

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

PRINTED: 12/20/2012
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 12/07/2012
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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 A standard health survey was initiated on 12/04/12 and concluded on 12/07/12 with a Life Safety Code survey initiated and concluded on 12/05/12. Deficiencies were cited with the highest scope and severity of an "F". The facility had the opportunity to correct the deficiencies before remedies would be recommended for imposition. An abbreviated survey investigating KY19487 was initiated on 12/06/12 and concluded on 12/07/12. The Division of Health Care found the allegation of KY19487 unsubstantiated with no deficiencies cited.	F 000	The preparation of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiency. This Plan of Correction is prepared and executed solely because it is required by Federal and State Law.	
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on interview, record review and policy review, it was determined the facility failed to place the last three (3) abbreviated survey investigation results in the survey book accessible to residents.	F 167	F-167 N 045 1. The abbreviated survey results from 10-4-12, 10-25-12 and 11-28-12 were placed in the survey binder located in the front lobby on 12-31-12 by the facility Administrator 2. Director of Nursing reviewed survey results in the binder in the front lobby to ensure results of all surveys conducted over last 3 years were present in the binder. This was completed on 12-31-12	1-1-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: *ADM* (X6) DATE: *1-1-13*

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 167 Continued From page 1
The findings include:

Record review of the Examination of Survey Results Policy, dated 07/27/08, revealed all Federal and State surveys from the past three (3) years, including the most recent inspection report were available at all times. The procedure was to update the survey binder after receipt of any survey results.

Record review of the abbreviated surveys which were completed on offsite, revealed a complaint was completed on 11/28/12 with the finding of substantiated with no deficiencies, a complaint was completed on 10/25/12 with the findings of unsubstantiated with no deficiencies and a complaint was completed on 10/04/12 with the finding of substantiated with no deficiencies.

Record review of the Survey Binder, on 12/06/12 at 3:00 PM, revealed no abbreviated surveys were placed in the survey binder after the date of 05/25/12.

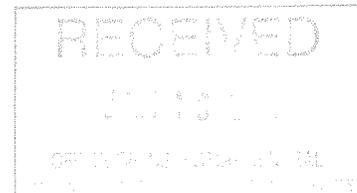
Interview with the Director of Nursing (DON), on 12/06/12 at 3:15 PM, revealed she did not place the abbreviated survey results in the survey binder, if the survey results was concluded by the state agency as having no regulatory violations. Further interview on, 12/06/12 at 5:47 PM, revealed she was not aware the abbreviated survey results were to be placed in the survey binder, no matter what the outcome of the investigation was.

F 167

- Corporate Clinical Consultant reviewed with Administrator and Director of Nursing the facility policy on Examination of Survey Results on 12-31-12. All results of any conducted survey by Federal or State Surveyors will be placed in survey binder located in front lobby. It will be the responsibility of the Administrator to place the results in the binder.
- Director of Nursing will audit the contents of the survey binder located in the front lobby monthly for three months then no less than quarterly. Audit findings will be presented to the facility QA Committee no less than quarterly.

F 248 483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES
SS=E
The facility must provide for an ongoing program

F 248



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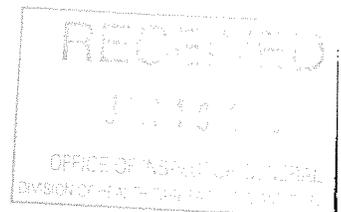
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F 248	<p>Continued From page 2</p> <p>of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy Activity Department, it was determined the facility failed to provide activities which met the needs and interests for five (5) of the twenty-two (22) sampled residents (# 5, 8, 15, 17, and 18) and six (6) of the fourteen (14) unsampled residents (C, I, J, K, L, and M). The facility did not provide an activity on the nationally recognized holidays of Thanksgiving, and Christmas.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Activity Department: Purpose, Intent and Development, not dated, revealed a purpose to provide an ongoing, organized program of activities designed in accordance with the comprehensive assessment, to meet the interests and to maintain the physical, mental, and psychosocial well-being of each resident. The policy revealed the activities program was an essential component of the facility's fulfillment of its obligation to care for its residents in a manner and environment that maintain or enhance each resident's quality of life. Further review of the policy revealed development of the activities program was an ongoing process, using resident's feedback via initial assessments, Minimum Data Set (MDS) section F and</p>	F 248	<p>1. The Activity Director met with the DON on 12-14-12 and planned out activities to be done by the nursing staff on Christmas Eve and Christmas Day. Materials were given to the DON to present to the CNAs who would be hosting the Christmas gathering on Christmas morning and a Christmas movie that night. On Christmas Eve morning staff played "Twelve Days of Christmas" bingo and had a special Christmas ice cream social Christmas Eve afternoon. Some 1:1s visits were also made by staff.</p> <p>Residents were asked what they would like to do for New Year's Eve by Activity Director on Saturday, December 29th, 2012. Resident #5, #14, #9 and Resident M requested a New Year's Eve party with meat/cheese tray, and cheese balls. This was all provided on New Year's Eve 12-31-12.</p> <p>Resident # 17 attended all activities offered on 12/24/12 (12 Days of Christmas Bingo) and the Christmas Gathering on 12/25/12.</p> <p>Resident #18 attended Bingo, Bunco and the Ice Cream social on 12/24/12. He/she attended both activities offered on 12/25/12.</p> <p>Resident "C" attended all activities offered on 12/24/12; he/she left the facility to visit with family on 12/25/12.</p> <p>Resident "I" attended all activities offered on 12/24/12, as well as having visitors. He/she left the facility to visit with family on 12/25/12.</p> <p>Resident "J" was in the bed by preference and did not come out to 12/24/12 activities. He/she attended the Christmas Gathering on 12/25/12.</p>	1-19-2013 1-20-2013
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F 248 Continued From page 3
conversation to build activity plans, calendar, one to one visits and self directed activities to meet the needs of each resident.

Review of the facility's activity calenders revealed there were no scheduled activities for Thanksgiving day, 11/22/12, Christmas Eve, 12/24/12, and Christmas Day, 12/25/12.

Observation of Resident #5, on 12/04/12 at 2:00 PM, revealed the resident was sitting in a wheelchair participating in the resident council meeting in the dining room.

Observation of Resident #5, on 12/04/12 at 3:30 PM, revealed the resident was in the dining room, sitting in a wheelchair, participating in a trivia activity.

Observation of Resident #5, on 12/06/12 at 3:30 PM, revealed the resident was sitting in a wheelchair, in the dining room, participating in the noodle balloon activity. The resident was laughing and smiling during the activity.

Review of Resident #5's MDS, dated 09/06/12, revealed the facility utilized a Brief Interview for Mental Status (BIMS) which determined a score of 13, that indicated an intact cognition and interviewable.

Interview with Resident #5, on 12/06/12 at 6:30 PM, revealed the resident would be staying in the facility for the Christmas Holiday. The resident revealed having no other place to go for the holidays. The resident revealed he/she was aware no activities were scheduled for Christmas Eve and Christmas Day and revealed he/she

F 248
Resident #5 attended Bingo on 12/24/12, and then left the facility to visit with family overnight, returning 12/25/12 afternoon. He/she refused participation in the 12/25/12 afternoon activity.

Resident #8 attended bingo and received one on one visit from staff as well as receiving visitors on both 12/24/12 and 12/25/12.

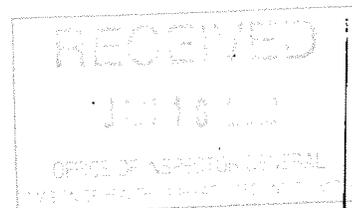
Resident #15 attended bingo on 12/24/12 and received visitors on both 12/24/12 and 12/25/12. Resident also received one on one visit from staff.

Resident "K" refused offers of activities on 12/24/12 and 12/25/12.

Resident "L" regularly refuses most activities. Resident received a visit from his/her brother on 12/24/12 and left the facility to visit with family on 12/25/12.

Resident "M" left facility 12/24 to stay overnight with family and significant other and returned 12/25. Resident refused activities before and after he/she left.

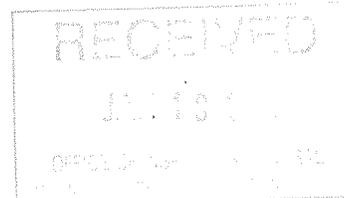
2. Activity Director will review the Activity Calendar with all interviewable resident s and resident council by 1-19-13 to get feedback on the activities planned for the upcoming month.



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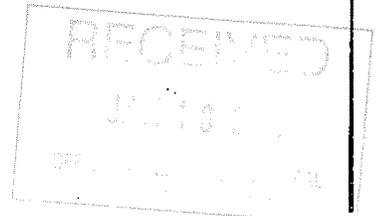
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F 248	<p>Continued From page 4</p> <p>would like to have something planned to do. The resident revealed he/she would definitely attend, and enjoy any activities that were provided. The resident revealed the facility did not provide any activities on Thanksgiving Day, and stated the facility had only provided a dinner that family had to pay to attend. The resident revealed not having anything planned made the day feel like just another day and not worth celebrating.</p> <p>Observation of Resident #8, on 12/05/12 at 10:45 AM, revealed the resident was sitting in a wheelchair, in the dining room, playing bingo. The resident yelled out "bingo", smiled and yelled out numbers to confirm the win. The resident continued to smile during the next game.</p> <p>Review of Resident #8's MDS, dated 09/13/12, revealed a BIMS score of 15, indicating intact cognition and interviewable.</p> <p>Interview with Resident #8, on 12/06/12 at 2:00 PM, revealed staff did not ask the residents what they would like to do for the holidays. The resident revealed the facility did not have activities on Thanksgiving Day, and they would like to have something to do for Christmas Eve and Christmas Day. The resident revealed just a movie was planned for those days and then Resident #8 was observed to shake his/her head back and forth and threw their hand in the air. The resident revealed the staff did not listen to the requests of the residents.</p> <p>Review of Resident #15's MDS, dated 11/27/12, revealed a BIMS score of 15, indicating intact cognition and interviewable.</p>	F 248	<p>3. Corporate Activity and Social Services Consultant to meet with Activity Director and review the current activity program, and provide education regarding the Activity Assessment, the MDS items related to activities, care planning as it related to activities, and establishing an activity program that meets the needs of each individual resident. This will be completed by 1-10-13 Activity Director to interview and complete a new Activity Assessment for each resident with the monthly Care Plan schedule beginning 1-1-13 and ongoing till a new assessment is completed for each resident. Corporate Activity and Social Service Consultant to review the Activity Calendar prior to implementation monthly for 6 months then quarterly to provide oversight and input regarding variety and the number of activities offered.</p> <p>Activity Director to maintain resident participation documentation to identify those activities that are well attended and to help determine resident preferences.</p> <p>4. Activity Director will conduct satisfaction surveys monthly for 3 months then quarterly with all interviewable residents to determine participation, choice and satisfaction related to the activity program. These surveys will be reviewed by the Corporate Consultant monthly. Corporate Consultant to report on the satisfaction surveys and her review of the activity program (including the calendar, activities provided, variety of activities offered, MDS Completion, activity assessment completion) to the QA Committee for one year.</p>	



