

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

PRINTED: 08/26/2010
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 08/12/2010
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NAME OF PROVIDER OR SUPPLIER ROCKFORD MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 4700 QUINN DR. LOUISVILLE, KY 40216
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS A standard health survey was conducted 08/10 - 12/10 and a Life Safety Code survey was conducted on 08/12/10. Deficiencies were cited with the highest scope and severity of an "F" with the facility having the opportunity to correct before remedies would be imposed.	F 000		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to report misappropriation of a resident's money as required for one (1) of twenty-two (22) sampled residents (Resident #22). The findings include: Review of the facility policy for identification of actual or suspected abuse, neglect, misappropriation of funds/property revealed the incident could be initially determined to be "suspected" abuse within the definitions of the facility policy a report was to be made to the Department for Community Based Services and to the Office of Inspector General immediately. Interview with Resident #22 during the group session on 08/10/10 at 2:30pm revealed she had sixty dollars (\$60.00) taken from her room. She stated she had reported the incident to the facility	F 226	<ol style="list-style-type: none"> 1. The money was repaid to this resident. The theft was internally reported appropriately and investigated internally appropriately by our staff. However, following our investigation, we failed to call and notify OIG and APS of our findings. 2. All other allegations and grievances related to misappropriation will be reviewed by the Social Service Director to ensure they are investigated appropriately and the initial and final reports are sent to the appropriate state agencies. 3. Staff was re-educated on Sept. 8th, regarding misappropriation of property. The in-service was conducted by the ADM and DON. 4. A review of all grievances and reports of missing items will be conducted by the Social Service Director to ensure our policy on reporting misappropriation is followed. This report will be submitted to the Administrator monthly. 	9-20-10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE <i>ADM</i>	(X6) DATE <i>9/10/10</i>
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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 required to continued program participation.

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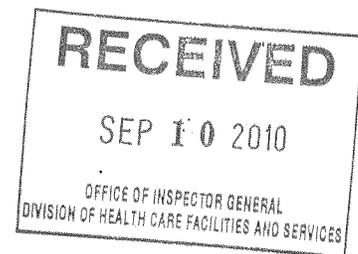
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F 226	Continued From page 2 money by the visitor's family member. Additionally, she stated a report should have been made to the appropriate agencies and was not done.	F 226		
F 246 SS=D	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES</p> <p>A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview it was determined the facility failed to assure reasonable accommodations were made to provide adaptive equipment for one (1) of twenty-two (22) sampled residents, keeping Resident #4 from reaching his/her highest level of function. Three days of observation of Resident #4 revealed the resident was bedfast, not by choice or medical condition, but due to the facility not having the equipment to transfer Resident #4 from the bed to a wheelchair, nor having a wheelchair that would serve the resident's needs.</p> <p>The findings include:</p> <p>Observations on 08/10/10 at 12:10pm revealed Resident #4 in bed eating lunch. At 2:40pm and 3:30pm Resident #4 remained in the same position in bed.</p> <p>Interview with Resident #4 on 08/10/10 at 3:30pm</p>	F 246	<p>1. Resident # 4 now has a bariatric wheelchair and lift.</p> <p>2. An audit will be conducted by the 1st shift charge nurses of all residents to determine the need for special equipment.</p> <p>3. The MDS staff will review all new physician orders daily. All orders for specialized equipment will be forwarded to the DON for ordering. The Rehab Department will communicate in writing to the DON all recommendations for specialized equipment if the resident is in therapy.</p> <p>4. Each resident will be assessed no less than quarterly by the MDS staff to ensure that all specialized equipment is present and functional, any noted problems will be communicated to the DON in writing. The DON will maintain a log of all specialized equipment for ordered for audit purposes.</p>	9-20-10



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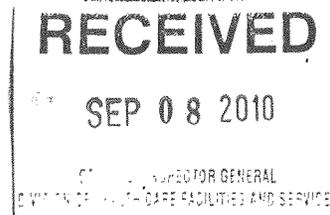
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F 226	<p>Continued From page 1</p> <p>administration. Resident #22 did not recall the outcomes of the investigation.</p> <p>Interview with the Social Services Director on 08/11/10 at 3:25pm revealed she had been made aware of the missing money by Resident #22. She stated she immediately initiated an investigation and reported this to the Administrator. It was determined a visitor to the facility who was a family member to a staff had taken the money. She stated the person was banned from the facility although the person had denied the allegation. The Social Services Director stated the staff associated with the facility visitor repaid the resident the \$60.00. She stated once her investigation was completed she turned it over to the Administrator for her to review and sign off on the resolution. Additionally she stated once the report was returned to her she would file it. She stated she did not know if the allegation was reported to the appropriate agencies or not.</p> <p>Interview on 08/11/10 at 4:35pm with the Administrator revealed she thought the money was missing and not reported as stolen. She stated the Social Services Director initiated an investigation and the facility had determined a staff's family member had gone into Resident #22's room and taken the money. She stated the visitor had been banned from the facility and the staff would be terminated if the family member was to return to the facility. She stated anyone could report an allegation of abuse, neglect, or misappropriation of property to the appropriate authorities and the Social Service Director should have reported the allegation. She stated she did not report the allegation to the appropriate agency because the resident was paid back the missing</p>	F 226			

