resident does not have enough brief? Does staff borrow briefs from other resident?
	How long does it take a resident to get assistance when needing a brief change?

SURVEYOR NOTES WORKSHEET

Facility Name: Rockford Health & Rehab Center

Surveyor Name: Jacqueline Miles

Provider Number: 18531

Surveyor Number: 29816 **Discipline:** NCI

Observation Dates: From 05/23/12 **To** 05/25/12

TAG/CONCERNS	DOCUMENTATION
	COMPLAINT INVESTIGATION SUMMARY - KY# 18301
	Facility Roster Matrix: Triggers
	Facility Identified Specific to Allegation
	Interviewable/Non
Sampled Residents:	
1. Res. #1, Barbara Taylor, (N) BIMS 12, named in complaint	Quality of Care, Incontinence
2. Res. #2, Carl Wilson, (I) BIMS 15	Quality of Care, Incontinence
3. Res. #3, Jerry McFall, (I) BIMS 15	Quality of Care, Incontinence
	Facility Roster Matrix: Triggers
	Facility Identified Specific to Allegation
	Interviewable/Non
Expanded Sample:	
1. Res.#4. Emma Bruce, (I) BIMS 14	Quality of Care
2.	
3.	
	Facility Identified
	Interviewable/Non
Unsampled Residents	
A. Paula Durrett	(I) BIMS 15
B.	
C.	
D.	
Interviews:	Res, Staff, Family, Contractors (Name, Title, Identifiers)
	Resident #1, Alleged Victim, Barbara Taylor
	Interviewable Residents #2, #3, and #4 and (1) one unsampled resident
	Complainant, Sylvia Rhodes, Ombudsman
	Unit Manager, Jessica Harpse, LPN
	Director of Nursing, Delisa Dunn, RN
	Administrator: Mary Campbell
	Staff Abuse Interviews x 5
	Amanda Sharf, RN, House Supervisor
	CNA #2, Kristy Blevin
	CNA#3, Brandy Wilson
	CNA #4, Michelle Culver
	CNA #5, Marlene Wise
	Staffing Coordinator, Crystal Barajas

SURVEYOR NOTES WORKSHEET

TAG/CONCERNS	DOCUMENTATION
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Evidence that is deciding factors	Complaint Ky18301 was investigated in conjunction with Ky18187 is basis for sub/unsub (Detail pert Int, Obs, Records that were)
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|--|---|
| | <ol style="list-style-type: none"> 1. Observation revealed Resident #1 was left in a soiled brief for one hour and fifteen minutes upon awakening in the morning. The Resident was told by the CNA she would be back to change her. Fifty minutes later it was observed the CNA had not returned to assist the resident. The surveyor requested someone help the resident. 2. Interview with Resident #2, #3, and one unsampled resident revealed residents often had to wait longer than thirty minutes to have their brief changed. All three residents had a BIMS score of 15. 3. Interview with the complainant revealed residents had complained to her that they had been left in wet briefs for extended periods of time and they were only allowed to have five briefs per day. If a resident needed more briefs the staff had to borrow from other residents. The residents revealed staff had told them they were short staffed and would be back to here them later. 4. Staff abuse interviews revealed the staff were trained on prevention, detection, and reporting of abuse. 5. Interview with the Unit Manager revealed that sometimes residents do run out of briefs and the staff has to go to the Med Room or the garage to obtain more briefs. The Unit Manager was unaware staff was borrowing briefs from other resident's. The Unit Manger confirmed that the residents were allotted five briefs per day. Every morning about 6:00 AM - 7:00 AM the residents' supply of briefs are reviewed and if below five, additional briefs are placed in the closets to bring the count of briefs to five. 6. Interview with CNA #2, #3, and #4 revealed the residents often run out of briefs in their room and the staff was borrowing briefs from other resident because there were no briefs in the Med Room and it took too long to get briefs from the garage. The CNA's also revealed the facility was often understaffed with CNA's and nurses were moved around to fill in for the CNA's. The residents said it often takes thirty minutes to get their brief changed. 7. Interview with the DON and the House Supervisor revealed the facility was often short staffed. 8. Interview with the Staffing Coordinator revealed the facility was often short staffed with CNA's and Nurses. 9. Record Review of the Grievance Log revealed there were no formal grievances submitted concerning staffing, the residents' supply of briefs, or residents being left in wet briefs for extended periods of time. 10. Review of Resident #2, #3, #4 and the unsampled resident revealed they all had BIMS between 14-15. Resident #1 had a BIMS score of 12. 11. The Administrator revealed she was aware there was a staffing problem with the Nursing Staff. |
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	The complaint was substantiated and the facility was cited for F 241 Dignity, F 353 sufficient staffing to meet resident care needs,
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Findings: Allegation: Substantiated Unsubstantiated

Deficiencies: Yes No
If yes, detail Federal/State tags and s/s if applicable, SOC, IJ, 23 day term, 90 day Term, COPs

F 241"E", F353 "F"
 Notifications: Complainant: Sylvia Rhodes, Ombudsman Letter Sent: emailed, called, 5/29/12
 Name, Date, Time Facility: 05/25/12 @ 9:00 PM Mary Campbell Other: NA

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 185311	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 7/5/2012
Name of Facility ROCKFORD HEALTH AND REHABILITATION CENTER	Street Address, City, State, Zip Code 4700 QUINN DR. LOUISVILLE, KY 40216	