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F 248	<p>Continued From page 5</p> <p>Interview with Resident #15, on 12/06/12 at 2:00 PM, revealed the resident did notice the activity calender and the lack of activities on the holidays, but did not say anything because facility staff do not listen to the requests of the residents. The resident said he would like to have something on the holidays, some sort of get together to make the day feel special.</p> <p>Interview with Resident #17, on 12/06/12 at 10:20 AM, revealed the facility had few activities on the weekends except church. She was disappointed in the lack of activities on Christmas Day.</p> <p>Interview with Resident #18, who was identified as interviewable by the facility, on 12/06/12 at 3:45 PM, revealed he/she did notice nothing was scheduled for Christmas Eve and Christmas Day. The resident revealed it would be nice if they did something other then just a movie.</p> <p>Interview with Unsampld Resident C, on 12/06/12 at 3:25 PM, who was identified as interviewable by the facility with a BIMS of 16, revealed no one had asked what the residents would like to do for the holidays. The resident revealed the facility had a Thanksgiving meal that family could participate in if they paid for their meal. The resident revealed most of the staff were off for the holidays.</p> <p>Interview with Unsampld Resident I, on 12/06/12 at 2:55 PM, identified as interviewable by the facility with a BIMS of 14 revealed he/she would like to have some sort of activity for Christmas and would definitely go if the facility provided something. The resident revealed no one had asked what they would like to do to celebrate the</p>	F 248	



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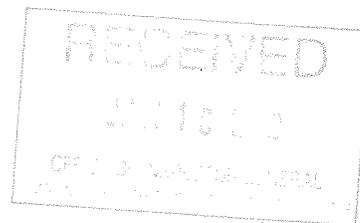
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F 248	<p>Continued From page 6 holidays.</p> <p>Interview with Unsampled Resident J, who was identified as interviewable by the facility, on 12/06/12 at 3:16 PM, revealed he/she would love to do something on Christmas Eve and Christmas Day. The resident revealed feeling it would be nice to celebrate the Holidays with everyone.</p> <p>Interview with Unsampled Resident K, on 12/06/12 at 3:00 PM, identified as interviewable by the facility with a BIMS of 13 revealed no one had asked was there something he/she would like to do for the Holidays. The resident revealed attending a facility party in years past and how much fun that was. The resident revealed if able, he/she would attend a Christmas Day activity.</p> <p>Interview with Unsampled Resident L, on 12/06/12 at 3:10 PM, identified as interviewable by the facility with a BIMS of 13 revealed being partially blind and watching a movie was not an appropriate activity. The resident revealed wishing he/she could participate in more activities. The resident revealed it would be nice to have carolers on Christmas Eve.</p> <p>Interview with Unsampled Resident M, on 12/06/12 at 6:30 PM, identified as interviewable by the facility with a BIMS of 14, revealed not having any other place to go and no family to visit on the Holidays. The resident revealed it would be nice to have something on Christmas Eve and Christmas Day and stated they would definitely attend.</p> <p>Interview with the Activities Director, on 12/06/12 at 3:35 PM, revealed she had been with the</p>	F 248		
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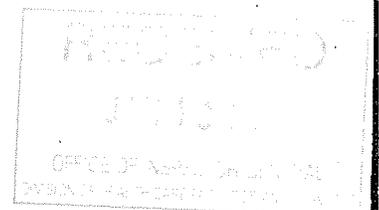
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F 248	<p>Continued From page 7</p> <p>facility for two (2) months. The Activities Director revealed she developed the activities and the calender. The Activities Director revealed she confers with the Activity Assistant to see what activities work and which ones the residents like to do. The Activities Director revealed the purpose of activities was to provide a purpose, ensure the quality of life, and enable them to continue with an interest they have had their whole life. She revealed there was also a therapy side too, it was as important, it was not just to keep them busy. It absolutely affects them emotionally and physically. It gave them the opportunity to use what they have mentally, physically, provides them enjoyment, a purpose, and will empower their lifestyle and their life. The Activities Director revealed on Thanksgiving Day the facility provided a dinner for the resident's family members. The family members could attend by purchasing a ticket to come to and eat with their loved ones, but no activity was provided. The Activities Director revealed she was told the facility did not do anything on the holidays by the Activities Assistant and the Administrator. The Activities Director revealed she personally felt there should be activities and scheduled the movies on Christmas Eve and Christmas Day because that would be something anyone could do.</p> <p>Interview with the Administrator, on 12/06/12 at 3:45 PM, revealed she was aware there were no activities on Thanksgiving and that nothing was planned for Christmas Eve or Christmas Day. The Administrator revealed a movie did not fulfill the needs of everyone, being that some cannot see, some cannot hear, and some cannot leave their room. She further reveled she had not</p>	F 248		
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F 248 Continued From page 8
asked the residents what they would like to do to celebrate the Holidays. The Administrator revealed she had told management staff they did not have to work on the holidays. The Administrator revealed no one had ever mentioned they had a problem with there being no activities on Holidays, and didn't know how her staff would take the news they would have to work. The Administrator revealed she didn't know if anyone would volunteer to come in and provide an activity.

F 256 SS=D 483.15(h)(5) ADEQUATE & COMFORTABLE LIGHTING LEVELS

The facility must provide adequate and comfortable lighting levels in all areas.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview and record review, it was determined the facility failed to provide adequate lighting in the room of one (1) resident of the twenty-two (22) sampled residents and fourteen (14) unsampled residents. Unsampled Resident #A.

The findings include:

No policy was provided by the facility.

Review of the clinical record revealed Unsampled Resident A had a BIM score of 15, which meant the resident was interviewable.

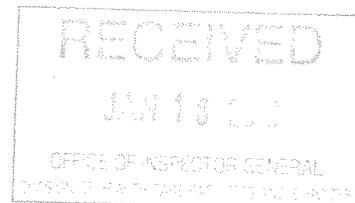
Observation of Unsampled Resident A's room, on 12/06/12 at 8:52 AM, revealed no overhead light was provided.

~~F 248~~
F 256

F 256

1. The over bed light for Resident A has been ordered. Resident A was offered a room change on 1-4-13 to another room with an over bed light until his was replaced and he refused the move. A light was placed on the bedside table until the over bed light is received and installed.
2. Maintenance Director and Director of Social Service audited each resident room on 1-11-13 to ensure that all residents had an over bed light or a replacement light and that all lights were properly functioning.
3. Administrator met with Director of Maintenance to review the deficient practice related to providing adequate and comfortable lighting and his role in ensuring the same on 1-11-13. Administrator reviewed with Director of Maintenance alternatives to over bed lighting including table top lights and floor lights.
4. Safety Committee Chairman to audit resident rooms monthly for 3 months then quarterly to ensure adequate lighting is provided. Finding of audits will be presented to the facility QA Committee no less than quarterly.

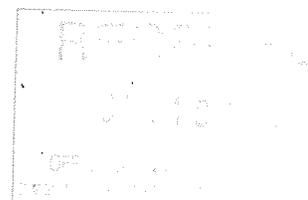
1-19-2013



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

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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 12/07/2012
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 256	Continued From page 9 Interview with Unsampld Resident A, on 12/06/12 at 8:52 AM, revealed he/she could not see clearly to read without adequate lighting provided. Interview with Certified Nursing Assistant (CNA) #1, on 12/06/12 at 1:57 PM, revealed Unsampld Resident A used to have an overhead light but he/she kept on adjusting the bed and the trapeze bar would hit the light and cause the light to fall. CNA #1 stated she thought the light was removed for safety and did not think to request another form of light for the resident to use. Interview with the Maintenance Director, on 12/06/12 at 11:30 AM, revealed he removed the overhead light because of the residents trapeze bar. The Maintenance Director further stated he did not think to accommodate the needs of Unsampld Resident A and no one told him to replace the light.	F 256		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns;	F 272		



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F 272 Continued From page 10
Communication;
Vision;
Mood and behavior patterns;
Psychosocial well-being;
Physical functioning and structural problems;
Continence;
Disease diagnosis and health conditions;
Dental and nutritional status;
Skin conditions;
Activity pursuit;
Medications;
Special treatments and procedures;
Discharge potential;
Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and
Documentation of participation in assessment.

F 272

1. A Comprehensive Assessment will be completed on Resident #4 with an ARD 1-4-13 by MDS Coordinator. A CAA related to the use of the Antipsychotic will be developed. On 12-31-12 a clarification order was given to add Anxiety as a reason for the use of the Antianxiety medication. A Psychiatric progress note written 12-28-12 by ARNP states Valium for diagnosis Anxiety. Residents Care Plan was reviewed by Director of Social Services on 12-28-12 for behaviors and specific interventions to manage the resident behaviors.

1-20-2013

For Resident#10 MDS staff developed a CAA related to the use of the Anticonvulsant used as Seizure/Mood Disorder and the resident care plan for behaviors was developed. The resident Care Plan was reviewed and revised to address the use of the Anticonvulsant for Mood Disorder and the residents behaviors. This was completed on 12-29-12

2. MDS staff will review all resident having triggered Mood and Psychotropic CAA on most recent comprehensive assessment. Each CAA was reviewed to ensure it accurately addressed the use of the medication and the residents behaviors. Addendums were added to the CAA if needed. This was completed by 1-19-13

3. Corporate Consultant will in service IDT on completion of CAA process. IDT to address identified areas in CAA resources to complete triggered CAA. In-service will be completed by 1-11-13. A post test will be administered on 1-17-13 to evaluate understanding of CAA process.

This REQUIREMENT is not met as evidenced by:

Based on interview, record review and review of the facility's policy, it was determined the facility failed to identify behaviors associated with the use of psychotropic medications in the comprehensive assessment of two (2) of twenty-two (22) sampled residents (Resident #4 and Resident #10) and fourteen (14) unsampled residents.