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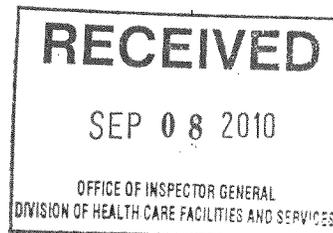
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F 226	Continued From page 2 money by the visitor's family member. Additionally, she stated a report should have been made to the appropriate agencies and was not done.	F 226		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview it was determined the facility failed to assure reasonable accommodations were made to provide adaptive equipment for one (1) of twenty-two (22) sampled residents, keeping Resident #4 from reaching his/her highest level of function. Three days of observation of Resident #4 revealed the resident was bedfast, not by choice or medical condition, but due to the facility not having the equipment to transfer Resident #4 from the bed to a wheelchair, nor having a wheelchair that would serve the resident's needs. The findings include: Observations on 08/10/10 at 12:10pm revealed Resident #4 in bed eating lunch. At 2:40pm and 3:30pm Resident #4 remained in the same position in bed. Interview with Resident #4 on 08/10/10 at 3:30pm	F 246	1. Resident #4 will have a rented bariatric wheelchair and lift by 9/20/2010. 2. An audit will be conducted by the 1st shift charge nurses of all residents to determine the need for special equipment. 3. Information will be relayed on a timely basis by the charge nurses or rehab staff to the DON in regards to the necessary equipment. The DON will ensure the necessary equipment is available as needed. 4. The MDS nurses will monitor or specialized equipment for availability and functionality.	9-20-10



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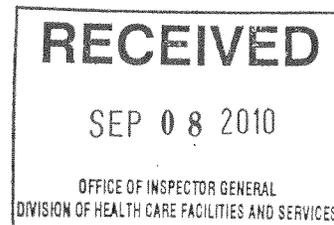
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F 246	<p>Continued From page 3</p> <p>revealed the resident had not been out of the bed due to the lack of necessary equipment to transfer. Additional interview with the resident on 08/11/10 at 8:45am revealed the resident did not like spending time in their room because he/she cannot get out of bed. The facility did not have a wheelchair that could accommodate the resident's body weight. The resident stated he/she had not attended any facility activities although they bring him a calendar. The resident stated the facility did not have an appropriate lift to transfer him/her from the bed to a wheelchair. The resident has not been out of the bed in more than a year and was told by the Director of Nurses (DON) the facility could not afford a wheelchair or bariatric bed. The resident further stated he/she would like to be out of his/her room some during the daytime.</p> <p>Record review on 08/11/10 revealed Resident #4 was admitted to the facility on 12/28/09 after having a left sided stroke. Admitting diagnoses included Seizures, High Blood Pressure, Depression, Bipolar Disorder, Anxiety, Congestive Heart Failure, Ischemic Heart Disease, Obesity (current weight 355 pounds), Insomnia, and Hyper-coagulation.</p> <p>Interview with the Social Worker on 08/11/10 at 10:00am revealed the facility did not have the appropriate equipment to transfer Resident #4 from the bed to a wheelchair.</p> <p>Interview on 08/12/10 at 9:30am with CNA #2 revealed she was unable to weigh Resident #4 on 8/02/10 because the Hoyer lift could not lift the resident's body off the bed.</p> <p>Interview on 08/12/10 at 10:30am with the</p>	F 246		



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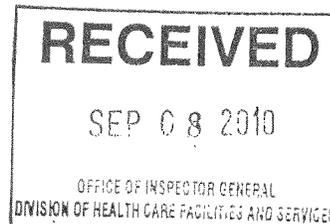
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F 246	Continued From page 4 Director of Nursing (DON) revealed the facility discussed the potential to purchase a wheelchair within the 2011 budget, but it will have to be custom made due to Resident #4's weight. The DON stated their present lift was supposed to weigh individuals up to 440 pounds. The DON further confirmed Resident #4 had been bedfast not for health reasons, but due to the lack of appropriate equipment.	F 246		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined the facility failed to provide nursing services to meet professional standards of quality of care by failing to recognize and report an error in regards to pharmacy directions on an order for Prozac 20mg (twenty milligrams) on a sixty (60) day physician order sheet for five (5) and one-half (1/2) months for one (1) of twenty-two (22) sampled residents (Resident #2). The findings include: Review of the facility policy "CHANGE OVER PROCESS" in regards to updating new Physician Order Sheets from the contracted pharmacy dated 12/28/09 revealed the "Charge Nurse checks thirty (30) and sixty (60) day Physician Order Sheets when they first arrive at the facility from the pharmacy for accuracy. A third shift nurse is responsible to complete a last check of the Physician Order Sheets for accuracy and sign	F 281		



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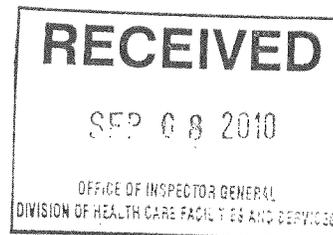
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F 281	Continued From page 5 and date that they are accurate." Record review on 08/10/10 for Resident #2 revealed the resident was admitted to the facility on 12/11/08 with diagnoses to include, Left Hemiplegia Residual Status Post Cerebrovascular Accident, Diabetes Mellitus, and Hypertension. Review of the Minimum Data Sheet assessment for cognition dated 06/01/10 revealed Resident #2 was a score of zero (0) indicating the resident was capable of daily decision-making and indicating the resident was interviewable. Review of the most current sixty day Physician Order Sheet revealed an error on the directions for a medication (Prozac 20mg.) order, specifically the order for Prozac 20milligrams read "Fluoxetine 20mg. capsule, Prozac 20mg. pulvule, give 1 capsule orally, with 10mg=20mg every day for depression". This order sheet was signed and dated by a facility nurse as having been verified as accurate. Further record review revealed the original order for thirty (30) milligrams of Prozac daily was written on 02/19/10. The current Medication Administration Record (MAR) (written per the most current Physician Order Sheet) revealed the same directions for the Prozac 20mg order. Review of the current MAR also revealed multiple nurses over the past 5 1/2 months had documented that one (1) 10mg plus one (1) 20mg Prozac had been given per the original physician's order to equal 30mg daily. Interview with LPN #7 on 08/10/10 at 5:00pm revealed it was the responsibility of every nurse in the facility to read an entire medication order with the pharmacy directions on the MAR sheet prior to medication administration to ensure accuracy. She also stated she had always administered the	F 281	F281 1. Resident #2 did receive the correct dosage of Prozac as ordered by the physician. Error in pharmacy direction was corrected immediately on 8/10/10 by the charge nurse and pharmacy services was notified of error in pharmacy direction. 2. A 100 % chart audit was completed on 8/30/2010 by the charge nurses to identify and correct any errors prior to change over. 3. A 20% chart audit will be completed by the DON or her designee quarterly to review 3/60 day physician order sheets with previous 30/60 day physician order sheets. 4. The DON will report all findings from chart audits to the Facility QA meeting.	8.30.10



