

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

PRINTED: 11/15/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185311	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/31/2013
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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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<p>F 000 INITIAL COMMENTS</p> <p>A standard health survey was initiated on 10/29/13 and concluded on 10/31/13 and a Life Safety Code survey conducted on 10/30/13 with deficiencies cited at the highest scope and severity of an "F".</p> <p>An abbreviated survey was conducted in conjunction with the standard survey to investigate KY20850 and KY20903. The Division of Health Care unsubstantiated the allegations with no regulatory violations.</p> <p>F 371 483.35(i) FOOD PROCURE, SS=F STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policies Food and Non-Food Storage, Environmental Sanitation/Infection Control, and Food Preparation and Safety, it was determined the facility failed to store, prepare, distribute, and serve food under sanitary conditions. There were six (6) of six (6) cans of tuna found dented and stored on the shelf. One (1) of one (1) convection oven was soiled. The range hood</p>		<p>F 000</p> <p>F 371</p>	<p>The preparation of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set. This Plan of Correction is prepared and solely because it is required by Federal and State Law.</p> <p>The identified dented cans of tuna were removed from the storage shelf on 10/29/2013. All caned items in storage were evaluated for dents on 10/30/2013 by the Director of Food Services. No other items in storage were found to be damaged. All dietary staff in-service on proper food storage and that any items found dented are to be labeled 'damaged' and stored away for distributor pick-up to be completed by 11/22/2013 by the Director of Food Service or Dietician. Completion Date: 11/23/2013.</p> <p>The range hood was cleaned 10/30/2013 and the convection oven was cleaned 11/8/2013 by the Director of Food Services and Cook. Cleaning of the convection oven has been added to a weekly cleaning schedule and the hood vents have been placed on a monthly cleaning schedule. All dietary staff in-service on proper cleaning of the convection oven and hood vents to be complete by 11/22/2013 by the Director of Food Service or Dietician. Completion Date: 11/23/2013.</p>	
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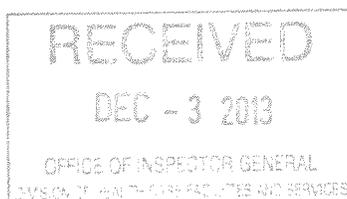
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *Administrator* (X6) DATE *11/22/2013*

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

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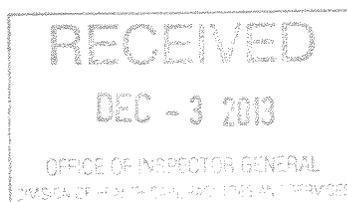
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F 371	<p>Continued From page 1</p> <p>was heavily soiled. The lids to the steam table were stored in the sink, then used to cover food without being sanitized, and two (2) bowls of chili were poured back into the main container of chili on the steam table.</p> <p>The findings include:</p> <p>Review of the facility's policy titled Food and Non-Food Storage, dated 2006, revealed the Food Service Department receives food for residents' meals from pre-approved vendors. The food is to be wholesome, undamaged and received at the proper temperature. Cans and packages within cartons are inspected for quality. Dents in the can seams or on the rim of the the lid makes the product unacceptable for use.</p> <p>Review of the facility's policy titled Environmental Sanitation/Infection Control, dated 2006, revealed ovens were to be kept clean and free of spills and grease.</p> <p>Review of the the facility's policy titled Food Preparation and Safety, dated 2006, revealed food was prepared using methods to provide the highest quality and nutritional value in proper quantities, and to assure appealing cost effective meals.</p> <p>Observation during the initial kitchen tour, on 10/29/13 at 8:20 AM, revealed six (6), four (4) pound cans of light tuna were stored on the shelf dated and ready for use with large dents. The convection oven had a build up of a black substance covering the entire bottom of the oven. The range hood was covered with brown fuzzy particles.</p>	F 371	<p>Staff re-education to Cook #5 on cross-contamination complete 10/31/2013 by the Director of Food Services. All dietary staff in -service on Food preparation and Safety, including cross-contamination and that all food is to be prepared using methods to provide the highest quality and nutritional value. This education will be complete by 11/22/2013 by the Director of Food Service or Dietician. Completion Date: 11/23/2013.</p> <p>Director of Food Services will monitor for dented cans in storage, appropriate oven and hood cleaning and observe tray line service monthly. Any issues will be addressed directly and reported to the QA Committee. Completion Date: 11/23/2013</p>