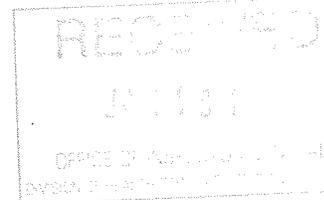
The findings include:



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F 272	Continued From page 11 Interview with the Director of Nursing (DON), on 11/06/12 at 1:00 PM, revealed the facility used the RAI Manual as the policy for completion of the Minimum Data Set (MDS). 1. Review of the clinical record for Resident #4, revealed the facility admitted the resident with diagnoses of Depression and Anxiety. The facility completed an annual MDS assessment on 02/04/12 which revealed the resident had a severe impairment in cognition, required extensive assistant with care and received an antianxiety medication for seizures. Review of the medication orders; however, revealed the resident received an antianxiety medication for the diagnosis of Anxiety. The facility was not able to provide documentation of the resident's behaviors in the CAA for antipsychotic medications utilization as required. In addition, the facility was not able to provide documentation of the medication's effectiveness on the resident. 2. Review of the clinical record for Resident #10, revealed the facility admitted the resident with diagnoses of Depression and Anxiety. The facility completed an annual MDS assessment on 09/01/12 which revealed the resident had a mild cognitive impairment, required extensive assistance with care and received a diuretic. Review of the physician orders dated 08/20/12, revealed the resident received an antipsychotic medication for mood. The facility could not provide documentation that the medication and behaviors were addressed in the CAAs. Interview with the MDS Nurse, on 12/06/12 at 3:10 PM, revealed she collected data on	F 272	4. Corporate consultant will audit 25% of comprehensive assessments completed monthly for three months, then 25% quarterly to ensure CAAs are completed accurately. Audit findings will be presented to Quality Assurance Committee for one year.		



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F 272 Continued From page 12
residents by reviewing physician orders, nursing documentation, 24 hour nursing report, and attending the daily nursing management meeting. She stated she was responsible for completion of the MDS and CAAs for residents. She stated she was not aware the physician ordered the antianxiety medication for anxiety on Resident #4 or the antipsychotic medication for Resident #10. She stated the resident's behaviors should have been addressed in the CAAs in order to assure the care plan addressed all the resident's needs.

Interview with the DON, on 12/06/12 at 4:00 PM, revealed her expectations were that residents MDS assessments were reflective of the residents status and Resident #4 and Resident #10's behaviors should have been addressed.

F 279 483.20(d), 483.20(k)(1) DEVELOP SS=D COMPREHENSIVE CARE PLANS

A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.

The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under

F 272

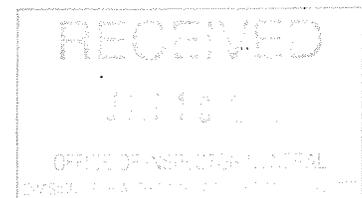
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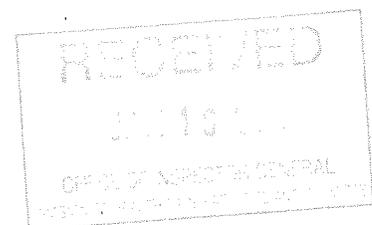
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F 279	<p>Continued From page 13</p> <p>§483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility failed to develop comprehensive care plans based on the Minimum Data Set (MDS) assessments for two (2) of twenty-two (22) sampled residents (Residents #4 and #10) and fourteen (14) unsampled residents. The facility failed to develop care plans to address Residents #4 and #10 behaviors for which they received psychotropic medications.</p> <p>The findings include:</p> <p>Interview with the Director of Nursing (DON), on 11/06/12 at 4:00 PM, revealed the facility used the RAI Manual as the facility policy for care planning.</p> <p>1. Review of the clinical record for Resident #4, revealed the facility admitted the resident with diagnoses of Depression and Anxiety. The facility completed an annual MDS assessment on 02/04/12 which revealed the resident had a cognitive impairment, was incontinent, required extensive assistance with care, and received psychotropic medications. Review of the care plan revealed the use of psychotropic medications for depression and anxiety. Interventions included anticipate needs, provide needed care and talk to resident during care. The resident's specific behaviors and interventions to manage those behaviors were</p>	F 279	<p>1. Care plan for Resident #4 reviewed and revised by Director of Social Service on 12-18-12 to include specific behavior and interventions to address behaviors. Add. Nurse aide assignment sheet updated to include individual interventions</p> <p>Care plan for Resident #10 reviewed and revised by Director of Social Service on 12-28-12 to include interventions to manage behaviors. Add. Nurse aide assignment sheet updated to include individual interventions</p> <p>2. Director of Social Service to review all resident behavior care plan for specific individualized intervention for behavior as indicated. The review will be completed by 1-19-13. Director of Social Services to review all Behavior Observation Profiles for last 60 days to identify any resident behaviors that may need to be care planned. Any resident with recorded behaviors will have their care plan reviewed, updated or revised as indicated and the nurse aide assignment sheet will be updated as needed. This will be completed by 1-19-13.</p> <p style="text-align: right;">1-19-13 1-20-2013</p>



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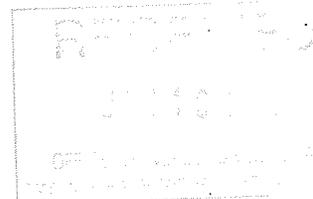
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F 279	<p>Continued From page 14</p> <p>not addressed. Review of the resident's Behavior Observation Profiles for November 2012 and December 2012, revealed the resident exhibited crying and insomnia on a daily basis.</p> <p>2. Review of the clinical record for Resident #10, revealed the facility admitted the resident with diagnoses of Depression and Anxiety. The facility completed an annual MDS assessment on 09/01/12 which revealed the resident had a cognitive impairment, required extensive assistance with care and received psychotropic medication. Review of the care plan, revealed the resident had impaired cognition, however, the resident's specific medication, behaviors and interventions to manage those behaviors were not addressed. Review of the resident's Behavior Observation Profiles for October and November 2012, revealed the resident exhibited cursing, insomnia, delusions, manipulation and demanding behaviors on a daily basis.</p> <p>Interview with Licensed Practical Nurse (LPN) #9, on 12/06/12 at 9:40 AM, revealed Resident #4 had difficulty sleeping and cried on a daily basis. The resident received medications for anxiety and depression. She stated the resident received psychiatric care. She revealed she could not locate a care plan for the resident's specific behaviors and interventions to manage those behaviors. In addition, she stated she could not locate a care plan for Resident #10's specific behaviors and interventions to manage those behaviors. She stated staff monitored for the behaviors and documented using the Behavior Observation Profiles, however, any interventions attempted were not documented. She stated the residents needed care plans with interventions</p>	F 279	<p>3. Corporate Social Service Consultant to provide education for the Director of Social Services on Care Planning for Behaviors. Included in the education will be ideas on interventions to address individual behaviors, resources for dealing with resident behaviors, care planning process, writing a Behavior CAA and behavior monitoring. This will be completed by 1-4-13. Corporate Social Service Consultant to evaluate understanding of process by reviewing behavior care plans as part of the Quality Assurance Program. The Director of Social Services also completed a post test on the CAA process on 1-17-13. Corporate Social Service Consultant to provide education to nursing staff on Identifying and Managing Resident Behaviors on 1-10-13. Handouts were provided to all staff for future reference.</p> <p>4. Corporate Social Service Consultant to audit 25% of all behavior care plans monthly for 4 months then will audit 10% of all Behavior Care Plans monthly for individualized plans. The results of these audits will be used to provide feedback to the Director of Social Services, and provide direction for any re-education that is needed. Audits will be reported no less than quarterly to the facility QA Committee.</p>	



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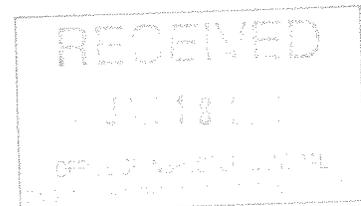
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F 279	Continued From page 15 and the effectiveness of those interventions should be evaluated. Interview with the MDS Nurse, on 12/06/12 at 3:10 PM, revealed she was responsible for developing a comprehensive care plan and stated Residents #4 and #10 did not have their behavior problems on the care plans or interventions to manage those behaviors. She stated the care plan should reflect the residents problems and interventions for those problems. She revealed this lack could impact the resident negatively. Interview with the DON, on 12/06/12 at 4:00 PM, revealed her expectations were that residents required care plans that were accurate, updated and individualized.	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to follow the initial plan and the comprehensive care plan for two (2) of the twenty-two (22) sampled residents and fourteen (14) unsampled residents. The facility failed to provide Resident #11 with staff assistance for meals and the facility failed to provide Resident #13 with wheelchair anti-tippers.	F 282		



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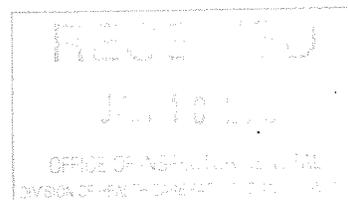
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F 282	<p>Continued From page 16</p> <p>The findings include:</p> <p>No policy was provided regarding following the residents' initial and comprehensive plans of care.</p> <p>1. Observation of Resident #13's wheelchair, on 12/04/12 at 8:40 AM, revealed no anti-tippers on the chair.</p> <p>Record review of the comprehensive plan of care for Resident #13 revealed he/she should have anti-tippers on the wheelchair as an intervention for safety (dated 03/20/12) due to the resident being at risk for falls.</p> <p>Interview with LPN #9, on 12/06/12 at 10:30 AM, revealed she was unaware Resident #13 did not have anti-tippers on his/her wheelchair. She stated each nurse was responsible to follow the residents' plans of care. As the unit manager, she tried to monitor the residents' plans of care; however, she stated she had missed this item on Resident #13's plan of care.</p> <p>Observation of Resident #11, on 12/06/12 at 9:20 AM, revealed the resident was seated upright in bed with the over bed table approximately five (5) feet away in the room. Resident #11's breakfast tray was on the over bed table with oatmeal and eggs in separate bowls and those appeared to be untouched. Resident #11 was asked if he/she was hungry and the response was "too busy". Observation of Resident #13's wheelchair on 12/04/12 at 8:40 AM revealed no anti-tippers on the chair.</p>	F 282	<p>1. Anti-tippers were put on the wheelchair of resident #13 on 12-6-12. This was completed by Director of Maintenance</p> <p>C.N.A. assignment sheet revised by MDS Coordinator on 12-6-12 to include assisting resident #11 with eating.</p> <p>2. Director of Nursing, MDS Coordinators and restorative aide, reviewed all resident care plans, and Nurse Aide assignment sheets to ensure that the two communication tools matched. The Director of Nursing, MDS Coordinators and restorative aide then compared the care plan to the resident to ensure that all devices were present as per the care plan and that the care plan reflected the current needs of each resident. This was completed on 1-19-13.</p> <p>3. Director of Nursing and Staff Development will educate nursing staff regarding importance of following each resident's written plan of care. Education will include the importance of revising C.N.A. assignment sheet to ensure consistent communication of resident care needs. This will be completed by 1-10-13 and will be repeated monthly for 3 months and included in the new hire orientation completed by Staff Development. Beginning 1-17-13 Staff Development to observe each nursing assistant provide care to at least one resident and evaluate the nursing assistant on following the nurse aide assignment sheet. Failure to follow the care plan/assignment sheet will be corrected immediately if observed.</p> <p>1-19-2013 1-20-2013</p>