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix <u>F0241</u> Reg. # <u>483.15(a)</u> LSC _____	Correction Completed <u>07/05/2012</u>	ID Prefix <u>F0353</u> Reg. # <u>483.30(a)</u> LSC _____	Correction Completed <u>07/05/2012</u>	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
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ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By <u>JM</u> State Agency	Reviewed By <u>J Mayo</u>	Date: <u>7.30.12</u>	Signature of Surveyor: <u>Jenny Mayo</u>	Date: <u>7.30.12</u>
Reviewed By _____ CMS RO	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____

Followup to Survey Completed on: <u>5/25/2012</u>	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
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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 C 05/25/2012
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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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F 000	INITIAL COMMENTS An abbreviated survey was initiated on 05/23/12 and concluded on 05/25/12 investigating Complaints KY18301 and KY18187. Ky18301 and KY18187 were substantiated with related deficiencies cited.	F 000	P.O.C. written by and in-service conducted by Director of Nursing	
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to maintain dignity and respect for three (3) of five (5) sampled residents and for one (1) un-sampled resident. Staff members did not respond to Resident #1, #2, #3 and Un-sampled Resident A's requests for assistance with brief changes in a timely manner. The findings include: Clinical record review revealed the facility admitted Resident #1 on 12/16/11 with a diagnosis of Chronic Kidney Disease and the resident was prescribed Lasix (a medication for fluid retention). Observation, on 05/25/12 at 8:30 AM, revealed Resident #1 was sitting on the side of the bed dressed in a hospital gown, waiting for the CNA to	F 241		



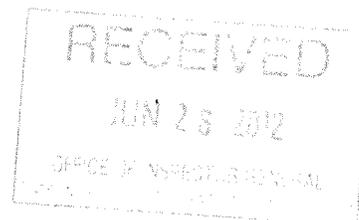
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE <i>[Signature]</i>	(X6) DATE X 6/26/12
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from 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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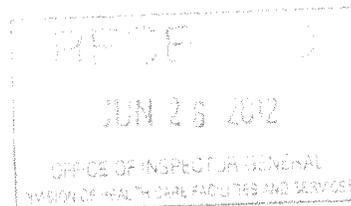
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F 241	<p>Continued From page 1</p> <p>come into the resident's room to assist with a brief change. The Resident showed the surveyor the heavily soaked brief.</p> <p>Observation, on 05/25/12 at 9:05 AM and 9:45 AM, revealed Resident #1 was still wearing the urine soaked brief and the hospital gown.</p> <p>Interview with Resident #1, on 05/24/12 at 3:45 PM, revealed the resident often wakes up in a urine soaked brief that is dripping with urine so much, the bed linens have to be changed.</p> <p>Interview with Resident #1, on 05/25/12 at 9:45 AM, revealed the resident had awakened at about 8:30 AM in a urine soaked brief and had put on the call light at 9:05 AM to request a brief change. A CNA came into the resident's room a few minutes later, turned off the call light, and told the resident the facility was short staffed and someone would be back soon to help. The resident revealed there usually was at least a thirty (30) minute wait to get assistance, because the facility was short staffed, and so many residents need assistance in the early morning. The resident said the wait today was longer than usual, and there was a burning feeling in the area where the wet brief was. The resident revealed the CNA's often tell the residents the facility was short staffed, therefore the resident tried to be patient.</p> <p>Review of the clinical record for Resident #2 revealed the facility admitted the resident on 10/20/10 with a diagnoses of Dysphasia (difficulty talking), Convulsions, and History of Stroke.</p> <p>Interview with Resident #2 in Room C12-B, on</p>	F 241	<p>Resident #2 and #3 had brief change around 11:00am. Director of Nursing completed rounds on all 4 halls at approximately 11:30am. Resident #2 stated he was OK and Resident #3 stated the morning was rough but is getting better. Resident A was not interviewed but was seen up and dressed. Resident #2 and #3 had no adverse effect or skin breakdown from the wait as evidence by intact skin on skin report for Resident #2 and #3. Director of Nursing was unaware of Resident A complaint on 5/22/2012. Resident A current skin breakdown to sacral area remained stable and resident A received shower on 5/25/2012 at 10:00am.</p> <p>2. On 5/25/2012 Director of Nursing made rounds to identify and resolve any issues. Immediately upon notification of situation related to Resident #1 Director of Nursing made rounds and interviewed/ re-educated all aides currently in building regarding call light response.</p> <p>3. Restorative nurse will review toileting programs for all residents to ensure the program is effective and appropriate. Any plan identified as needing modification will be modified by 7/5/12 which may include a new voiding diary, assessment and implementation of a new plan. Care Plan and nurse aide assignment sheets will be reviewed to ensure proper communication of the individualized plan. This will be completed by 7/5/12. All nursing staff will be re-educated by Director of Nursing on 6/21/12 regarding call light timeliness and response in regards to dignity.</p>	7/5/2012