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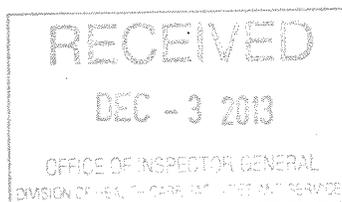
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F 371	<p>Continued From page 2</p> <p>Interview with the Dietary Manager during the initial tour, on 10/29/13 at 8:20 AM, revealed the range hood was cleaned every six (6) months and was scheduled for November.</p> <p>Observation of the tray line during the lunch meal service, on 10/30/13 at 11:15 AM, revealed the Cook stored the lids to the steam table, which covered the food, in the sink behind the steam table. The Cook proceeded to take the food temperatures rinsing the thermometer in the sink containing the lids between each food item. The Cook then rinsed the lids with water and placed them over the food while still wet and dripping with water.</p> <p>Continued observation of the tray line, on 10/30/13 at 11:55 AM, revealed the Cook picked up two (2) bowls of previously dispensed chili and poured them back into the main container of chili on the steam table after the hall tray carts were served. The tray line resumed for dining room service, on 10/30/13 at 12:00 PM, using the same container of chili on the steam table.</p> <p>Interview with Cook #5, on 10/31/13 at 11:05 PM, revealed she placed the lids in the sink while preparing trays for the employees. The Cook revealed she did not realize she had covered the food with the same lids from the sink and stated a potential for cross contamination. The Cook revealed she did not think it would be a problem to pour the undistributed portions of chili back into the container, but did state it could potentially contaminate the food.</p> <p>Interview with Cook #7, on 10/31/13 at 1:22 PM, revealed she was responsible for stocking food and stated she did not notice the cans of tuna</p>	F 371	



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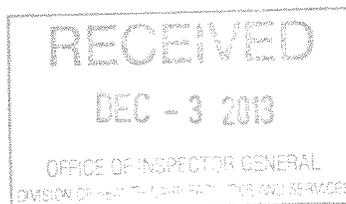
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F 371	Continued From page 3 were dented at the time of delivery. The Cook revealed a potential for food born illness by using dented cans. Interview with the Dietary Manager, on 10/31/13 at 1:20 PM, revealed the Maintenance Director had been removing the range hood panels and washing them monthly; however, this had not been done since the previous Maintenance Director left several months ago. The Dietary Manager revealed the hood was covered with dirt and dust and posed a potential to contaminate the food. The Dietary Manager revealed she had not been monitoring the hood, as it had always been the responsibility of the Maintenance Department. The Dietary Manager revealed the convection oven was not on the routine cleaning list and never had been. The Dietary Manager revealed she was aware of the condition of the oven, and either her or the cook would work on cleaning the oven when time allowed. The Dietary Manager revealed she had not had an inservice on proper storage of steam table lids, or the protocol for disposal of distributed food that was not served.	F 371			
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections	F 441			



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F 441	<p>Continued From page 4</p> <p>in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, review of the training records, and review of the facility's policies, it was determined the facility failed to consistently implement their Infection Control Program regarding the prevention of transmission of disease and infection during resident care for three (3) of seventeen (17) sampled residents, Resident #1, #5, and #9 and three (3) of three (3) unsampled residents, Unsampled Resident A, B, and C. The facility staff failed to clean reusable</p>	F 441	<p>Residents #1, #5, #9 and un-sampled residents A, B, and C were monitored for signs and symptoms of infection by the Director of Nursing for 3 days beginning 11/18/2013. No issues were noted to Residents #1, #5, #9 or un-sampled residents A, B, and C and no patterns of infection related to the deficient practice. Director of Nursing reviewed the 24 hour report sheets for the last 30 days to determine any resident with signs or symptoms of infection. There were no issues noted related to the deficient practice. LPN #5 received re-education on 11/11/13 by the Director of Staff Development and 11/12/13 with the Wound Care Nurse. After re-education LPN #5 completed a competency test. All licensed nurse re-education on infection control, including prevention of transmission of disease, hand hygiene, cleaning multi-use equipment and skin assessments and treatments was complete on 11/21/2013 by the Director of Staff Development. All licensed staff completed a competency test after this education. To monitor the effectiveness of this re-education, the Wound Care Nurse or Director of Staff Development or the Weekend Supervisor will observe each nurse perform an assessment, a treatment and the use of multi-use equipment to ensure proper procedure monthly for 2 months beginning in December then quarterly for two quarters. Results of these observations will be reviewed by the QA committee.</p>	