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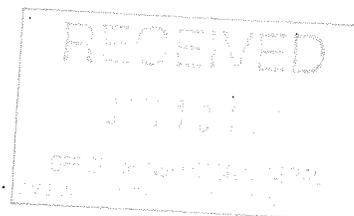
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F 282	Continued From page 17 Interview with CNA #5, on 12/06/12 at 9:25 AM, revealed she was assigned to Resident #11 on that date and she had been told in report from the off-going CNA that the resident was to have the meal tray set up only and the resident was capable of feeding himself/herself. CNA #5 stated she carried an assignment sheet which revealed Resident #11 was to have a meal tray set-up and that assignment sheet did not indicate Resident #11 needed assistance with eating. CNA #5 further revealed the CNAs could reference the nursing plan of care if they needed to know anything further about their assigned residents. Further observation, on 12/06/12 at 9:35 AM, revealed CNA #5 assisted Resident #11 to eat the breakfast meal and Resident #11 ate seventy-five (75) percent of that meal. 2. Record review revealed Resident #11 was assessed by the facility on the Minimum Data Set as needing one (1) staff assistance with eating. The facility also assessed Resident #11 as having impaired vision, as needing assist of one (1) staff for ambulation and as being non-interviewable. In addition, Resident #11 was assessed by the facility on the initial plan of care as needing assist with eating and as needing to be fed. Interview with Resident #11's Mother, on 12/05/12 at 1:00 PM, revealed she thought Resident #11 needed help with meals and she was afraid the resident did not always get the meal assistance he/she needed. Resident #11's Mother stated she came to the facility daily to assist the resident with the lunch meal and she knew there was staff on the evening shift who helped the resident with	F 282	4. Staff Development or MDS Coordinator to audit care plan and C.N.A. assignment sheet to ensure that there is accurate communication of the resident care needs. Beginning 1-1-13 Care Plans and C.N.A assignment sheets will be audited monthly with the Care Plan schedule. Audit findings will be presented to Quality Assurance Committee no less than quarterly for one year to monitor compliance with the POC.	



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F 282	Continued From page 18 the supper meal when she was working. Interview with LPN #9, on 12/06/12 at 10:30 AM, revealed she was not aware there was a discrepancy between the plan of care and the CNA assignment sheet for Resident #11. She stated the Minimum Data Set nurse was responsible to update the CNA assignment sheets but she also stated any nurse could do so. LPN #9 further stated she felt Resident #11 needed assistance with eating and it was a failure on their part not to have followed the initial care plan. Interview with the Director of Nursing (DON), on 12/06/12 at 11:00 AM, revealed the nursing staff was responsible to follow the plan of care for each resident and it was inexcusable not to do so.	F 282	
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of facility's shower schedule, it was determined the facility failed to provide the necessary resident hygiene for four (4) of twenty-two (22) sampled residents (Resident #8, #14, #15, #18) and two (2) of fourteen (14) unsampled residents (Unsampled Residents A,	F 312	



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NAME OF PROVIDER OR SUPPLIER ROCKFORD HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4700 QUINN DR. LOUISVILLE, KY 40216	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 19 and B). The findings include: No bathing policy was provided by the facility. 1. Record review of Resident #14, revealed Resident #14 was admitted on 03/18/12 with a diagnosis of late hemiplegia, muscle disorder and paralysis. Review of Resident #14's Minimum Data Set (MDS) quarterly assessment dated 10/24/12 revealed Resident #14 had a BIM score of 15, which meant the resident was interviewable. Interview with Resident #14, on 12/05/12 at 2:47 PM, revealed he/she received his/her showers on Wednesdays and Saturdays. Resident #14 stated he/she could not get his/her shower when there were only two (2) staff members on the hall. Record review of Resident #14's shower log, revealed he/she received a shower on 09/12/12 (Wednesday), next shower occurred on 09/19/12 (Wednesday) seven days apart. No shower occurred on Saturday 09/15/12. A shower occurred on 10/20/12 (Saturday) and then next shower occurred on 10/27/12 (Saturday) seven days apart. No shower occurred on Wednesday 10/24/12. A shower occurred on 11/07/12 (Wednesday) and 11/08/12 (Thursday), the next shower occurred on 11/14/12 (Wednesday) six days apart. No shower occurred on Saturday 11/10/12. A shower occurred on 11/21/12 (Wednesday) and the next shower occurred on 11/28/12 (Wednesday), seven days apart. No shower occurred on Saturday 11/24/12.	F 312	1. Director of Nursing reviewed the shower records for all residents on 12-10-12 and any resident who had not received a shower in the past 7 days was offered a shower. 2. The shower schedule was reviewed to ensure all residents were on the schedule. 3. Director of Nursing provided written communication to nurses on 1-3-13 regarding providing showers for all residents. This was presented by way of a read and sign memo that was also reviewed verbally with the nurse by Staff Development. Nurses were responsible to communicate the procedure to the nurse aides at the beginning of each shift. Staff must provide to the Director of Nursing each day a list of any shower scheduled but not completed. Any shower not completed must be explained. If the resident refuses, the nurse is to approach the resident to ensure it is the resident's choice to refuse the shower. An alternative bathing process will be offered, such as a bed bath, partial bath, etc. If the resident refuses any type of personal hygiene the family will be contacted and informed. Administrator, Staffing Coordinator and Director of Nursing met on 12-10-12 to review current staffing levels and to discuss a plan to improve staffing. The following plan was developed. 1. Authorization received to utilize temporary staffing agency to improve staffing 2. Identify additional resources for recruitment of staff and place additional ads for staff.	1-19-2013



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F 312	<p>Continued From page 20</p> <p>2. Record review of Resident #18, revealed Resident #18 was admitted on 10/31/07 with a diagnosis of late effective cardiovascular disease, neuropathy, abnormal gait, pleural effusion, shortness of breath and chronic obstructive pulmonary disease. Record review of Resident #18 MDS annual assessment dated 11/27/12 revealed he/she had a BIM score of 15 which means the resident was interviewable.</p> <p>Interview with Resident #18, on 12/06/12 at 11:33 AM, revealed he/she demanded his/her bath be given by staff. Resident #18 stated he/she had heard Certified Nursing Assistants (CNA) telling residents they were not going to be given a bath because of the staffing issue. Resident #18 stated he/she would not allow the CNA to tell him/her they would receive a bath on another day. Resident #18 stated this was his/her right.</p> <p>Record review of the shower schedule revealed Resident #18 was to receive a shower on Tuesdays and Fridays.</p> <p>Record review of Resident #18's shower log, revealed he/she received a shower on 10/16/12 (Tuesday), the next shower occurred on 10/23/12 (Tuesday) seven (7) days apart. No shower occurred on Friday 10/19/12. A shower occurred on 10/23/12 (Thursday) and the next shower occurred on 11/06/12 (Tuesday) fourteen (14) days apart. A shower occurred on 11/13/12 (Tuesday) and the next shower occurred on 11/23/12 (Friday) ten (10) days apart.</p> <p>3. Review of the clinical record for Unsampled Resident A revealed a BIM score of fifteen (15), which meant the resident was interviewable.</p>	F 312	<p>3. Utilize Administrative nursing staff on week-ends to provide restorative services, provide assistance with dining service, and provide additional supervision to ensure resident needs are met.</p> <p>4. Utilize light duty staff to provide support and assistance with resident care based on limitations.</p> <p>5. Contact local CNA training programs to increase visibility.</p> <p>6. Establish Staffing committee to meet weekly to review recruitment efforts, orientation process, and staffing patterns to ensure resident care needs are met.</p> <p>7. Review non-essential duties assigned to aides and delegate those non-essential duties to other staff members as needed.</p> <p>8. Establish staffing ratios and monitor staffing numbers daily.</p> <p>Staffing Committee met on 1-11-13 to begin the task of implementing the plan outlined above. Staffing Committee includes Director of Nursing, Staffing Coordinator, Director of Social Service, Corporate Clinical Consultant, a CNA and a Staff Nurse.</p> <p>Staffing Committee to report weekly to the Administrator and the VP of Operations for Elmcroft Senior Living regarding progress in recruitment, and retention of staff.</p> <p>Staffing Committee will meet weekly until staffing ratios are attained and maintained for no less than 3 months and then will continue to meet monthly to monitor/review daily staffing patterns, hiring process, interviews/ observation of ADL care.</p> <p>4. Staffing Committee will report on their activities and plans to Quality Assurance Committee who will monitor compliance with POC for one year.</p>

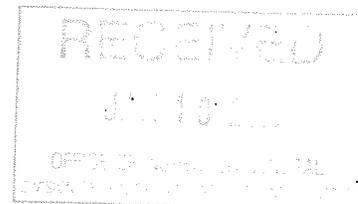
mittee who will monitor compliance with POC for one year.