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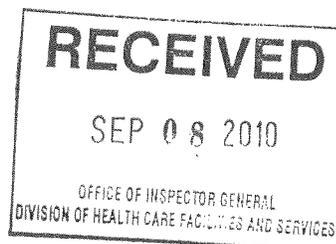
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F 281	<p>Continued From page 6</p> <p>correct dosage of Prozac to Resident #2.</p> <p>Interview with LPN #6 on 08/10/10 at 5:15pm revealed she did see the error in the directions for the Prozac 20mg order after surveyor discussion. She also stated she had always given the Prozac 10mg plus Prozac 20mg to equal 30mg per the original physician's order and that Resident #2 was not harmed. She did however state that she should have read the directions for the Prozac 20mg more carefully, caught and reported the error to have it corrected.</p> <p>Interview with the Director of Nursing (DON) on 08/12/10 at 2:10pm revealed the nursing staff is trained on the "CHANGE OVER PROCESS" regarding Physician Order Sheets generated by the pharmacy upon hire, annually, and as needed. The DON stated this was an error in the pharmacy directions for the Prozac 20mg administration and it should have been recognized and reported prior to surveyor discussion.</p> <p>Interview with the consulting Pharmacist on 08/12/10 at 2:30pm revealed the surveyor should contact the PCA Pharmacy regarding any quality checks they did in regards to review of thirty (30) or sixty (60) day Physician Order Sheets generated for the facility. The Pharmacist stated it is her responsibility to review all of the residents' Physician Order Sheets monthly and report any irregularities to the attending physician and the DON. The Pharmacist also stated it was her fault for not "catching" the error in directions for the Prozac 20mg for Resident #2. However, her monthly review for Resident #2's latest Physician Order Sheet was after the facility nursing staff had documented that the orders were accurate.</p>	F 281			



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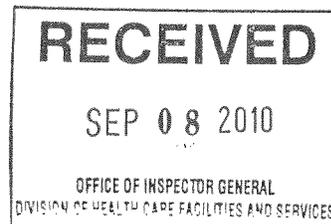
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F 371 SS=E	<p>Interview with a PCA Pharmacy LPN on 08/12/10 at 3:00pm revealed the pharmacy received a carbon copy of the resident's previous months' orders and corrections were made on these orders from physician orders faxed to the pharmacy from the facility. She stated that once the new order sheets were printed, they were sent to the facility. The PCA Pharmacy LPN also stated there was no pharmacy quality check of the new Physician Order Sheet once it was printed and prior to being sent to the facility.</p> <p>483.35(l) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to store food under sanitary conditions. Observation during the initial tour of the kitchen revealed the walk-in freezer had a large ice formation on the ceiling near the fan, multiple frozen products in the walk-in freezer which were open to air and unlabeled, multiple expired food items, and one uncovered item in the walk-in refrigerator. Observation during the sanitation tour found the inside and outside temperature of the walk-in freezer to be ten (10)</p>	F 371	<ol style="list-style-type: none"> On 8/13/2010, the ice buildup in the walk in freezer was addressed by the Maintenance Director. The walk-in, freezer and reach in were all checked by F D Pierce Company on 8/19/2010. F D Pierce Company found walk-in, freezer and reach in to be working properly and no repairs were needed and no food items were affected. The Dietary Manager will re-educate her staff regarding our policies on expired food, labeling of food items and recording of temperatures of equipment. The Dietary Manager will do an audit for 4 weeks; checking the temperature logs, labeling of food items and checking for expired food items. Following the 4 weeks of audits, it will be the cook's responsibility to monitor these areas. The dietician consultant will conduct a sanitation inspection quarterly to ensure we remain in compliance. 	9-20-10



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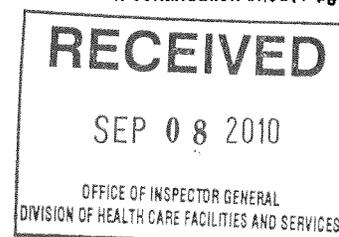
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F 371	<p>Continued From page 8</p> <p>degrees Fahrenheit, while the reach-in refrigerator temperature was fifty (50) degrees Fahrenheit outside, and fifty-one (51) degrees Fahrenheit inside.</p> <p>The findings include:</p> <p>Upon record review, facility policy 7.2 states that foods removed from original containers are to be clearly marked with contents, dated, and wrapped to exclude as much air as possible. Policy 7.2 also states that frozen foods are to be held at a temperature less than or equal to zero (0) degrees Fahrenheit, while refrigerated foods are maintained at a temperature of less than or equal to forty-one (41) degrees Fahrenheit. Facility policy 8.14 indicates that leftovers are to be checked daily, and discarded after 3 days.</p> <p>Observation during the initial tour of the kitchen revealed an ice formation on the ceiling of the walk-in freezer near the fan, approximately the size of a football. Multiple frozen products in the walk-in freezer were found to be open to air and unlabeled including: a bag of six (6) pepperoni pizzas, two (2) boxes of mixed vegetables, one (1) box of carrots, four (4) boxes of cookie dough, and one (1) box of unbreaded fish fillets. Observation of the walk-in refrigerator revealed one (1) gallon of grape drink unsealed and unlabeled, and one (1) gallon container of red-skinned potato salad with an expiration date of 07/21/10. Also the walk-in refrigerator contained left-over containers of pineapple dated 08/03/10, and green beans dated 08/08/10.</p> <p>Interview with the Dietary Director on 08/10/10 at 10:00am regarding items open to air in the freezer and refrigerator which were unlabeled</p>	F 371		