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F 241	<p>Continued From page 2</p> <p>05/25/12 at 5:35 PM, revealed the Resident had put on the call light at 8:45 AM that morning to request a brief change. Someone came into the resident's room within a few minutes and told the resident the facility was very short staffed and someone would be back as soon as they could. The resident said someone finally came back to help at 10:45 AM. This long wait had caused the resident's groin to hurt with a burning sensation.</p> <p>Interview with Resident #3 in Room C12-A, on 05/25/12 at 5:50 PM, revealed the same incident as described above had occurred that morning when he/she had requested assistance. When asked how this made him/her feel. The resident wrote "makes me feel helpless".</p> <p>Interview, on 05/25/12 at 7:30 PM, with un-sampled Resident A revealed she/he was scheduled to have a shower on Tuesday, 5/22/12, but was told the facility was short staffed, and would not be able to assist the resident with a bath that day. About three (3) to four (4) weeks ago the resident had an episode of diarrhea and put on her/his call light to request assistance. About an hour later no one had come to help the resident. Therefore, she/he self propelled in a wheelchair to the Nurses' Station to request help. The nurse got someone to help the resident. The resident revealed this made her/him feel nasty and uncomfortable. The resident revealed the skin was burning around her/his tail bone.</p> <p>Interview with CNA #5, on 05/24/12 at 2:35 PM, revealed she/he cared for Resident #1 often on the first shift. There had never been a day she had come into the facility, that the resident had not been saturated in urine, requiring the entire</p>	F 241	<p>4. Social Service will discuss Resident Rights, Dignity, Call light response and Incontinent care during the next Resident Council meeting scheduled 7/2/2012 and any concerns will be referred to the Director of Nursing for resolution and report of findings will be reviewed by facility QA committee no less than quarterly to ensure compliance is achieved and maintained.</p>		



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F 241	<p>Continued From page 3</p> <p>bed to be stripped, and the mattress to be wiped down.</p> <p>Interviews with CNA #3 and #4, on 05/25/12 at 9:45 AM, revealed neither CNA had changed resident #1's brief. CNA #4 admitted she had gone into the resident's room at 9:05 AM, turned off the call light, told the resident the facility was short staff, and someone who return as soon as possible. CNA #3 and #4 both confirmed the facility was short staffed this morning, and there was a period of time that no one was covering the back-right portion of the C-Hall. CNA #4 revealed, she had gone to the House Supervisor to inform her of the situation. CNA #3 and #4 confirmed the facility had a staffing problem. Residents should not have to wait forty-five (45) minutes or longer for assistance. Both CNA's agreed this could be very uncomfortable for the residents, and could cause skin breakdown.</p> <p>Interview, on 05/25/12 at 10:40 AM, with LPN #1 revealed the facility was short staffed two (2) to three (3) times per week because CNA's and Nurses often call in. LPN #1 commented that it was understandable the residents may have to wait longer to get help when the facility was short staffed.</p> <p>Interview with the House Supervisor, on 05/25/12 at 1:00 PM, confirmed that a resident sitting in a wet brief for an extended period of time could cause skin breakdown as well as infection and make a resident very uncomfortable.</p> <p>Interview with the Director of Nursing (DON), on 05/25/12 at 10:20 AM, revealed Resident #1, #2, #3, and un-sampled Resident A, should not have</p>	F 241			

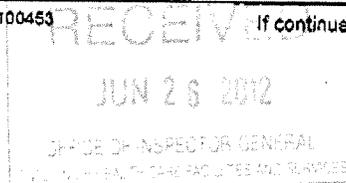
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 JUN 15 2012
 OFFICE OF INSPECTOR GENERAL
 DIVISION OF HEALTHCARE FACILITIES AND SERVICES

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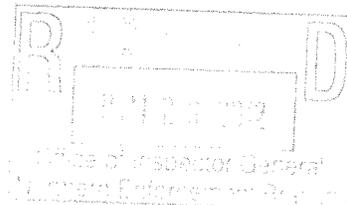
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F 241	Continued From page 4 to sit in a soiled brief for an extended period of time. This would be very uncomfortable and could cause skin breakdown.	F 241		
F 353 SS=F	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's staffing schedule, it was determined the facility failed to provide sufficient staff to meet the residents' needs including answering call lights promptly, and providing incontinent care promptly, for three (3) of five (5) sampled residents and one (1)	F 353		



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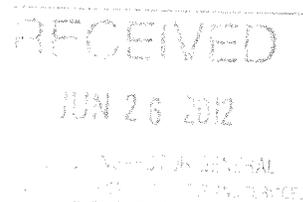
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F 353	Continued From page 5 un-sampled resident. Residents #1, #2, #3 and un-sampled Resident A's call lights were not answered timely and were left in soiled briefs for extended periods of time. The findings include: Observation, on 05/25/12 at 8:30 AM, revealed Resident #1 was sitting on the side of the bed dressed in a hospital gown, waiting for the CNA to come into the room to assist with a brief change. The Resident showed the surveyor the heavily soaked brief. Observation, on 05/25/12 at 9:05 AM and 9:45 AM, revealed Resident #1 was still wearing the urine soaked brief and the hospital gown. Interview with Resident #1, on 05/24/12 at 3:45 PM, revealed the resident often wakes up in a urine soaked brief that was dripping with so much urine, the bed linens had to be changed. Interview with Resident #1, on 05/25/12 at 9:45 AM, revealed the resident had awakened at about 8:30 AM in a urine soaked brief and had put on the call light at 9:05 AM to request a brief change. A CNA came into the resident's room and said the facility was short staffed and someone would be back soon to help. The Resident revealed that usually in the morning there was a thirty (30) minute wait to get assistance, because the facility was short staffed and so many residents needed assistance in the early morning. The resident said today was a longer wait than usual. The resident revealed the CNA's often tell the residents the facility was short staffed. Therefore, the resident tried to be patient.	F 353	Resident #1 had brief change on 5/25/12 at approximately 10:00 am. Resident #2 and #3 had brief change around 11:00am. Director of Nursing completed rounds on all 4 halls at approximately 11:30am. Resident #2 stated he was OK and Resident #3 stated the morning was rough but is getting better. Resident A was not interviewed but was seen up and dressed. Resident #2 and #3 had no adverse effect or skin breakdown from the wait as evidence by intact skin on skin report for Resident #2 and #3. Director of Nursing was unaware of Resident A complaint on 5/22/2012. Resident A current skin breakdown to sacral area remained stable and resident A received shower on 5/25/2012 at 10:00am. 2. On 5/25/2012 Director of Nursing made rounds to identify and resolve any issues. Immediately upon notification of situation related to Resident #1 Director of Nursing made rounds and interviewed/ re-educated all aides currently in building regarding call light response. 3. Beginning July 5, 2012 the following procedure will be followed to ensure staffing levels do not fall below minimum staffing levels (minimum staffing level is determined by the census of the facility). Charge nurse or floor nurse is responsible to monitor staffing levels at the beginning of each shift.	7/5/2012	