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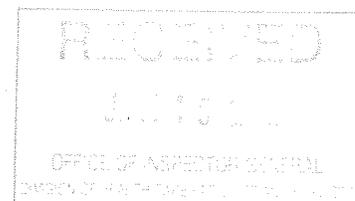
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F 312	<p>Continued From page 21</p> <p>Interview with Unsampled Resident A, on 12/06/12 at 8:52 AM, revealed he/she had heard staff complaining about being too short staffed and not being able to give baths.</p> <p>Record review of the shower schedule revealed Unsampled Resident A was to receive a shower on Monday and Thursdays.</p> <p>Record review of Resident A's shower log, revealed he/she received a shower on 09/20/12 (Thursday) and the next tub bath occurred on 09/27/12 (Thursday) seven (7) days apart. No shower occurred on 09/24/12 (Monday). A shower occurred on 10/07/12 (Sunday) and the next shower occurred on 10/15/12 (Monday) eight (8) days apart. No shower was given on 10/08/12 (Monday) or 10/11/12 (Thursday).</p> <p>4. Review of the clinical record for Unsampled Resident B's revealed he/she had a BIM score of nine (9) which meant Unsampled Resident B was interviewable.</p> <p>Interview with Unsampled Resident B, on 12/06/12 at 9:00 AM, revealed he/she had heard staff say they would not have enough staff to give baths and that this had happened to him/her once.</p> <p>Record review of the shower schedule revealed Resident B was to receive a shower on Wednesday and Saturday.</p> <p>Record review of Resident B's shower log, revealed he/she received a shower on 09/19/12 (Wednesday) and the next shower occurred on</p>	F 312		



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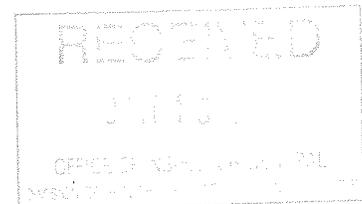
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F 312	Continued From page 22 09/26/12 (Wednesday) seven (7) days later. A shower occurred on 10/03/12 (Wednesday) and the next shower occurred on 10/10/12 (Wednesday) seven (7) days later. A shower should of occurred on 10/06/12 (Saturday). A shower occurred on 10/13/12 (Saturday) and the next shower occurred on 10/20/12 (Saturday) seven (7) days later. A shower should of occurred on 10/17/12 (Wednesday). A shower occurred on 11/07/12 (Wednesday) and the next shower occurred on 11/14/12 (Wednesday) seven (7) days later. A shower should of occurred on 11/10/12 (Saturday). A shower occurred on 11/21/12 (Wednesday) and the next shower occurred on 11/28/12 (Wednesday) seven (7) days apart. A shower should have occurred on Saturday 11/24/12. Interview with CNA #6, on 12/06/12 at 2:13 PM, revealed she had heard CNAs tell residents they were not going to receive a bath because they were understaffed. There has been some staffing issues and it appears that it has become worse. CNA #6 stated she had told supervisors and feel like they were thinking the she was just over reacting. CNA #6 also stated she had told the Director of Nursing (DON), but nothing had come of it. CNA #6 stated she had heard residents complaining and she had told the residents to complain to the facility because the facility does not listen to the staff. CNA #6 further stated some of the staff helped and some of the staff did not help. Interview with CNA #7, on 12/06/12 at 2:28 PM, revealed their was not enough staff to provide care. CNAs have about 15 residents a piece. When she first started at the facility the facility	F 312		



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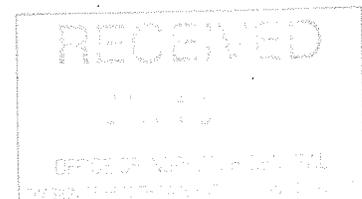
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F 312	<p>Continued From page 23</p> <p>was fully staffed. CNA #7 stated she had told residents they would not receive a shower because she could not get them to the shower room. CNA #7 stated she tries to clean them up the best way she could and has informed nurses she needed help and received responses like, it is not my job to do showers. CNA #7 stated she has heard residents complain and she tries the best way she can. The Director of Nursing was aware, but she ignores the issue. CNA #7 stated she felt the resident not receiving a shower could affect the residents and bring the residents moral down.</p> <p>Interview with Charge Nurse LPN #9, on 12/06/12 at 2:50 PM, revealed she had noted some staff changes. LPN #9 stated they had lost two CNAs at once and one moved away. LPN #9 stated CNAs have reported to her they have had some care concerns like not being able to get the resident to the toilet in time, making beds and providing oral care. LPN #9 further stated she had heard CNAs state it was harder to give showers with minimal staff and she tries to help staff give showers. She has tried to get staff to come in the facility early to help with showers in the building. LPN #9 stated she has never told a CNA it was not her job to give showers.</p> <p>Interview with the Director of Nursing (DON), on 12/06/12 at 6:47 PM, revealed she was aware the residents were not receiving showers as they should. The DON stated if she knew it was a specific aid not giving showers she would educate the aid on the spot and go and talk to the nurse. The DON stated she talks to the nurse to see if there was a conversation about a shower not being given with the aid. It is the nurses</p>	F 312	



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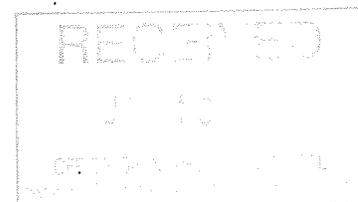
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F 312	<p>Continued From page 24</p> <p>responsibility to know if a resident did not receive a shower and document in the nursing notes. The DON stated she has had nurses working as aids to provide the care needed. The DON stated she had been monitoring showers on D-Hall because the residents were not aware what days their showers were to be given. D-Hall has mainly short term residents who come in for therapy. The DON finally stated it upsets her that the residents were not receiving showers like they were supposed to.</p> <p>5. Observation of Resident #8, on 12/04/12 at 12:07 PM, revealed the resident was sitting in a wheelchair in their room, and the resident's face appeared oily.</p> <p>Review of Resident #8's medical record revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was interviewable.</p> <p>Interview, on 12/05/12 at 12:25 PM, revealed the resident felt the facility staff did not listen. The resident revealed asking for something, such as an alternate meal choice, to be changed, or to get washed up, and they just ignored him/her or made him/her wait forever. The resident revealed the 2nd and 3rd shifts were the worst, stating they did not have enough help and they don't listen. The resident revealed having to sit in a soiled brief and waiting, and when the staff finally did come in to find out what they needed they turned around and left. The resident revealed he/she had talked to the nurses, the Director of Nursing (DON), and Social Services, but no one listened, they just brushed him/her off or made excuses.</p>	F 312		



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F 312	Continued From page 25 6. Review of Resident #15's medical record revealed a BIMS score of 15, indicating the resident was interviewable. Interview with Resident #15 on, 12/06/15 at 9:15 AM, revealed having a hard time getting the facility staff to answer call lights, especially at night, to provide incontinent care. The resident revealed the staff did not brush his/her teeth daily and only used a baby wipe to provide daily hygiene. Interview with Resident #15's family member, on 12/06/12 at 2:00 PM, revealed they had repeatedly told the facility staff to clean Resident #15 with soap and water, and brush his/her teeth. When they asked for help or used the call light, they were told they didn't have enough help, or the nursing assistant was on a break and no one ever came to help. The family member revealed having personally spoken to the DON about these concerns and was told the facility used baby wipes. The family member revealed getting very upset and telling the DON that residents were not getting their showers and they needed more than a baby wipe to be clean and to prevent infections, but had not seen any changes made since that meeting.	F 312	
F 353 SS=E	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.	F 353	



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F 353

Continued From page 26

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 daily staffing worksheets, it was determined the facility failed to provide adequate numbers of staff to provide the necessary hygiene care to four (4) of twenty-two (22) sampled residents. (Residents #8, #14, #15 #18) and two (2) of fourteen (14) unsampled residents. (Unsampled Residents A and B).

The findings include:

The facility did not provide a policy on staffing; however, record review of the Daily Staffing Worksheets, revealed the facility could have as many as three CNAs on A-hall, B-hall and C-hall and two CNAs on D-hall.

Interviews with Resident #14, on 12/05/12 at 2:47 PM, Resident #18, on 12/06/12 at 11:33 AM, Unsampled Resident A, on 12/06/12 at 8:52 AM,

F 353

1. Director of Nursing reviewed the shower records for all residents on 12-10-12 and any resident who had not received a shower in the past 7 days was offered a shower.

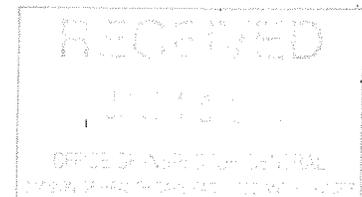
2. The shower schedule was reviewed to ensure all residents were on the schedule.

3. Director of Nursing provided written communication to nurses on 1-3-13 regarding providing showers for all residents. This was presented by way of a read and sign memo that was also reviewed verbally with the nurse by Staff Development. Nurses were responsible to communicate the procedure to the nurse aides at the beginning of each shift. Staff must provide to the Director of Nursing each day a list of any shower scheduled but not completed. Any shower not completed must be explained. If the resident refuses, the nurse is to approach the resident to ensure it is the resident's choice to refuse the shower. An alternative bathing process will be offered, such as a bed bath, partial bath, etc. If the resident refuses any type of personal hygiene the family will be contacted and informed.

Administrator, Staffing Coordinator and Director of Nursing met on 12-10-12 to review current staffing levels and to discuss a plan to improve staffing. The following plan was developed.

1. Authorization received to utilize temporary staffing agency to improve staffing
2. Identify additional resources for recruitment of staff and place additional ads for staff.

1-19-2013



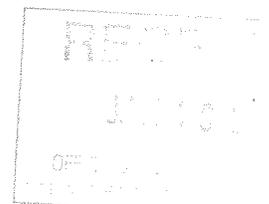
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F 353	Continued From page 27 and Unsamped Resident B, on 12/06/12 at 9:00 AM, revealed they were not receiving showers like they should. Interview with CNA #6, on 12/06/12 at 2:13 PM, revealed there had been some staffing issues and it appeared that it had become worse. CNA #6 stated she had told supervisors and felt like they were thinking she was over reacting. CNA #6 stated she had heard residents complaining and she had told the residents to complain to the facility because the facility did not listen to the staff. CNA #6 further stated some of the staff helped, and some of the staff did not help, when it came to providing care. Interview with CNA #7, on 12/06/12 at 2:28 PM, revealed there was not enough staff to provide care to the residents. CNAs had about 15 residents each. When she first started the facility was fully staffed. CNA #7 stated she had told residents they would not receive a shower because she could not get them to the shower room. CNA #7 stated she tried to clean them up the best way she could. CNA #7 stated the Director of Nursing was aware, but she ignored the issue and felt it affected the resident's moral and could bring the resident down. Interview with Charge Nurse LPN #9, on 12/06/12 at 2:50 PM, revealed she had noted some staff changes. LPN #9 stated they had lost two CNAs at once and one moved away. LPN #9 stated CNAs have reported to her they had some care concerns, like not being able to get the resident to the toilet in time, make beds and provide oral care. LPN #9 further stated she had heard CNAs state it was harder to give showers with minimal	F 353	3. Utilize Administrative nursing staff on week-ends to provide restorative services, provide assistance with dining service, and provide additional supervision to ensure resident needs are met. 4. Utilize light duty staff to provide support and assistance with resident care based on limitations. 5. Contact local CNA training programs to increase visibility. 6. Establish Staffing committee to meet weekly to review recruitment efforts, orientation process, and staffing patterns to ensure resident care needs are met. 7. Review non-essential duties assigned to aides and delegate those non-essential duties to other staff members as needed. 8. Establish staffing ratios and monitor staffing numbers daily. Staffing Committee met on 1-11-13 to begin the task of implementing the plan outlined above. Staffing Committee includes Director of Nursing, Staffing Coordinator, Director of Social Service, Corporate Clinical Consultant, a CNA and a Staff Nurse. Staffing Committee to report weekly to the Administrator and the VP of Operations for Elmcroft Senior Living regarding progress in recruitment, and retention of staff. Staffing Committee will meet weekly until staffing ratios are attained and maintained for no less than 3 months and then will continue to meet monthly to monitor/review daily staffing patterns, hiring process, interviews/observation of ADL care.	