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F 441	<p>Continued From page 5</p> <p>equipment between residents; failed to wash hands and change gloves per policy; failed to sanitize hands when going from an area of the body considered to be dirty (buttocks) and then moving to a area considered to be clean (mouth); and failed to dispose of sharps in a safe and sanitary manner.</p> <p>The findings include:</p> <p>Review of the facility's Hand Hygiene policy, revised November 1, 2012, revealed hand hygiene was the primary means to prevent the transmission of infection. Hands should be washed after removal of gloves, before and after direct resident contact, before and after changing a dressing, before moving from a contaminated body site to a clean body site during resident care.</p> <p>Review of the facility's Wound Dressings policy, dated February 1, 2013, revealed the staff was to put on clean gloves, loosen the tape and remove the soiled dressing. To remove the dirty gloves the staff was to pull the glove over the soiled dressing and discard into a plastic or biohazard bag. The staff was to wash and dry hands thoroughly and then put on clean gloves.</p> <p>Review of the CDC guidelines, revealed gloves should be changed: when soiled (e.g., with blood, or other body fluids); and when going from a dirty area or task to a clean area or task. The CDC defined a dirty area as an area where there was a potential for contamination with blood or body fluids and areas where contaminated or used supplies, equipment, blood supplies or biohazard containers are stored or handled. A clean area was an area designated only for clean and</p>	F 441	<p>All sharps containers were checked and replaced as needed on 10/29/2013. Housekeeper #15 received re-education on proper razor disposal and policy for sharps container process. All housekeeping staff received re-education on razor disposal and the policy for sharps container process by the Director of Housekeeping by 11/22/2013. All staff re-education on infection control, including hand-hygiene, proper sharps disposal/process and cleaning of multi-use equipment by the Director of Staff Development or Weekend Supervisor by 11/27/2013. Director of Staff Development to check sharps containers monthly for three months then quarterly 3 quarters to ensure continued compliance. The Director of Staff Development will review these audits with the QA committee.</p> <p>There was no evidence of infection for the identified residents. Director of Nursing reviewed the 24 hour report sheets for the last 30 days to determine any resident with signs or symptoms of infection. There were no issues noted related to the deficient practice. All licensed nursing staff re-education on infection control, including cleaning of multi-use equipment, hand-hygiene and proper sharps disposal/process by the Director of Staff Development or Weekend Supervisor by 11/27/2013. To monitor the effectiveness of this re-education, the Wound Care Nurse or Director of Staff Development or the Weekend Supervisor will observe each licensed nursing staff during the use of multi-use equipment to ensure proper procedure monthly for 2 months beginning in December then quarterly for two quarters. Results of these observations will be reviewed by the QA committee.</p>