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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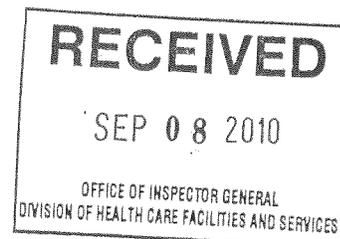
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185311	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/12/2010
NAME OF PROVIDER OR SUPPLIER ROCKFORD MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 4700 QUINN DR. 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 371	Continued From page 9 found that staff have been trained to reseat opened items and label with date opened. The Dietary Director was uncertain of the policy on storage of left-over's stating the rule changes frequently. It was thought that the expired item went unidentified. Interview with the Dietary Director on 08/12/10 at 2:05pm regarding the ice formation on the ceiling of the walk-in indicated that she reported the ice build-up on 08/11/10. The Dietary Director agreed that the ice was football-size and created a potential for cross-contamination. She explained that the Maintenance department was responsible for repair/maintenance of the freezer. The Dietary Director had no explanation for the elevated temperature in the freezer, but said she would contact Maintenance immediately. It was revealed that all the food in the reach-in refrigerator was moved to the walk-in the night before because of elevated temperatures. Upon discussion of the elevated temperatures in the reach-in refrigerator, the Dietary Director moved the food to the walk-in refrigerator and said a request for service would be initiated with a contracted repair company. Interview with the Maintenance Director on 08/12/10 at 3:00pm regarding the ice formation indicated the request for service was received on 08/11/10 and the work would be completed on 08/13/10. He stated the ice build-up occurs "from time to time, and it was not a problem." He said the maintenance included turning off the freezer and hosing off the coils to melt the ice. Regarding the temperature of the freezer, he stated the temperature was coming down now.	F 371		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON	F 428		



DEPARTMENT OF HEALTH AND HUMAN 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 08/12/2010
NAME OF PROVIDER OR SUPPLIER ROCKFORD MANOR			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)	(X6) COMPLETION DATE
F 428	Continued From page 10 The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility Pharmacist failed to recognize a medication order irregularity and report it to the attending physician and the Director of Nursing (DON) for one (1) of twenty-two (22) sampled residents. (Resident #2) The findings include: Record review on 08/10/10 for Resident #2 revealed the resident was admitted to the facility on 12/11/06 with diagnoses to include, Left Hemiplegia Residual Status Post Cerebrovascular Accident, Diabetes Mellitus, and Hypertension. Review of the Minimum Data Sheet (MDS) assessment for cognition dated 06/01/10 revealed Resident #2 to have a score of zero (0) indicating the resident was capable of daily decision-making and indicating the resident was interviewable. Review of the most current sixty day Physician Order Sheet revealed an error on the directions for a medication (Prozac 20mg.) order, specifically the order for Prozac 20milligrams read "Fluoxetine 20mg. capsule,	F 428	F428 1. Resident #2 did receive the correct dose of Prozac as ordered by the physician. Pharmacy was notified on 8/10/10 and the error in pharmacy direction was corrected. 2. The pharmacy consultant started an audit of all resident charts on 8/30/2010 with a completion of all audits by 9/20/2010 and will report all findings to the DON. 3. At least monthly, the pharmacist consultant will review each resident's physician orders Sheets and report any discrepancy to the DON and pharmacy. 4. A 20 % chart audit will be completed quarterly to compare current 30/60 day physician order sheets to previous 30/60 day physician order sheets by the DON or her designee. All audits will be reported at the Facility QA committee meetings for review.	9-20-10



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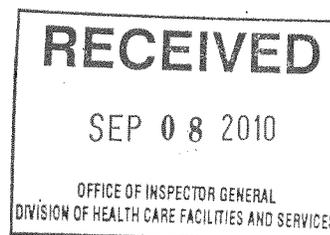
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185311	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/12/2010
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NAME OF PROVIDER OR SUPPLIER ROCKFORD MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 4700 QUINN DR. LOUISVILLE, KY 40216
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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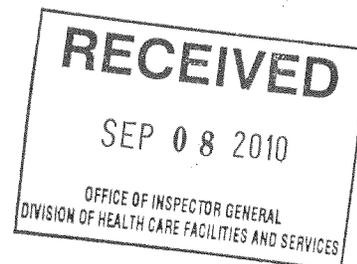
F 428	<p>Continued From page 11</p> <p>Prozac 20mg. pulvule, give 1 capsule orally, with 10mg=20mg every day for depression". This order sheet was signed and dated by a facility nurse as having been verified as accurate. Further record review revealed the original order for thirty (30) milligrams of Prozac daily was written on 02/19/10. The current Medication Administration Record (MAR) (written per the most current Physician Order Sheet) revealed the same directions for the Prozac 20mg order. Review of the current Medication Administration Record also revealed multiple nurses over the past 5 1/2 months had documented that one (1) 10mg plus one (1) 20mg Prozac had been given per the original physician's order to equal 30mg daily.</p> <p>Interview with the DON on 08/12/10 at 2:10pm revealed this was an error in the pharmacy directions for the Prozac 20mg administration and it should have been recognized and reported prior to surveyor intervention by nursing staff or the consulting Pharmacist.</p> <p>Interview with the consulting Pharmacist on 08/12/10 at 2:30pm revealed the surveyor should contact the PCA Pharmacy regarding any quality checks they did in regards to review of thirty (30) or sixty (60) day Physician Order Sheets generated for the facility. The Pharmacist stated it is her responsibility to review all of the residents' Physician Order Sheets monthly and report any irregularities to the attending physician and the DON. The Pharmacist also stated it was her fault for not 'catching' the error in directions for the Prozac 20mg for Resident #2.</p> <p>Interview with a PCA Pharmacy LPN on 08/12/10 at 3:00pm revealed the pharmacy received a</p>	F 428		
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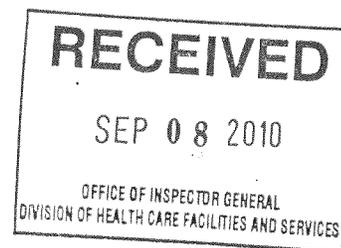
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 188311	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/12/2010
NAME OF PROVIDER OR SUPPLIER ROCKFORD MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 4700 QUINN DR. 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 441	<p>Continued From page 13 hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to maintain sanitary conditions in food handling as evidenced by observation of six (6) staff handling residents' food with bare hands on one or more occasions.</p> <p>The findings include:</p> <p>Record review of facility's Infection Control policy mandates employees with communicable disease or infected skin lesions are prohibited from contact with residents' or their food, and that employees with direct resident contact are required to wash their hands in accordance with infection control/universal precautions guidelines.</p> <p>1. Observation on 08/10/10 at 12:25pm revealed CNA #2 assisted the resident in room C09 with lunch and removed a ham sandwich from the wrapper with bare hands. The CNA also assisted the resident in room A04 by picking up red-skinned potatoes with bare hands to remove the skins. Additional observation at 12:40pm found CNA #2 assisted the resident in room C08 with lunch and removed two peanut butter sandwiches from the wrappers with bare hands.</p>	F 441		