A. Staffing Committee will report on their ac-

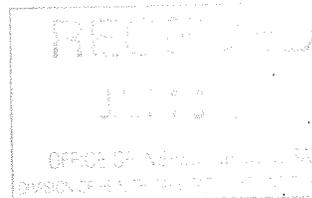
tion and plans to Quality Improvement Committee who will monitor compliance with POC for one year.



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F 353	<p>Continued From page 28</p> <p>staff. She had tried to get staff to come in the facility early to help with showers in the building.</p> <p>Interview with Social Services, on 12/06/12 at 3:15 PM, revealed residents usually talked to her about their concerns. Social Services stated she had heard complaints from residents about the staffing in Resident Council. The Social Services Director stated the facility continued to hire staff, but were continuing to have a high turn over rate. The Social Services Director stated the Director of Nursing (DON) was aware of the staffing issues and the residents' complaints and she felt the staffing issue could not be an excuse for not providing care. The DON told the residents she would talk to the staff about their concern.</p> <p>Interview with the Staffing Coordinator, on 12/06/12 at 3:19 PM, revealed her job duty was to schedule staffing for two (2) weeks at a time. The Staffing Coordinator stated she had a hard time staffing the facility and in that effort to hire staff, potential new hires do not call back. The Staffing Coordinator stated she interviewed all walk-ins. The Staffing Coordinator stated on an ideal day if the facility would have three (3) CNAs on the A, B and C hall and two (2) CNAs on the D hall. She stated they had been working with eight (8) to ten (10) CNAs a day. They normally had two (2) CNAs to a hall and split staff on the C and D hall. The Staffing Coordinator stated the CNAs do not go over 15 residents per CNA. They would like to have ten (10) residents to one (1) CNA. They obviously did not want to work short. CNA staff had not voiced any concerns about needing additional help.</p> <p>Interview with the Staff Development Coordinator,</p>	F 353		



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F 353 Continued From page 29
on 12/06/12 at 3:29 PM, revealed she had heard about the lack of staff. The Staff Development Coordinator stated she interviewed potential new hires on the spot. During the first week of orientation the staff members get one (1) day of orientation and then two (2) weeks of floor orientation. The Staff Development Coordinator stated it could be hard for the CNAs to have fourteen (14) to fifteen (15) residents at a time. The nursing staff were encouraged to help the CNAs in every inservice provided. The Staff Development Coordinator stated she had heard residents complain about not having a shower and then the resident would get a shower that day. The Staff Development Coordinator stated she had discussed the lack of staff and tried to get a job fair together with the DON. She stated she found it disheartening that some residents have not received a shower as scheduled.

F 353

Interview with the Director of Nursing (DON), on 12/06/12 at 5:47 PM, revealed she was aware the residents were not receiving showers as they should. She stated if she knew it was a specific aid not giving showers she would educate the aid on the spot and go and talk to the nurse. The DON stated she talked to the nurses to see if there was a conversation about a shower not being given with the aid. The DON stated she had nurses working as aids to provide the care needed and stated CNAs having fifteen (15) residents could be hard. The DON stated she hires new aids and the work can be over whelming. There was a period of time when staff did not know what group they were assigned to in the facility. The Charge nurse was not informing the aids when there was a change in the schedule. The DON stated she had talked to the



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F 353

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nurses about why they felt like they could not help the aids and their answer was because they were busy with their own work. The option they came up with was less patients or less duties. The majority of the nurses stated fewer patients. The DON stated they also offered to add another nurse. The DON finally stated it upsets her that the residents were not receiving showers like they were supposed to.

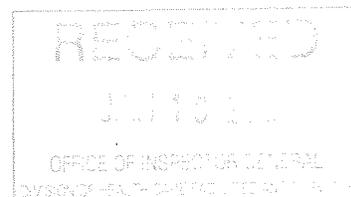
Observation of Resident #8, on 12/04/12 at 12:07 PM, revealed the resident was sitting in a wheelchair in their room, and the resident's face appeared oily.

Review of Resident #8's medical record revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was interviewable.

Interview, on 12/05/12 at 12:25 PM, revealed the resident felt the facility did not have enough staff and reported asking for something, such as an alternate meal choice, to be changed, or to get washed up, and ignored or made to wait. The resident revealed the 2nd and 3rd were worse stating they do not have enough help and they don't listen. The resident revealed having to sit in a soiled brief and wait on staff to respond, and when the staff finally did come in to find out what they need, they turn around and left. The resident revealed he/she had talked to the nurses, the Director of Nursing (DON), and Social Services, but no one listened, they just brushed him/her off or made excuses.

Review of Resident #15's medical record revealed a BIMS score of 15, indicating the resident was interviewable.

F 353



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F 353

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Interview with Resident #15 on, 12/06/15 at 9:15 AM, revealed having a hard time getting the facility staff to answer call lights, especially at night, to provide incontinent care. The resident revealed the staff did not brush his/her teeth daily and only used a baby wipe to provide daily hygiene.

F 353

Interview with Resident #15's family member, on 12/06/12 at 2:00 PM, revealed they had repeatedly told the facility staff to clean Resident #15 with soap and water, and brush their teeth. When they asked for help or used the call light, they were told they didn't have enough help, or the nursing assistant was on a break and no one ever came to help. The family member revealed having personally spoken to the DON about these concerns and was told the facility used baby wipes. The family member revealed getting very upset and telling the DON that residents were not getting their showers and they needed more than baby wipes to be clean and to prevent infections, but had not seen any changes made since that meeting.

F 364
SS=E

483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP

Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.

F 364

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review



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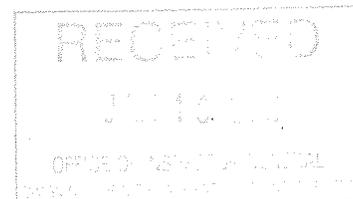
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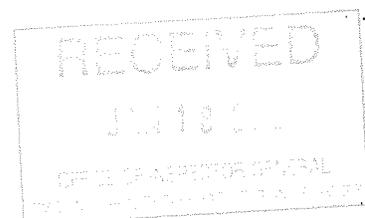
F 364	Continued From page 32 and review of the facility's policy, it was determined the facility failed to prepare palatable food for four (4) of twenty-two (22) sampled residents (Residents #5, #8, #15, #18) and five (5) of fourteen (14) unsampled residents, (Unsampled Residents D, E, F, G and H). The findings include: Review of the facility's policy regarding Menu Alternatives and Substitutions, dated 2006, revealed alternatives and substitutions made to the standard menu comply with the nutritional requirements of menu planning. Changes to the standard menu program are minimized by utilizing: planned alternate menu items including on the master menu and periodic "special" programs. Planned alternate menu items are posted in the dining room for staff to review when offering substitutions to residents. Also posted are temporary changes due to delivery shortages and production errors. Temporary changes are documented on the "Daily Menu Substitutions" form. A limited number of permanent changes on the standard menu program may be necessary to meet overall resident preferences. These permanent changes to the standardized menu program comply with standards of menu planning to ensure nutritional adequacy. The Registered Dietitian will review and approve permanent menu alternatives and changes to assure nutritional adequacy. 1) Observation of the Lunch meal, on 12/04/12 12:52 PM, revealed fish was served. Some of the fish meat was observed to have a dark brown to black substance on the fish. Observation of Resident #5 in the dining room, on	F 364	1. The residents identified were interviewed by the Dietary Manager regarding their food concerns. The interviews were conducted as noted ; #5 on 1-3-13, #8 on 1-3-13, #15 in hospital, #18 on 1-2-13, and unsampled resident on 1-2-13, E on 1-3-13, F on 1-2-13, G on 1-2-13, and h on 1-2-13. Interviews were mostly positive. Resident likes and dislikes were discussed. 2. Other interviewable residents will be interviewed regarding their dietary concerns by Dietary Manager or Assistant Cook by 1-19-13. 3. Education provided to cooks on 1-9-13 on Prevention of Over Cooked Food, following recipes, and ensuring food is prepared correctly and on Menu Item Substitution. This education was presented by the Consultant Dietician and the Dietary Manager. A post test will be administered by the Dietary Manger on 1-17-13 to determine understanding of education presented and will be used to determine need for re-education. These will be reviewed by the Dietary Manager.	1-20-2013
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F 364	<p>Continued From page 33</p> <p>12/04/12 at 12:50 PM, revealed the resident's fish patty appeared blackish/brown in color. Interview with Resident #5 at that time revealed the fish was burnt, dry, and just not good. The resident revealed the lima beans were too mushy and was not able to eat them.</p> <p>Interview with Resident #18 during group interview, on 12/04/12 at 2:45 PM, revealed the food was always cooked too long and revealed the lima beans at lunch were so mushy he/she was not able to eat them.</p> <p>Interview with Resident #8, on 12/05/12 at 12:25 PM, revealed the food was terrible. The resident revealed having the chicken for lunch on 12/04/12 and stated it was very dry, the lime beans were too mushy and not seasoned. Thre resident revealed the facility used the same menu over and over and its always bad, stating they just put stuff together that does not make sense. The resident revealed he/she had refused to eat meals before that were not edible, but stated the alternat was just as bad or worse.</p> <p>Interview with Resident #15, 12/06/12 at 9:15 AM, revealed the food tasted terrible, it was either overcooked or undercooked. The resident revealed he/she required assistance with feeding, and notified the Certified Nursing Assistant (CNA) at the time, but they just say it did look bad and never got anything different.</p> <p>Interview with Resident #15's family member, on 12/06/12 at 2:00 PM, revealed the food did not look edible and the fish was always messed up being burnt, dry, or undercooked.</p>	F 364	<p>4. Tray audits will be completed weekly for 3 months by the Dietary Manager to evaluate presentation and appropriate temps. These audits will be presented to the QA Committee at the quarterly meeting. An alternative food list will be available for substitutions that has adequate nutrition value. This list will be available by 1-18=13. We will be having a resident choice meal once a month. The meal will be planned at the monthly Resident Council Meeting. Interviews will be conducted weekly on 25% of interviewable residents regarding any food concerns for 4 weeks and then once per month for 2 months then quarterly. We will monitor trays of non-interviewable residents to determine what foods are regularly refused. All audits, interviews and observations will be presented to the QA Committee who will monitor compliance with the POC for one year.</p>