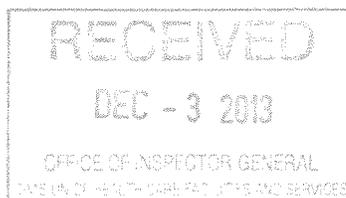
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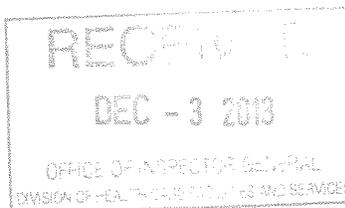
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F 441	Continued From page 6 unused equipment and supplies and medications; when moving from a contaminated body site to a clean body site of the same patient; and after touching one patient or their machine and before arriving to care for another patient or touch another patient's machine. According to the CDC, even with glove use, hand hygiene was necessary after glove removal because hands could become contaminated through small defects in the gloves and from the outer surface of the gloves during glove removal. Review of Licensed Personal Orientation Checklist, revealed Licensed Practical Nurse (LPN) #3 was provided education then performed demonstration of the task and signed off by the facilities Staff Development Nurse which included skin assessments on 04/04/13, and infection control, biohazards/sharps on 04/19/13. Review of Licensed Personal Orientation Checklist, revealed LPN #5 was provided education then performed demonstration of the task and signed off by the facilities Staff Development Nurse which included skin assessments, and infection control 06/17/13, then biohazards/sharps on 06/19/13. 1. Observation of a skin assessment and a wound care treatment with LPN #5 for Resident #1, on 10/30/13 at 9:25 AM, revealed during the skin assessment and wound care, LPN #5 with gloved hands retrieved an ink pen and paper from her pocket to make notes on and placed both items in Resident #1's bed. LPN #5 started at the resident head going downward to reveal the resident had labial cyst in the peri area. The nurse rolled the resident over to reveal her bottom with the same gloved hands the nurse	F 441			



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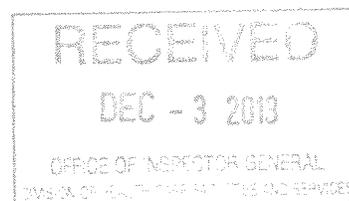
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F 441	<p>Continued From page 7</p> <p>used to remove Resident #1's dressing. The nurse continued to clean the residents wound and applied a new dressing without performing hand hygiene and fresh gloves. The nurse removed her gloves and performed hand hygiene after she applied barrier cream to the resident peri area. LPN #5 wrote on the paper with an ink pen and returned the paper and ink pen were it laid on the residents bed. The nurse continued the skin assessment which ended at the resident toes. With the same gloved hands the nurse picked up the ink pen and placed in her pocket. The nurse removed her gloves exited the room holding a tied bag of trash, the paper she had written on in the other hand was placed on the treatment cart. No hand hygiene was performed before she exited the residents room.</p> <p>2. Observation of a skin assessment and a wound care treatment with LPN #5 for Resident #5, on 10/30/13 at 10:10 AM, revealed LPN #5 had washed her hands and put on gloves, was assisted by LPN #3 who had washed her hands and put on gloves. LPN #3 was observed talking to Resident #5's roommate when she reached over and gave the roommate a hug with her gloved hands. LPN #3 continued to use the same gloved hands to assist LPN #5 with turning of Resident #5 during skin assessment and wound care. LPN #5 had quickly started the skin assessment beginning with the upper part of the resident's body. LPN #5 requested the resident be turned on his/her side, the nurse was observed touching the resident's bottom and proceeded to the resident's head with a request for the resident to open her mouth, LPN #5 was observed with her arms stretched out toward the resident's mouth, the surveyor stopped LPN #5 before she touched the resident mouth. LPN #5</p>	F 441		



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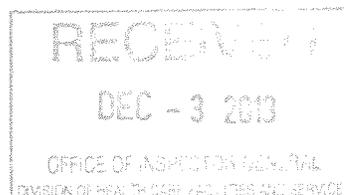
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F 441	Continued From page 8 removed her gloves, washed her hands and put on fresh gloves. LPN #3 exited the room. LPN #5 assessed Resident #5's head again with a visual oral exam and then then retracted the resident's labia. LPN #5 continued the skin assessment of the legs then the feet, at that time she pulled out an ink pen and paper, took down notes then returned those items back to her pocket with the same gloved hands, glove change or hand hygiene was observed. LPN #5, with the same gloves performed wound care for Resident #1, no glove change or hand hygiene was observed during any of the resident's wound care. LPN #5 reached back into her pocket and retrieved an ink pen and adhesive tape, the nurse was observed placing the pen back in her pocket after writing the date on the tape used to secure Resident #5's dressing to her right foot. The nurse with gloved hands lowered the resident's bed, bagged and tied the trash from the wound care, handed the resident her television remote and pulled back the resident's privacy curtain. LPN #5 removed her gloves then washed her hands. Interview with LPN #5, on 10/30/13 at 10:40 AM, revealed she had touched Resident #5 bottom with gloved hands and went back up to the residents' face. The nurse stated she should have done a head to toe assessment and then the front per area then the bottom. LPN #5 explained she had not received any facility training on hand hygiene or wound care procedures. The nurse further stated she was not ever trained to change her gloves during wound care from the facility or in nursing school. LPN #5 confirmed she had used the ink pen and paper to write resident information down on with her contaminated gloves and returned those	F 441		