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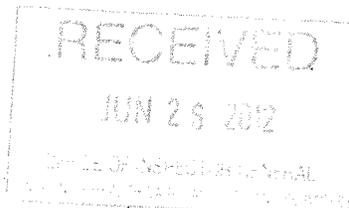
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F 353	Continued From page 5 un-sampled resident. Residents #1, #2, #3 and un-sampled Resident A's call lights were not answered timely and were left in soiled briefs for extended periods of time. The findings include: Observation, on 05/25/12 at 8:30 AM, revealed Resident #1 was sitting on the side of the bed dressed in a hospital gown, waiting for the CNA to come into the room to assist with a brief change. The Resident showed the surveyor the heavily soaked brief. Observation, on 05/25/12 at 9:05 AM and 9:45 AM, revealed Resident #1 was still wearing the urine soaked brief and the hospital gown. Interview with Resident #1, on 05/24/12 at 3:45 PM, revealed the resident often wakes up in a urine soaked brief that was dripping with so much urine, the bed linens had to be changed. Interview with Resident #1, on 05/25/12 at 9:45 AM, revealed the resident had awakened at about 8:30 AM in a urine soaked brief and had put on the call light at 9:05 AM to request a brief change. A CNA came into the resident's room and said the facility was short staffed and someone would be back soon to help. The Resident revealed that usually in the morning there was a thirty (30) minute wait to get assistance, because the facility was short staffed and so many residents needed assistance in the early morning. The resident said today was a longer wait than usual. The resident revealed the CNA's often tell the residents the facility was short staffed. Therefore, the resident tried to be patient.	F 353 1.	Resident #2 and #3 had brief change around 11:00am. Director of Nursing completed rounds on all 4 halls at approximately 11:30am. Resident #2 stated he was OK and Resident #3 stated the morning was rough but is getting better. Resident A was not interviewed but was seen up and dressed. Resident #2 and #3 had no adverse effect or skin breakdown from the wait as evidence by intact skin on skin report for Resident #2 and #3. Director of Nursing was unaware of Resident A complaint on 5/22/2012. Resident A current skin breakdown to sacral area remained stable and resident A received shower on 5/25/2012 at 10:00am. 2. On 5/25/2012 Director of Nursing made rounds to identify and resolve any issues. Immediately upon notification of situation related to Resident #1 Director of Nursing made rounds and interviewed/ re-educated all aides currently in building regarding call light response. 3. Beginning July 5, 2012 the following procedure will be followed to ensure staffing levels do not fall below minimum staffing levels (minimum staffing level is determined by the census of the facility). Charge nurse or floor nurse is responsible to monitor staffing levels at the beginning of each shift.	7/5/2012



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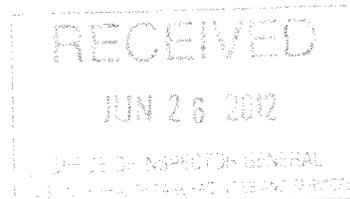
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F 353	Continued From page 6 Interview with Resident #2 in Room C12-B, on 05/25/12 at 5:35 PM, revealed the resident had put on the call light at 8:45 AM that morning to request a brief change. Someone came into the resident's room within a few minutes and told the resident the facility was very short staffed and someone would be back as soon as they could. The Resident said someone finally came back to help at 10:45 AM. Interview with Resident #3 in Room C12-A, on 05/25/12 at 5:50 PM, revealed the same incident as described above had occurred that morning when he/she had requested assistance. Interview with un-sampled Resident A, on 05/25/12 at 7:30 PM, revealed she/he was scheduled to have a shower on Tuesday, 5/22/12, but was told the facility was short staffed, and would not be able to assist the resident with a bath that day. Additionally, about three (3) to four (4) weeks ago the resident had an episode of diarrhea, put on her/his call light, and requested help. About an hour later no one had come to help the resident. She/he self propelled in a wheelchair to the Nurses' Station to request help. Interview with CNA #5, on 05/24/12 at 2:35 PM, revealed she/he cared for Resident #1 often on first shift. There had never been a day she had come into the facility the resident had not been saturated in urine, requiring the entire bed to be stripped, and the mattress to be wiped down. Interview with CNA #3 and #4, on 05/25/12 at 9:45 AM, revealed they had not changed Resident #1's brief. CNA #4 admitted she had	F 353	Assignments are to be made based on routine staffing level or minimum staffing levels. If minimum staffing levels are not attained, the "stand-by" staff member will be required to stay over for a minimum of 2 hours. During that time the staffing coordinator and DON will make calls and staff facility to no less than minimum staffing levels. The "stand-by" staff member will be noted on the schedule for each shift. On 6-14-12 shift times were discussed with staff and on 8-12-12 shift times will change with shifts starting 30 minutes later. Routine and minimum staffing levels were discussed with staffing coordinator on 5-28-12 and all nursing staff will be educated on the new procedure on 6-21-12 by the DON. 4. Staffing coordinator will monitor staffing for every shift daily and report daily staffing to the Director of Nursing daily x4 weeks then no less than 2x a week to ensure minimum staffing is maintained and report of findings will be reviewed by facility QA committee no less than quarterly to ensure compliance is achieved and maintained.		