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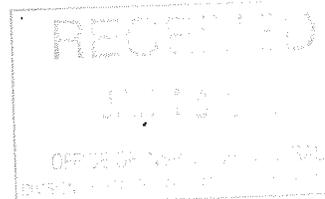
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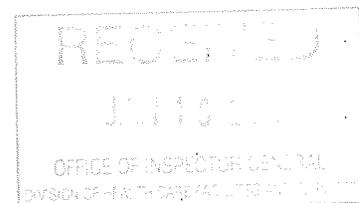
F 364	<p>Continued From page 34</p> <p>Interview with Residents D and E, on 12/04/12 at 12:52 PM, revealed the fish was hard and tasted burnt.</p> <p>Interview with Resident F, on 12/04/12 at 1:10 PM, revealed the fish was hard as a rock.</p> <p>Interview with Resident G, on 12/04/12 at 1:19 PM, revealed his/her chicken was tough to cut and sometimes the meat was tough.</p> <p>Observation of Resident G's chicken, on 12/04/12 at 1:19 PM, revealed the chicken appeared dark brown in color, dry and when the resident was observed to cut his/her meat, the meat was hard to cut.</p> <p>Observation of the meal service, on 12/05/12 at 12:30 PM, revealed residents in the dining room were served a breaded fish for lunch. The breading on the fish was noted to have areas which were black.</p> <p>Interview with the Food Service Manager, on 12/05/12 at 1:05 PM, revealed she did not see any fish that appeared to be burned, however, if the fish was burnt looking, it should not have been served as it would not taste good.</p> <p>Observation of Resident H meal, on 12/06/12 at 6:27 PM, revealed he/she was given a Chicken sandwich, soup and pea salad.</p> <p>Interview with Resident H, on 12/06/12 at 6:27 PM, revealed the food did not look right, nor taste right. Resident H stated he/she was not to have fried or salty food. Resident H stated everything he/she received was salty. Resident H stated the alternative for dinner was hot dogs and beets. Resident H further stated he/she did not want the</p>	F 364		
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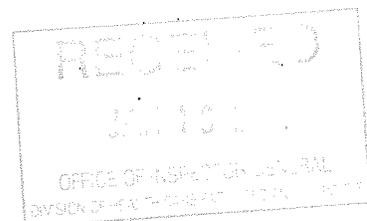
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F 364	<p>Continued From page 35</p> <p>alternative and who said hot dogs and beets go well together?</p> <p>Observation revealed Resident H asking Certified Nursing Assistant (CNA) # 9, on 12/06/12 at 6:35 PM, for a baloney sandwich from the kitchen. However, no sandwich was brought to the resident.</p> <p>Interview with CNA #9, on 12/06/12 at 6:45 PM, revealed the dietary staff stated they could not make the resident a baloney sandwich. CNA #9 stated if the resident wanted a grilled cheese sandwich, they could have one. Sometimes the residents get what they ask for and sometimes they do not depending on which staff was working in the kitchen.</p> <p>Interview with Dietary Aide #4, on 12/06/12 at 6:47 PM, revealed she intended to get the resident a baloney sandwich after the tray line was done serving all other residents and did not intend for the staff to go to Resident H and tell him/her they were not going to receive a baloney sandwich.</p> <p>Interview with Dietary Manager, on 12/06/12 at 6:53 PM, revealed she did not have a set menu for alternatives. The Dietary Manager stated they have soups, sandwiches and cottage cheese as substitutes. She stated there was no posting of the alternatives offered and was not aware the nursing staff did not know what the alternatives were. The Dietary Manager stated the cook decided what meals to cook. Record review of the Dietary menu revealed the residents received hot dogs two days in a row. Continued interview with the Dietary Manager, revealed the residents</p>	F 364		



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F 364	Continued From page 36 should not have received hot dogs two days in a row. When asked who monitors the nutritional value, the Dietary Manager said nothing. When asked how she ensured the diet was of equal value, the Dietary Manager stated the staff was trained on how to cook a balanced meal. The Dietary Manager stated she had not addressed alternatives with the staff and this was an issue.	F 364		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY 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 This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policy, it was determined the facility failed to store, prepare and serve food under sanitary conditions as evidenced by soiled paper signs, heavily stained food preparation carts, tape residue on surfaces, stairway with built-up debris, utensils stored in a soiled bin and chicken noodle soup sitting out at room temperature. The findings include: Review of the facility's policy for Food Preparation and Safety, dated 2006, revealed perishable and	F 371	1. The chicken soup was discarded on 12-5-12. All signs were removed from the walls of the kitchen. The mop handle and broom were discarded. The water pitchers were cleaned and the tape residue removed. The serving carts were cleaned and the stained cart will be replaced. The silverware bin has been washed and cleaned. The stairway has been cleaned. The maintenance department will remove the old thermostat and repair the rusted wall in the walk in. 2. 24 Hour reports, lab results and physicians orders were reviewed for the dates 12-4,5,6,7,8, and 9, 2012 to identify any resident with any gastrointestinal symptoms that may be related to the unsanitary environment of the kitchen. There were no reports of resident being ill. This was completed by the DON.	1-20-2013



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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 371 Continued From page 37
potentially hazardous foods do not remain at room temperature more than 30 minutes.

Review of the facility's policy for Environmental Sanitation/Infection Control, dated 2006, revealed employees follow routine cleaning schedules that indicate frequency for cleaning equipment and kitchen areas.

1. Observation of the kitchen, on 12/04/12 at 8:20 AM, revealed numerous soiled paper signs taped to the walls all around the kitchen. A stairway in the kitchen leading to an attic was soiled with built-up brown substances in the corners of the stairs. A broom and a mop were propped up in the stairway.

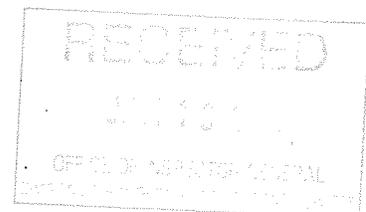
Observation of the kitchen, on 12/05/12 at 11:50 AM, revealed a plastic container of chicken noodle soup sitting on a counter next to the microwave. Observation at 12:30 PM, revealed the server dipped up a bowl of the soup, heated it up in the microwave, then sent the bowl of soup out for a resident.

Interview with the Server, on 12/05/12 at 12:35 PM, revealed she had opened a large can of soup and placed it in a container for residents requesting soup at lunch. She stated she was not sure if the soup should have been on the steam table.

Interview with the Food Service Manager, on 12/05/12 at 12:40 PM, revealed the soup should have been heated to the correct temperature then placed on the steam table to maintain the proper temperature. She stated bacteria could grow in the soup at room temperature.

F 371 3.
Staff has been educated on cleaning the silverware bin, water pitchers, and cleaning of the carts. This was completed on 1-9-13. Staff was instructed to monitor the stairwell for any items and is to be maintained in a sanitary manner. All cleaning items have been added to the cleaning schedule. This education was provided by the Dietary Manager. Dietary Manager will have each attendee complete a questionnaire regarding the cleaning schedule and responsibility to maintain the kitchen in a sanitary manner by 1-19-13 to evaluate understanding. Education provided to cooks on 1-9-13 on Prevention of Over Cooked Food, following recipes, and ensuring food is prepared correctly and on Menu Item Substitution. This education was presented by the Consultant Dietician and the Dietary Manager. A post test will be administered by the Dietary Manger on 1-17-13 to determine understanding of education presented and will be used to determine need for re-education. These will be reviewed by the Dietary Manager.

4. Cook or Dietary Manager to audit food temperatures and storage of food items weekly for 4 weeks and then monthly for 4 months. A log has been put in place to document storage of the broom and mop. A corkboard has been put up to use for posting notes. New carts will be ordered. All monitoring for compliance with the POC will be completed by the Dietary Manger or Cook. All monitoring will be presented to the facility QA Committee which will monitor compliance with POC for one year.



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F 371 Continued From page 38

Observation of the kitchen, on 12/06/12 at 3:20 PM, revealed utensils wrapped in napkins for the evening meal were stored in a plastic bin with dried black and brown particle in the bottom of the bin. A water pitcher was noted to have a heavy residue of tape on the top of the pitcher. The thermostat in the kitchen had partially separated from the wall and wiring was exposed. In addition, the thermostat was covered with fuzzy gray dustlike substances. The metal outside wall of the walk-in refrigerator had separated from the floor and a rust like substance was present. The outside door in the kitchen had large areas of the door frame missing and the presence of a rust colored substance was noted.

F 371

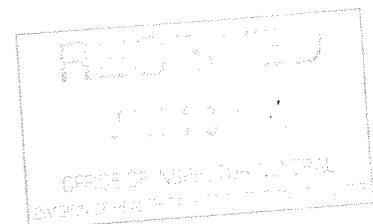
Interview with the Food Service Manager and the Assistant Manager, on 12/06/12 at 3:40 PM, revealed soiled areas and items in the kitchen could cause infection to spread.