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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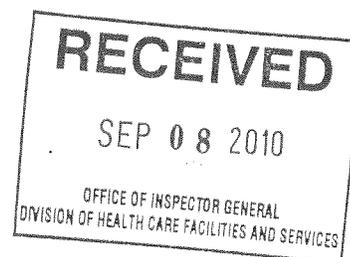
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185311	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/12/2010
NAME OF PROVIDER OR SUPPLIER ROCKFORD MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 4700 QUINN DR. 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 441	Continued From page 14 Observation on 08/11/05 at 8:15am revealed CNA #4 assisted Resident #15 with breakfast by spreading the butter on the bread with her bare hands. Observation on 08/11/10 at 8:25am revealed CNA #3 assisted the resident in room A04 with breakfast by buttering toast with bare hands. Interview on 08/11/10 at 8:15am with CNA #4 regarding handling of food revealed they were trained to wash their hands and it was acceptable to touch food with clean hands. Interview with CNA #2 on 08/11/10 at 8:45am revealed the CNA was trained to use hand-sanitizer between delivery of each resident's food tray and that it was acceptable to touch food with bare hands as long as the hands were clean. Interview with CNA #3 on 08/11/10 at 9:00am regarding handling of food indicated the CNA was trained to keep hands off the resident's food as much as possible, but that it was acceptable to touch the food with bare hands if contact was unavoidable. Interview with the Infection Control Nurse on 8/12/10 at 11:40am regarding the policy on handling of ready to eat foods indicated the staff were not to touch the food at all even to butter the bread, but if it is necessary to touch the food, gloves should be worn. Interview with the Director of Nursing (DON) on 08/12/10 at 3:35pm regarding handling of food revealed that staff were instructed to use gloves if it was necessary to handle food, and that it would	F 441		



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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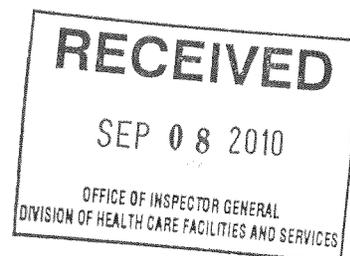
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185311	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/12/2010
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F 441	<p>Continued From page 15</p> <p>not be acceptable to touch ready to eat food with bare hands.</p> <p>2. Observation on 08/11/10 at 8:15am revealed CNA #1 had straightened the bed covers and repositioned the resident in room D14. The CNA then set up the breakfast tray and spread jam on toast with her bare hands. In addition, further observation revealed the CNA had also spread jam on toast with her bare hands for the resident in room D9.</p> <p>Interview on 08/11/10 at 8:35am with CNA #1 revealed she thought it was "OK" to pick up food with her bare hands as long as she had washed them prior to and after handling the food. She stated she was told something new about wearing gloves with handling food; however, it was not enforced.</p> <p>3. Observation on 08/11/10 at 8:15am revealed CNA #4 touched Resident #15's bread with bare hands.</p> <p>Observation on 08/11/10 at 8:20am revealed CNA #5 touched several whole tomatoes for Resident #10 with her bare hands.</p> <p>Interview with CNA #4 on 08/11/10 at 8:15am revealed she had been trained on the facility infection control practice and it was her understanding that if she washed her hands first it would be okay to touch the residents' food with her bare hands.</p> <p>Interview with CNA #5 on 08/11/10 at 8:20am revealed she also had been trained on the facility infection control practice and it was her understanding that if she washed her hands first it</p>	F 441		



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

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F 441	Continued From page 16	F 441		
F 456 SS=E	<p>would be okay to touch the residents' food with her bare hands.</p> <p>483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION</p> <p>The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to maintain essential resident equipment in safe operating condition for ten (10) unsampled residents, specifically, in regards to torn and frayed wheelchair and cardiac chair armrests.</p> <p>The findings include:</p> <p>Observation on 08/10/10 from 9:00am to 5:30pm and on 08/11/10 from 7:45am to 5:30pm revealed wheelchairs for nine (9) unsampled residents and one (1) cardiac chair for an unsampled resident had torn and frayed armrests with sharp edges to the covering of the armrests.</p> <p>Interview with the Maintenance Director on 08/12/10 at 7:30am revealed the Therapy Department is responsible to order armrests for the facility wheelchairs and the Therapy Department personnel would replace those armrests when frayed. He stated he did not know if this was done only for the residents receiving therapy services. He further stated he sometimes received work orders to replace wheelchair armrests and if he did he would go to the Therapy Department to get the armrests or have the</p>	F 456	<p>F 456</p> <ol style="list-style-type: none"> 1. Replacement arm rests have been ordered and are being placed on wheelchairs with torn or frayed arm rests by the Asst. Maintenance Director. 2. An audit of all wheelchairs currently in use was conducted by the nursing staff and the therapy staff during the week of August 31st-Sept.3, 2010. this audit was given to the DON and Asst. Maintenance Director to replace torn/frayed arm rests. 3. A quarterly audit will be conducted by the Maintenance Director or Asst. Maintenance Director of all wheelchairs in use and repairs will be made by the Maintenance Department. 4. The monthly audit of wheelchairs in use will be given to the administrator for review on a monthly basis. 	9.20.10