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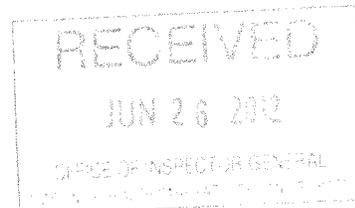
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185311	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/25/2012
NAME OF PROVIDER OR SUPPLIER ROCKFORD HEALTH AND REHABILITATION CENTER		STREET ADDRESS, CITY, 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 353	<p>Continued From page 7</p> <p>gone into the resident's room at 9:05 AM, turned off the call light, told the resident the facility was short staff, and someone who return as soon as possible. CNA #3 and #4 both confirmed the facility was short staffed this morning, and there was a period of time that no one was covering the back-right portion of the C-Hall. CNA #4 revealed she had gone to the House Supervisor to inform her of the situation. CNA #3 and #4 confirmed the facility had a staffing problem. The residents should not have to wait forty-five (45) minutes or longer for assistance.</p> <p>Interview, on 05/25/12 at 10:40 AM, with LPN #1 revealed the facility was short staffed at least two (2) to three (3) times per week because CNA's and Nurses often call in. LPN #1 commented it was understandable the residents may have to wait longer to get help when the facility was short staffed.</p> <p>Interview with the House Supervisor, on 05/25/12 at 1:00 PM, confirmed the facility had three (3) CNA's and one (1) nurse call in that morning and there were not sufficient as needed (PRN) staff to fill the positions. There was a period of time that Hall-C was not covered by the CNA staff. Therefore, nurses and a restorative aid were pulled to cover. A staff member from Dietary was pulled to cover the Restorative Aid position.</p> <p>Telephone Interview with the Staffing Coordinator, on 05/25/12 at 6:15 PM, revealed she was aware of the staffing problem. The Staffing Coordinator revealed there was not enough staff to cover if a staff member took off for sick or annual leave. The facility was short staffed at least two (2) to three (3) shifts per week. The Staffing</p>	F 353		



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

PRINTED: 06/04/2012
FORM APPROVED
OMB NO. 0938-0391

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F 353	<p>Continued From page 8</p> <p>Coordinator revealed there was not a pool of PRN CNA's for first shift at this time. She calls CNA's and Nurses to take on an extra shift when she realized the facility was short staffed. Nurses fill in for CNA's and the Dietary Staff even help out.</p> <p>Interview with the Director of Nursing (DON), on 05/25/12 at 10:20 AM, revealed she was aware the facility was short staffed and the facility did not have enough regular or PRN staff to cover. The DON stated this was something they need to get solved.</p> <p>Interview with the Administrator, on 05/25/12 at 7:00 PM, revealed she was out of the facility for a period of time for Emergency Surgery in the early part of the year and realized that the staffing quota had gotten low.</p>	F 353		



State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number 100453	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 7/5/2012
Name of Facility ROCKFORD HEALTH AND REHABILITATION CENTER		Street Address, City, State, Zip Code 4700 QUINN DR. LOUISVILLE, KY 40216

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix N0113 Reg. # 902 KAR 20:300-6(1) LSC _____	Correction Completed 07/05/2012	ID Prefix N0239 Reg. # 902 KAR 20:300-9 LSC _____	Correction Completed 07/05/2012	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By <u>JM</u>	Reviewed By <u>J Mayo</u>	Date: <u>7.30.12</u>	Signature of Surveyor: <u>Jerry Mayo</u>	Date: <u>07.30.12</u>
Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____

Followup to Survey Completed on: 5/25/2012	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? <table style="float: right;"> <tr> <td>YES</td> <td>NO</td> </tr> </table>	YES	NO
YES	NO		

PRINTED: 06/04/2012
FORM APPROVED

Office of Inspector General

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N 000	INITIAL COMMENTS A complaint survey was initiated on 05/23/12 and concluded on 05/25/12 investigating Complaints KY18301 and KY18187. Ky18301 and KY18187 were substantiated with related deficiencies cited.	N 000		
N 113	902 KAR 20:300-6(1) Section 6. Quality Of Life (1) Dignity. The facility shall promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This requirement is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to maintain dignity and respect for three (3) of five (5) sampled residents and for one (1) un-sampled resident. Staff members did not respond to Resident #1, #2, #3 and Un-sampled Resident A's requests for assistance with brief changes in a timely manner. The findings include: Clinical record review revealed the facility admitted Resident #1 on 12/16/11 with a diagnosis of Chronic Kidney Disease and the resident was prescribed Lasix (a medication for fluid retention). Observation, on 05/25/12 at 8:30 AM, revealed Resident #1 was sitting on the side of the bed dressed in a hospital gown, waiting for the CNA to come into the resident's room to assist with a brief change. The Resident showed the surveyor the heavily soaked brief. Observation, on 05/25/12 at 9:05 AM and 9:45 AM, revealed Resident #1 was still wearing the	N 113		