F 441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS

F 441

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

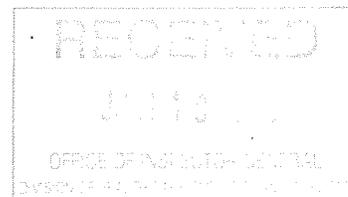
- (a) Infection Control Program
The facility must establish an Infection Control Program under which it -
- (1) Investigates, controls, and prevents infections in the facility;
 - (2) Decides what procedures, such as isolation, should be applied to an individual resident; and
 - (3) Maintains a record of incidents and corrective



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F 441	Continued From page 39 actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure medications were stored and administered under sanitary conditions for four (4) of four (4) medication carts and four (4) of four (4) pill crushers. The pill crushers and insides of the medication carts were soiled. In addition, the facility failed to ensure staff sanitized their hands in the dining room when moving from a dirty to a clean task. CNA #8 was observed to not change gloves after contamination and then touched Resident's food.	F 441	1 Medication carts and pill crushers for hall A, B, C, and D were cleaned on 12-6-12 by the Licensed Nurse assigned to the hall. C.N.A. #8 re-educated 12-6-12 by Director of nursing on proper hand hygiene during meal service. 2. Director of Nursing checked all medication carts, treatment carts and pill crushers on 12-7-12 to ensure they were cleaned as instructed. Director of Nursing observed dining service on 12-10-12 for breakfast, 12-22-12 for lunch, and 12-21-12 for dinner To identify any other staff not maintaining proper hand hygiene during dining service. Re-education was provided as indicated. 3. Schedule developed to clean medication carts and pill crushers. This cleaning will be the responsibility of the 3rd shift nursing staff and will be done weekly. Education provided to licensed nurses by Staff Development on 1-10-13 regarding the new cleaning schedule for medication carts and pill crushers. Observations of the med carts and pill crushers will be used to evaluate understanding of the responsibility and schedule for cleaning. Nursing staff educated by Staff Development on 1-10-13 regarding infection control related to proper hand hygiene during meal service. This education will be repeated monthly for 3 months then included in the facility annual in-service calendar. All newly hired nursing staff will be educated during orientation by Staff Development. Competency of staff with proper hand hygiene will be demonstrated with return demonstrations beginning 1-19-13.	1-19-2013 1-20-2013	



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F 441	<p>Continued From page 40</p> <p>The findings include:</p> <p>The facility did not have a policy for cleaning the medication carts.</p> <p>Interview with the Director of Nursing, on 12/06/12 at 4:00 PM, revealed the facility practice was for the night shift nurses to clean the medication carts and pill crushers.</p> <p>Observation of the medication carts for the A, B, C and D units, on 12/06/12 at 9:30 AM, revealed all carts had pill crushers with brownish and tan debris built up on the bases and handles. The insides of the carts had pill wrappers, spilled dry medication powder, dried and sticky residue, and bits of dried particles. Liquid medication bottles had dried residue on the outsides.</p> <p>Interview with Licensed Practical Nurse (LPN) #3, on 12/06/12 at 9:30 AM, revealed there was no schedule for cleaning the medication carts and the B unit cart and pill crusher were not clean. She stated the medication cart and equipment should be clean to prevent the spread of bacteria.</p> <p>Interview with LPN #5, on 12/06/12 at 10:00 AM, revealed the medication cart and pill crusher on D unit were not clean and she had no knowledge of a cleaning schedule. She stated the medication cart and equipment should be clean to prevent infection.</p> <p>Interview with LPN #4, on 12/06/12 at 1:30 PM, revealed the medication cart and pill crusher on C unit were not clean and should be to prevent infection. She stated there was no policy on cleaning the medication cart and equipment.</p>	F 441	<p>4. Staff Development will check medication carts and pill crushers weekly x 4, then monthly. Audit findings will be presented to Quality Assurance Committee no less than quarterly.</p> <p>Staff Development or Charge Nurse will observe meal service daily x 7 days, then no less than 2 times per week x 3 weeks, and then observations will be completed weekly. The goal will be to observe each nursing assistant a minimum of 2 times. Observations (recorded on a log) will be used to determine the need for individual re-education and findings will be presented to Quality Assurance Committee no less than quarterly.</p> <p>QA Committee to monitor compliance with POC for one year.</p>	
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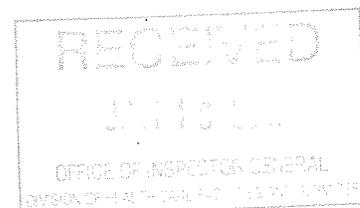
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F 441	<p>Continued From page 41</p> <p>Interview with LPN #1, on 12/06/12 at 1:45 PM, revealed she was not aware of any policy for cleaning the medication cart and the equipment. She stated the cart and pill crusher on A unit were not clean and should be to prevent the spread of germs.</p> <p>Interview with the DON, on 12/06/12 at 4:00 PM, revealed her expectation was for the night shift nurses to clean the medication carts and equipment.</p> <p>2. Observation of Resident #6, on 12/04/12 at 12:55 PM, in the dining room revealed CNA #8 touched the resident's tray, several items on the tray, and the resident's shoulder with gloved hands. CNA #8 then touched Resident #6's bread with the same gloved hands and spread butter on the bread.</p> <p>Observation of Unsampled Resident L, on 12/04/12 at 1:15 PM, revealed CNA #8 touched Unsampled Resident L on the hand, touched several items on the tray and then touched the resident's bologna with the same gloved hands to cut it up.</p> <p>Interview with CNA #8, on 12/04/12 at 1:30 PM, revealed she had been trained by the facility to use hand sanitizer on her bare hands between trays delivered or to wear gloves. She stated it was the CNAs' choice which to do and she was taught she could touch food with gloved hands even when she had previously touched a resident or other items on the resident's tray. CNA #8 further stated she could not identify potential</p>	F 441		
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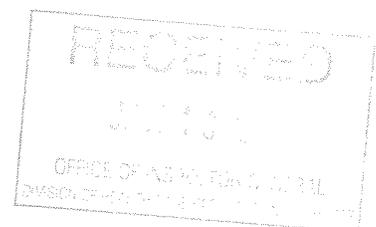
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F 441	Continued From page 42 concerns with cross contamination if she did not remove soiled gloves, wash her hands with soap and water and don new gloves before touching bare food.	F 441	1. Hall A room #5, 6, 9, and 16 bathroom scuffed marks will be repaired by Maintenance department by 1-19-13.	1-20-2013
F 465 SS=F	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure a sanitary environment for four (4) of four (4) units, Units A, B, C and D. The facility failed to ensure floors and doors were maintained in an orderly fashion. The findings include: No policy could be provided by the facility. Observation of the A-Hall, on 12/06/12 at 8:52 AM, revealed rooms #5, #6, #9 and #16's bathroom doors were scuffed at the base of the door and the floors had clear patches all over the floor. Room #16 was observed to have a door with a broken base. Observation of the B-Hall, on 12/06/12 at 9:00 AM, revealed rooms #4, #5 and #10 all had scuffed doors and clear patches all over the floors. Room #4's door was observed to have a hole in the door.	F 465	Floors on Hall A room 5, 6, 9, and 16, Hall B room 4,5, and 10, Hall C room 5 and 8 identified having clear patches will be stripped and refurbished by 1-19-13. Hall A room 16 door base will be repaired by Maintenance Department by 1-19-13. Hall B room #4, 5, and 10 door scuffed marks will be repaired by Maintenance department by 1-19-13. Hall B hole in door in room 4 will be repaired by Maintenance Department by 1-19-13. Hall C room 5 & 8 scuffed marks on door will be repaired by Maintenance Department by 1-19-13. Hall C room 8 bedside commode was removed and replaced by Director of Nursing on 1-2-13. Hall C room 15 will have bathroom door painted white by Maintenance Department by 1-19-13. Hall D room 3, 5, and 12 scuffed and chipped marks will be repaired by Maintenance Department by 1-19-13.	



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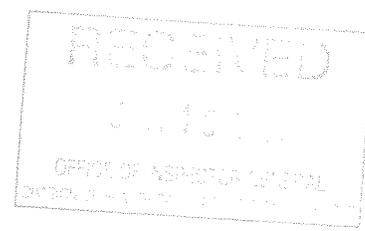
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F 465	<p>Continued From page 43</p> <p>Observation of the C-Hall, on 12/06/12 at 9:35 AM, revealed rooms #5 had scuffed door and clear patchy floors. Room #8's door were scuffed and had clear patchy floors. Room #8's bedside commode revealed rust all along the rim of the toilet. Room #15 bathroom door had not been painted white to make it uniform with the other doors.</p> <p>Interview with the Maintenance Director, on 12/06/12 at 11:30 AM, revealed he did not think to paint room #15's door. The Maintenance Director stated he did not know he was authorized to paint the door. When asked was the room homelike, he stated he would want the room to be homelike.</p> <p>Observation of the D-Hall, on 12/06/12 at 9:52 AM, revealed rooms #3, #5 and #12's doors were scuffed and chipped.</p> <p>Interview with Housekeeper #2, on 12/06/12 at 9:35 AM, revealed she was not sure when they were going to wax the floors. She stated it was a process and they would have to strip the floors first.</p> <p>Interview with the Housekeeping Manager, on 12/06/12 at 11:30 AM, revealed when it came to cleaning the floors, she had to move the patient and all of their belongings to another room. The Housekeeping Manager stated she had to wait for Admissions, Social Services and the DON to inform her which rooms would be deep cleaned.</p> <p>Interview with the Maintenance Director, on 12/06/12 at 11:30 AM, revealed he had to wait for the room turn over to complete the doors. The</p>	F 465	<ol style="list-style-type: none"> Director of Maintenance and the Safety Committee Chairman will complete an audit of facility to identify any other environmental issues that may be present. The audit will include all resident rooms, resident bathrooms, hallways and all common areas. This audit will be completed by 1-18-13 Any areas identified as needing repairs will be noted and repairs will be initiated. Education will be provided to Director of Maintenance by Administrator by 1-17-13 regarding providing a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. <p>Director of Maintenance will complete a room audit monthly to identify any repair needs. This audit will be recorded in the TELs program for monitoring . The Regional Director of Facility Maintenance will complete a review of the TELs documentation monthly to ensure the audit is completed.</p> <p>4. Director of Maintenance will report on the monthly room audits to the facility QA Committee no less than quarterly. The Regional Director of Facility Maintenance will report to the administrator monthly on his review of the TELs documentation. The Safety Committee Chairman will perform a room audit monthly for 3 months to ensure the repairs identified by the Maintenance Director are completed timely. After 3 months the audit will be done quarterly. Results of all audits will be reported to the facility QA Committee.</p>	
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F 465	<p>Continued From page 44</p> <p>Maintenance Director further stated he touched up the paint to the doors periodically, but did not remember the last time he did it.</p> <p>Interview with Maintenance Director and Housekeeping Manager, on 12/06/12 at 3:00 PM, revealed both agreed there was no set schedule for waxing the floors and painting the doors.</p> <p>Interview with the Admission Director, on 12/06/12 at 3:41 PM, revealed the facility did not have many discharges. The Admission Director stated there was a deep cleaning schedule, and she thought the Director of Nursing (DON) had the schedule. The Admission Director finally stated the Maintenance Director did not have to wait on her to tell him when to paint the doors.</p> <p>Record review of the rooms which had been deep cleaned, revealed between the days of 08/11/12 through 10/18/12; nine (9) rooms had been completed. The facility had a total bed capacity of 110 beds.</p> <p>Interview with the DON, on 12/06/12 at 5:47 PM, revealed the Maintenance Director did not need any guidance when touching up the paint to the doors. The DON further stated she did not have a deep cleaning schedule.</p>	F 465		
F 490 SS=F	<p>483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING</p> <p>A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p>	F 490		