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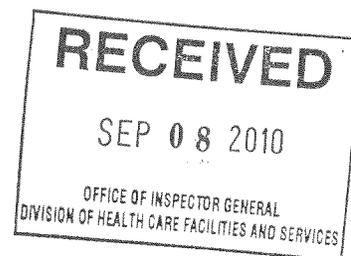
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185311	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/12/2010
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NAME OF PROVIDER OR SUPPLIER ROCKFORD MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 4700 QUINN DR. LOUISVILLE, KY 40216
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F 456	<p>Continued From page 17 Therapy Department order the needed parts.</p> <p>Interview with the Therapy Department Manager on 08/12/10 at 1:25pm revealed the Therapy Department is not responsible to monitor wheelchairs for the condition of the armrests but if a resident is receiving services in the Therapy Department the staff there would try to fix the armrests.</p> <p>Interview with the Occupational Therapy Assistant on 08/12/10 at 1:30pm revealed the Therapy Department kept no stock of wheelchair armrests to use as replacements for torn, frayed armrests. She stated if any of the Therapy Department staff noticed wheelchairs for residents not receiving their services needing repairs those would be referred to the Maintenance Department. The Occupational Therapy Assistant also stated that there used to be a staff person at the facility who was responsible for wheelchair maintenance but he had left about a year ago and no one was responsible for wheelchair repairs after that staff person had left.</p> <p>Interview with the Administrator on 08/12/10 at 3:30pm revealed wheelchair repairs had not been included in the monthly quality assurance meeting and she was aware there were wheelchairs in the facility which needed repairs to include replacement armrests. She stated she had received a purchase request from the therapy department for replacement wheelchair parts but that request had not been filled by survey date.</p>	F 456		
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 188311	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/12/2010
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NAME OF PROVIDER OR SUPPLIER ROCKFORD MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 4700 QUINN DR. LOUISVILLE, KY 40216
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K 000	INITIAL COMMENTS	K 000		
K 025 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to maintain smoke barrier walls according to NFPA standards.</p> <p>The findings include:</p> <p>Observation on 08/12/10 at 9:05am revealed that the smoke barrier wall above the cross corridor doors for the Main Hall had a hole in which metal conduit was running through. Further observation revealed that the smoke barrier wall in the A Hall above room 3 had a (1) inch size hole that had a telephone line running through it. The</p>	K 025		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE x ADON	(X6) DATE 08/10/10
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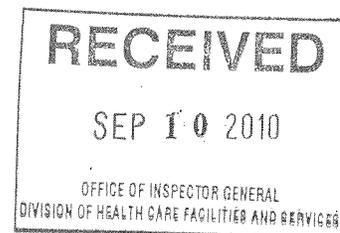
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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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DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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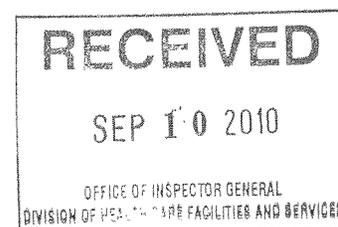
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185311	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/12/2010
NAME OF PROVIDER OR SUPPLIER ROCKFORD MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 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
K 062	<p>Continued From page 2</p> <p>periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure sprinkler heads were maintained according to NFPA standards.</p> <p>The findings include:</p> <p>Observation on 08/12/10 at 9:40am, revealed that (6) sprinkler heads in the Kitchen area were dirty from a buildup of grease. Further observation revealed (1) sprinkler head in the kitchen area had paint on the deflector and struts. The observation was confirmed with the Maintenance Director.</p> <p>Interview on 08/12/10 at 9:40am, with the Maintenance Director, revealed that he was unaware of the sprinkler heads being dirty.</p> <p>Reference: NFPA 25 (1998 Edition).</p> <p>2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation.</p>	K 062	<p>1. The painted sprinkler head in the Dietary Department will be replaced by Kentuckiana Sprinkler Company.</p> <p>2. All sprinkler heads will be inspected by the Maintenance Department. All dirty sprinkler heads will be cleaned.</p> <p>3. All sprinkler heads will be inspected monthly by the Maintenance Director or his Assistant. The monthly QA form includes checking sprinkler heads.</p> <p>4. A report will be provided and reviewed at the monthly Safety Committee meeting and at the Facility QA meeting.</p> <p>9-21-10</p>
K 072 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Means of egress are continuously maintained free</p>	K 072	



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

PRINTED: 08/28/2010
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 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/12/2010
NAME OF PROVIDER OR SUPPLIER ROCKFORD MANOR			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
K 144	Continued From page 4 This STANDARD is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that the emergency generator was maintained according to NFPA standards. The findings include: Record review on 08/12/2010 at 10:00 AM, revealed that from 08/06/10 to 08/09/2010 the facility was using portable generators due to the main emergency generator being down for repairs. Interview on 08/12/2010 at 10:00 AM, with the Maintenance Director, revealed that the portable generators was not hook directly to the building, and if the building would have had to use the portable generators he would have had to hook the portable generators up to the building. Further interview revealed that the Maintenance Director was the only person during that time period that could hook the portable generators up for emergency power and that after hours if he was called in it would take him approximately 20 minutes to reach the facility. Reference: NFPA 99 (1999 edition) 3-5.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches. (a) Maintenance of Alternate Power Source. The generator set or other alternate power source and associated equipment, including all appurtenant	K 144	1. Rockford Manor's emergency generator automatically runs under load for 30 minutes every Thursday. 2. Our generator is fully functional and meets the requirements per state regulations. In the event of a generator failure we have arrangements to obtain portable generators for our facility. <i>9-2-10</i> 3. The Maintenance Director monitors the generator and results are recorded weekly on the Maintenance Security form. 4. Any irregularities will be reported immediately to the Administrator and Regional Maintenance Director.	