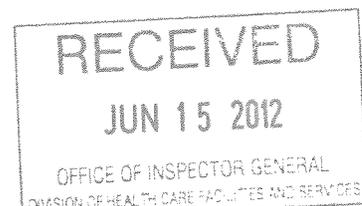
[Signature]
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
STATE FORM

TITLE
X *[Signature]* X *[Signature]*
GIL911 (X6) DATE

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OFFICE OF INSPECTOR GENERAL
STATE OF KY

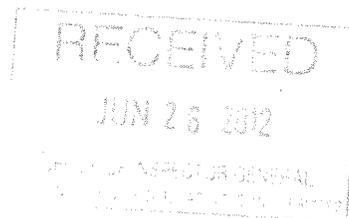
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N 113	Continued From page 1 urine soaked brief and the hospital gown. Interview with Resident #1, on 05/24/12 at 3:45 PM, revealed the resident often wakes up in a urine soaked brief that is dripping with urine so much, the bed linens have to be changed. Interview with Resident #1, on 05/25/12 at 9:45 AM, revealed the resident had awakened at about 8:30 AM in a urine soaked brief and had put on the call light at 9:05 AM to request a brief change. A CNA came into the resident's room a few minutes later, turned off the call light, and told the resident the facility was short staffed and someone would be back soon to help. The resident revealed there usually was at least a thirty (30) minute wait to get assistance, because the facility was short staffed, and so many residents need assistance in the early morning. The resident said the wait today was longer than usual, and there was a burning feeling in the area where the wet brief was. The resident revealed the CNA's often tell the residents the facility was short staffed, therefore the resident tried to be patient. Review of the clinical record for Resident #2 revealed the facility admitted the resident on 10/20/10 with a diagnoses of Dysphasia (difficulty talking), Convulsions, and History of Stroke. Interview with Resident #2 in Room C12-B, on 05/25/12 at 5:35 PM, revealed the Resident had put on the call light at 8:45 AM that morning to request a brief change. Someone came into the resident's room within a few minutes and told the resident the facility was very short staffed and someone would be back as soon as they could. The resident said someone finally came back to help at 10:45 AM. This long wait had caused the	N 113	1. Resident #1 had brief change on 5/25/2012 at approximately 10:00 a.m. Incident with Resident #2,3, and A occurred prior to the survey and was already resolved. Director of Nursing completed a follow up interview on 5/25/2012 with resident #1,2, and 3 to ensure incidents were resolved. 2. On 5/25/2012 Director of Nursing made rounds to identify and resolve any issues. Immediately upon notification of situation related to Resident #1 Director of Nursing made rounds and interviewed/ re-educated all aides currently in building regarding call light response. 3. Restorative nurse will review toileting programs for all residents to ensure the program is effective and appropriate. Any plan identified as needing modification will be modified by 7/5/2012 which may include a new voiding diary, assessment and implementation of a new plan. Care Plan and nurse aide assignment sheets will be reviewed to ensure proper communication of the individualized plan. This will be completed by 7/5/2012. All nursing staff will be re-educated by Director of Nursing on 6/21/2012 regarding call light timeliness and response in regards to dignity. 4. Social Service will discuss Resident Rights, Dignity, Call light response and Incontinent care during the next Resident Council meeting scheduled 7/2/2012 and any concerns will be referred to the Director of Nursing for resolution.	7/5/2012



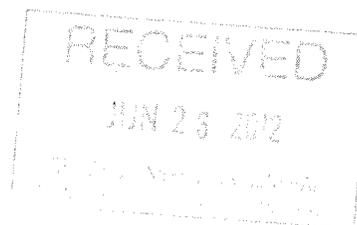
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N 113	Continued From page 2 resident's groin to hurt with a burning sensation. Interview with Resident #3 in Room C12-A, on 05/25/12 at 5:50 PM, revealed the same incident as described above had occurred that morning when he/she had requested assistance. When asked how this made him/her feel. The resident wrote "makes me feel helpless". Interview, on 05/25/12 at 7:30 PM, with un-sampled Resident A revealed she/he was scheduled to have a shower on Tuesday, 5/22/12, but was told the facility was short staffed, and would not be able to assist the resident with a bath that day. About three (3) to four (4) weeks ago the resident had an episode of diarrhea and put on her/his call light to request assistance. About an hour later no one had come to help the resident. Therefore, she/he self propelled in a wheelchair to the Nurses' Station to request help. The nurse got someone to help the resident. The resident revealed this made her/him feel nasty and uncomfortable. The resident revealed the skin was burning around her/his tail bone. Interview with CNA #5, on 05/24/12 at 2:35 PM, revealed she/he cared for Resident #1 often on the first shift. There had never been a day she had come into the facility, that the resident had not been saturated in urine, requiring the entire bed to be stripped, and the mattress to be wiped down. Interviews with CNA #3 and #4, on 05/25/12 at 9:45 AM, revealed neither CNA had changed resident #1's brief. CNA #4 admitted she had gone into the resident's room at 9:05 AM, turned off the call light, told the resident the facility was short staff, and someone who return as soon as possible. CNA #3 and #4 both confirmed the	N 113	1. Resident #2 and #5 had brief change around 11:00am. Director of Nursing completed rounds on all 4 halls at approximately 11:30am. Resident #2 stated he was OK and Resident #3 stated the morning was rough but is getting better. Resident A was not interviewed but was seen up and dressed. Resident #2 and #3 had no adverse effect or skin breakdown from the wait as evidence by intact skin on skin report for Resident #2 and #3. Director of Nursing was unaware of Resident A complaint on 5/22/2012. Resident A current skin breakdown to sacral area remained stable and resident A received shower on 5/25/2012 at 10:00am. 2. On 5/25/2012 Director of Nursing made rounds to identify and resolve any issues. Immediately upon notification of situation related to Resident #1 Director of Nursing made rounds and interviewed/ re-educated all aides currently in building regarding call light response. 3. Restorative nurse will review toileting programs for all residents to ensure the program is effective and appropriate. Any plan identified as needing modification will be modified by 7/5/12 which may include a new voiding diary, assessment and implementation of a new plan. Care Plan and nurse aide assignment sheets will be reviewed to ensure proper communication of the individualized plan. This will be completed by 7/5/12. All nursing staff will be re-educated by Director of Nursing on 6/21/12 regarding call light timeliness and response in regards to dignity.	7/5/2012



Office of Inspector General

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N 113	Continued From page 3 facility was short staffed this morning, and there was a period of time that no one was covering the back-right portion of the C-Hall. CNA #4 revealed, she had gone to the House Supervisor to inform her of the situation. CNA #3 and #4 confirmed the facility had a staffing problem. Residents should not have to wait forty-five (45) minutes or longer for assistance. Both CNA's agreed this could be very uncomfortable for the residents, and could cause skin breakdown. Interview, on 05/25/12 at 10:40 AM, with LPN #1 revealed the facility was short staffed two (2) to three (3) times per week because CNA's and Nurses often call in. LPN #1 commented that it was understandable the residents may have to wait longer to get help when the facility was short staffed. Interview with the House Supervisor, on 05/25/12 at 1:00 PM, confirmed that a resident sitting in a wet brief for an extended period of time could cause skin breakdown as well as infection and make a resident very uncomfortable. Interview with the Director of Nursing (DON), on 05/25/12 at 10:20 AM, revealed Resident #1, #2, #3, and un-sampled Resident A, should not have to sit in a soiled brief for an extended period of time. This would be very uncomfortable and could cause skin breakdown.	N 113	4. Social Service will discuss Resident Rights, Dignity, Call light response and Incontinent care during the next Resident Council meeting scheduled 7/2/2012 and any concerns will be referred to the Director of Nursing for resolution and report of findings will be reviewed by facility QA committee no less than quarterly to ensure compliance is achieved and maintained.	
N 239	902 KAR 20:300-9 Section 9. Nursing Services The facility shall have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.	N 239		



Office of Inspector General

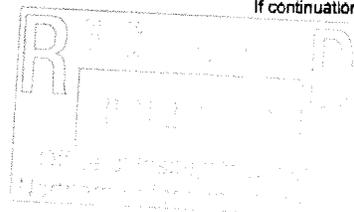
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N 239	Continued From page 4 This requirement is not met as evidenced by: Based on observation, interview, record review, and review of the facility's staffing schedule, it was determined the facility failed to provide sufficient staff to meet the residents' needs including answering call lights promptly, and providing incontinent care promptly, for three (3) of five (5) sampled residents and one (1) un-sampled resident. Residents #1, #2, #3 and un-sampled Resident A's call lights were not answered timely and were left in soiled briefs for extended periods of time. The findings include: Observation, on 05/25/12 at 8:30 AM, revealed Resident #1 was sitting on the side of the bed dressed in a hospital gown, waiting for the CNA to come into the room to assist with a brief change. The Resident showed the surveyor the heavily soaked brief. Observation, on 05/25/12 at 9:05 AM and 9:45 AM, revealed Resident #1 was still wearing the urine soaked brief and the hospital gown. Interview with Resident #1, on 05/24/12 at 3:45 PM, revealed the resident often wakes up in a urine soaked brief that was dripping with so much urine, the bed linens had to be changed. Interview with Resident #1, on 05/25/12 at 9:45 AM, revealed the resident had awakened at about 8:30 AM in a urine soaked brief and had put on the call light at 9:05 AM to request a brief change. A CNA came into the resident's room and said the facility was short staffed and someone would be back soon to help. The Resident revealed that usually in the morning there was a thirty (30)	N 239	1. Resident #1 had brief change on 5/25/12 at approximately 10:00 am. Resident #2 and #3 had brief change around 11:00am. Director of Nursing completed rounds on all 4 halls at approximately 11:30am. Resident #2 stated he was OK and Resident #3 stated the morning was rough but is getting better. Resident A was not interviewed but was seen up and dressed. Resident #2 and #3 had no adverse effect or skin breakdown from the wait as evidence by intact skin on skin report for Resident #2 and #3. Director of Nursing was unaware of Resident A complaint on 5/22/2012. Resident A current skin breakdown to sacral area remained stable and resident A received shower on 5/25/2012 at 10:00am. 2. On 5/25/2012 Director of Nursing made rounds to identify and resolve any issues. Immediately upon notification of situation related to Resident #1 Director of Nursing made rounds and interviewed/ re-educated all aides currently in building regarding call light response. 3. Beginning July 5, 2012 the following procedure will be followed to ensure staffing levels do not fall below minimum staffing levels (minimum staffing level is determined by the census of the facility). Charge nurse or floor nurse is responsible to monitor staffing levels at the beginning of each shift.	7/5/2012