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

SEP 08 2010

PRINTED: 08/26/2010
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 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/12/2010
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NAME OF PROVIDER OR SUPPLIER ROCKFORD MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 4700 QUINN DR. LOUISVILLE, KY 40216
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K 000	INITIAL COMMENTS	K 000		
K 025 SS=D	<p>A Life Safety Code survey was initiated and concluded on 08/12/10. The facility was found not to meet the minimal requirements with 42 Code of the Federal Regulations, Part 483.70. The highest scope and severity deficiency identified was an "F".</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to maintain smoke barrier walls according to NFPA standards.</p> <p>The findings include:</p> <p>Observation on 08/12/10 at 9:06am revealed that the smoke barrier wall above the cross corridor doors for the Main Hall had a hole in which metal conduit was running through. Further observation revealed that the smoke barrier wall in the A Hall above room 3 had a (1) Inch size hole that had a telephone line running through it. The</p>	K 025	<p>K 025</p> <ol style="list-style-type: none"> The 2 small holes were repaired by the Maintenance Director on September 3rd. All smoke barrier walls have been inspected for openings by the Maintenance Director on September 3rd. The Maintenance Director will do monthly checks for holes in smoke barrier walls. This will be added to his weekly maintenance checklist. All subcontractors will be required to demonstrate to the Maintenance Director that any holes they create are repaired prior to completion of job. Results of the monthly checklist will be reviewed by the Administrator and a summary report will be presented at the monthly safety committee meeting. 	9-7-10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *[Signature]* (X6) DATE 9-7-10

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.

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 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/12/2010
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NAME OF PROVIDER OR SUPPLIER ROCKFORD MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 4700 QUINN DR. LOUISVILLE, KY 40216
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X8) COMPLETION DATE
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K 025	<p>Continued From page 1 observation was confirmed with the Maintenance Director.</p> <p>Interview on 08/12/10 at 9:05am, with the Maintenance Director, revealed that he was unaware of the holes in the smoke barrier walls.</p> <p>Reference: NFPA 101 2000 edition</p> <p>8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows:</p> <p>(a) The space between the penetrating item and the smoke barrier shall</p> <ol style="list-style-type: none"> 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. <p>(b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall</p> <ol style="list-style-type: none"> 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. <p>(c) Where designs take transmission of vibration into consideration, any vibration isolation shall</p> <ol style="list-style-type: none"> 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose. 	K 025		
K 062 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested</p>	K 062		

RECEIVED

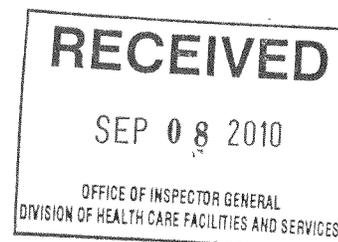
SEP 08 2010

OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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

PRINTED: 08/26/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 188311	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/12/2010
NAME OF PROVIDER OR SUPPLIER ROCKFORD MANOR			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)	(X8) COMPLETION DATE
K 062	Continued From page 2 periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.6 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure sprinkler heads were maintained according to NFPA standards. The findings include: Observation on 08/12/10 at 9:40am, revealed that (6) sprinkler heads in the Kitchen area were dirty from a buildup of grease. Further observation revealed (1) sprinkler head in the kitchen area had paint on the deflector and struts. The observation was confirmed with the Maintenance Director. Interview on 08/12/10 at 9:40am, with the Maintenance Director, revealed that he was unaware of the sprinkler heads being dirty. Reference: NFPA 25 (1998 Edition). 2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation.	K 062	K 062 1. The dirty /painted sprinkler heads noted in the dietary department have been cleaned by the Maintenance Director. 2. All sprinklered heads will be inspected by the Maintenance Director by 9/20/2010. all dirty sprinkler heads will be cleaned. 3. All sprinkler heads will be inspected monthly by the Maintenance Director or his Assistant. The monthly QA form includes checking of sprinkler heads. 4. A report will be provided monthly at the Safety Committee meeting and at the Facility QA meeting.	9-20-10
K 072 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free	K 072		



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

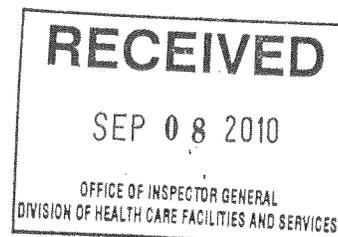
PRINTED: 08/26/2010
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185311	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/12/2010
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NAME OF PROVIDER OR SUPPLIER ROCKFORD MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 4700 QUINN DR. LOUISVILLE, KY 40216
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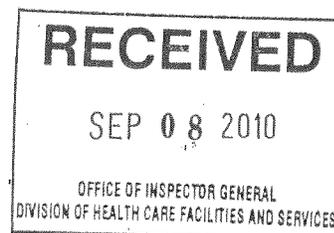
K 072	<p>Continued From page 3</p> <p>of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that corridors were maintained free from obstructions to full instant use in the case of fire or other emergency.</p> <p>The findings include:</p> <p>Observation on 08/12/10 at 8:56am revealed a clean linen cart was noted to not be in use and unattended in Hallway D. Further observation revealed that in Hallways C, and B had clean linen carts not in use and unattended. Corridors are intended for means of egress, internal traffic and emergency use, not storage spaces. The Life Safety Code has specific requirements for storage spaces. These items would also limit the use of the hand rails by occupants of the building when needed.</p> <p>Interview on 08/12/2010 at 9:45 AM, with the Maintenance Director, revealed that the clean linens carts were routinely left in the hallways due to lack of storage space.</p>	K 072	<p>K 072</p> <ol style="list-style-type: none"> 1. Rockford Manor will maintain safe and clutter free corridors to allow full instant use in accordance with NFPA requirements. 2. Linen carts will be stored of the halls in the laundry room when not in use and they will be moved and relocated every 30 minutes while in use. 3. Staff will be reminded of this requirement at our September 8th in-service conducted by the DON. The facility environment will be monitored by use of an Environmental Audit monthly to ensure continued compliance. 4. This plan of correction will be incorporated into the QA and Safety programs. 	9-20-10
K 144 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 09. 3.4.4.1.</p>	K 144		