STATE FORM

6896

GIL911

If continuation sheet 5 of 8



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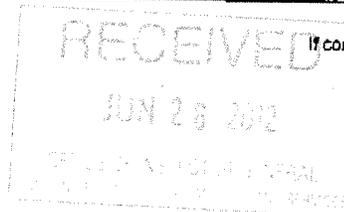
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 HEALTH SERVICES AND SERVICES

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NAME OF PROVIDER OR SUPPLIER ROCKFORD HEALTH AND REHABILITATION C		STREET ADDRESS, CITY, STATE, ZIP CODE 4700 QUINN DR. LOUISVILLE, KY 40216		
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N 239	Continued From page 5 minute wait to get assistance, because the facility was short staffed and so many residents needed assistance in the early morning. The resident said today was a longer wait than usual. The resident revealed the CNA's often tell the residents the facility was short staffed. Therefore, the resident tried to be patient. Interview with Resident #2 in Room C12-B, on 05/25/12 at 5:35 PM, revealed the resident had put on the call light at 8:45 AM that morning to request a brief change. Someone came into the resident's room within a few minutes and told the resident the facility was very short staffed and someone would be back as soon as they could. The Resident said someone finally came back to help at 10:45 AM. Interview with Resident #3 in Room C12-A, on 05/25/12 at 5:50 PM, revealed the same incident as described above had occurred that morning when he/she had requested assistance. Interview with un-sampled Resident A, on 05/25/12 at 7:30 PM, revealed she/he was scheduled to have a shower on Tuesday, 5/22/12, but was told the facility was short staffed, and would not be able to assist the resident with a bath that day. Additionally, about three (3) to four (4) weeks ago the resident had an episode of diarrhea, put on her/his call light, and requested help. About an hour later no one had come to help the resident. She/he self propelled in a wheelchair to the Nurses' Station to request help. Interview with CNA #5, on 05/24/12 at 2:35 PM, revealed she/he cared for Resident #1 often on first shift. There had never been a day she had come into the facility the resident had not been saturated in urine, requiring the entire bed to be	N 239	Assignments are to be made based on routine staffing level or minimum staffing levels. If minimum staffing levels are not attained, the "stand-by" staff member will be required to stay over for a minimum of 2 hours. During that time the staffing coordinator and DON will make calls and staff facility to no less than minimum staffing levels. The "stand-by" staff member will be noted on the schedule for each shift. On 6-14-12 shift times were discussed with staff and on 8-12-12 shift times will change with shifts starting 30 minutes later. Routine and minimum staffing levels were discussed with staffing coordinator on 5-28-12 and all nursing staff will be educated on the new procedure on 6-21-12 by the DON. 4. Staffing coordinator will monitor staffing for every shift daily and report daily staffing to the Director of Nursing daily x4 weeks then no less than 2x a week to ensure minimum staffing is maintained and report of findings will be reviewed by facility QA committee no less than quarterly to ensure compliance is achieved and maintained.	



Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100453	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/25/2012
NAME OF PROVIDER OR SUPPLIER ROCKFORD HEALTH AND REHABILITATION C		STREET ADDRESS, CITY, STATE, ZIP CODE 4700 QUINN DR. LOUISVILLE, KY 40216		
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N 239	Continued From page 6 stripped, and the mattress to be wiped down. Interview with CNA #3 and #4, on 05/25/12 at 9:45 AM, revealed they had not changed Resident #1's brief. CNA #4 admitted she had gone into the resident's room at 9:05 AM, turned off the call light, told the resident the facility was short staff, and someone who return as soon as possible. CNA #3 and #4 both confirmed the facility was short staffed this morning, and there was a period of time that no one was covering the back-right portion of the C-Hall. CNA #4 revealed she had gone to the House Supervisor to inform her of the situation. CNA #3 and #4 confirmed the facility had a staffing problem. The residents should not have to wait forty-five (45) minutes or longer for assistance. Interview, on 05/25/12 at 10:40 AM, with LPN #1 revealed the facility was short staffed at least two (2) to three (3) times per week because CNA's and Nurses often call in. LPN #1 commented it was understandable the residents may have to wait longer to get help when the facility was short staffed. Interview with the House Supervisor, on 05/25/12 at 1:00 PM, confirmed the facility had three (3) CNA's and one (1) nurse call in that morning and there were not sufficient as needed (PRN) staff to fill the positions. There was a period of time that Hall-C was not covered by the CNA staff. Therefore, nurses and a restorative aid were pulled to cover. A staff member from Dietary was pulled to cover the Restorative Aid position. Telephone Interview with the Staffing Coordinator, on 05/25/12 at 6:15 PM, revealed she was aware of the staffing problem. The Staffing Coordinator revealed there was not enough staff to cover if a	N 239		

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N 239	Continued From page 7 staff member took off for sick or annual leave. The facility was short staffed at least two (2) to three (3) shifts per week. The Staffing Coordinator revealed there was not a pool of PRN CNA's for first shift at this time. She calls CNA's and Nurses to take on an extra shift when she realized the facility was short staffed. Nurses fill in for CNA's and the Dietary Staff even help out. Interview with the Director of Nursing (DON), on 05/25/12 at 10:20 AM, revealed she was aware the facility was short staffed and the facility did not have enough regular or PRN staff to cover. The DON stated this was something they need to get solved. Interview with the Administrator, on 05/25/12 at 7:00 PM, revealed she was out of the facility for a period of time for Emergency Surgery in the early part of the year and realized that the staffing quota had gotten low.	N 239			