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

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NAME OF PROVIDER OR SUPPLIER ROCKFORD MANOR		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)
K 144	<p>Continued From page 4</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that the emergency generator was maintained according to NFPA standards.</p> <p>The findings include:</p> <p>Record review on 08/12/2010 at 10:00 AM, revealed that from 08/06/10 to 08/09/2010 the facility was using portable generators due to the main emergency generator being down for repairs.</p> <p>Interview on 08/12/2010 at 10:00 AM, with the Maintenance Director, revealed that the portable generators was not hook directly to the building, and if the building would have had to use the portable generators he would have had to hook the portable generators up to the building. Further interview revealed that the Maintenance Director was the only person during that time period that could hook the portable generators up for emergency power and that after hours if he was called in it would take him approximately 20 minutes to reach the facility.</p> <p>Reference: NFPA 99 (1999 edition) 3-5.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches. (a) Maintenance of Alternate Power Source. The generator set or other alternate power source and associated equipment, including all appurtenant</p>	K 144	<p>1. Our emergency generator automatically runs under load for 30 minutes every Thursday.</p> <p>2. On Thursday August 5th ⁹⁻¹⁻¹⁰ our generator did not kick on as normal. This is the first time our generator has failed. Therefore, it is an isolated incident. We have no little control over malfunctions and we cannot predict when any piece of equipment will fail. A call was made immediately to have the generator inspected and repaired. However, during this time we took precautionary actions by borrowing portable generators from another facility in the event of a power failure. The generator has been repaired and there is no need to have portable generators.</p> <p>3. The Maintenance Director monitors the generator and the results are recorded weekly on the maintenance Security form.</p> <p>4. Any irregularities will be reported the the Administrator.</p>



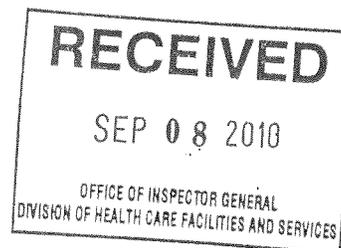
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/26/2010
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186311	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/12/2010
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NAME OF PROVIDER OR SUPPLIER ROCKFORD MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 4700 QUINN DR. LOUISVILLE, KY 40216
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K 144	Continued From page 5 parts, shall be so maintained as to be capable of supplying service within the shortest time practicable and within the 10-second interval specified in 3-4.1.1.8 and 3-5.3.1.	K 144	K 147	9-10-10
K 147 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure electrical wiring was maintained according to NFPA standards.</p> <p>Observation on 08/12/2010 at 9:49 AM, revealed that the cover was missing from the electrical wall socket in room A2. The observation was confirmed with the Maintenance Director.</p> <p>Interview on 08/12/2010 at 9:49 AM, with the Maintenance Director, revealed that he audits the rooms once a month for problem such as the missing cover from the electrical wall socket, and nursing staff have a policy for reports maintenance issues, but that he was unaware of the missing cover for the electrical wall socket.</p> <p>Reference: NFPA 70 1999 edition 110.27 Guarding of Live Parts. (A) Live Parts Guarded Against Accidental Contact. Except as elsewhere required or permitted by this Code, live parts of electrical equipment operating at 50 volts or more shall be guarded against accidental contact by approved</p>	K 147	<ol style="list-style-type: none"> 1. The receptacle cover was replaced immediately in Room A 2 by the Maintenance Assistant. 2. A complete audit of all rooms will be completed by the Maintenance Department by 9/10/2010 to ensure no other receptacle covers are missing. 3. The nursing staff will be reminded to advise Maintenance Department of any problems with any electrical wiring, receptacle covers or other safety issues. This will be addressed in the September 8th in-service by the ADM and/or DON. 4. The department directors will make rounds of resident's rooms prior to our monthly safety committee. They will check all receptacle cover to ensure they are not missing from the sockets. Any missing receptacle cover will be replaced immediately. The Maintenance Director will report all electrical repairs at the monthly safety committee. 	



DEPARTMENT OF HEALTH AND HUMAN SERVICES
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K 147	Continued From page 6 enclosures or by any of the following means: (1) By location in a room, vault, or similar enclosure that is accessible only to qualified persons. (2) By suitable permanent, substantial partitions or screens arranged so that only qualified persons have access to the space within reach of the live parts. Any openings in such partitions or screens shall be sized and located so that persons are not likely to come into accidental contact with the live parts or to bring conducting objects into contact with them. (3) By location on a suitable balcony, gallery, or platform elevated and arranged so as to exclude unqualified persons. (4) By elevation of 2.5 m (8 ft) or more above the floor or other working surface. (B) Prevent Physical Damage. In locations where electric equipment is likely to be exposed to physical damage, enclosures or guards shall be so arranged and of such strength as to prevent such damage. (C) Warning Signs. Entrances to rooms and other guarded locations that contain exposed live parts shall be marked with conspicuous warning signs forbidding unqualified persons to enter.	K 147		