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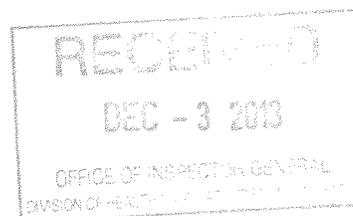
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185311	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/31/2013
NAME OF PROVIDER OR SUPPLIER ROCKFORD HEALTH AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4700 QUINN DR. LOUISVILLE, KY 40216	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
F 441	<p>Continued From page 9</p> <p>items back to her pocket when finished. The nurse stated she laid the items in Resident #5's bed because there was no place to put them, she stated that it was cross contamination and knew there was a policy on cross contamination. The nurse further stated cross contamination caused disease and illness that placed all residents, other employees, and visitors at risk.</p> <p>Interview with LPN #3, on 10/31/13 at 2:15 PM, revealed when she assisted LPN #5 with Resident #5's skin assessment and wound care, she knew why LPN #5 had been stopped during the skin assessment, because LPN #5 started touching the residents backside then she heard LPN #5 say let me see your mouth, and she did not change her gloves. She further stated it was the facility's policy to wash hands before and after glove change and using clean to dirty technique. She further stated she had received facility training on blood borne pathogens, hand hygiene with glove use, and infection control.</p> <p>Review of Licensed Personal Orientation Checklist, revealed Licensed Practical Nurse (LPN) #3 was provided education then performed demonstration of the task and signed off by the facilities Staff Development Nurse which included skin assessments on 04/04/13, and infection control, biohazards/sharps on 04/19/13.</p> <p>Review of Licensed Personal Orientation Checklist, revealed LPN #5 was provided education then performed demonstration of the task and signed off by the facilities Staff Development Nurse which included skin assessments, and infection control 06/17/13, then biohazards/sharps on 06/19/13.</p>	F 441	



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F 441	<p>Continued From page 10</p> <p>3. Observation with LPN #3 of Resident #9, on 10/30/13 at 9:55 AM, revealed LPN #3, during a skin assessment and brief change, entered the residents room; and put on gloves without washing her hands. The brief was soiled with urine, when the nurse assisted Resident #9 on his/her side, she touched the residents' bottom then removed the brief. The resident was assisted back to his/her back and the nurse performed male peri care. LPN #3 applied barrier cream from the tube with gloved hands and placed the barrier cream and wipes back onto the resident's side table.</p> <p>Interview with LPN #3, on 10/31/13 at 2:15 PM, revealed she was to wash her hands before putting on gloves for a head to toe skin assessment and should not have touched Resident #9's personal items with her dirty gloves on. The nurse further stated doing so was a risk for cross contamination and the spread of infection to other residents, staff and visitors. LPN #3 revealed she was provided facility training on bloodborne pathogens, hand hygiene with glove change, and infection control.</p> <p>4. Review of the Needle Handling and/or Disposal policy, dated November 1, 2012, revealed after using needles the staff was to place the needles in a needle disposal box. Do not discard used needles into trash receptacles.</p> <p>Interview with Administrator, on 10/30/13 at 11:30 AM, revealed the facility followed the Needle Handling and/or Disposal policy for all sharps including razors.</p> <p>Review of Bloodborne Pathogens Training Materials, undated revealed razors were to be</p>	F 441		



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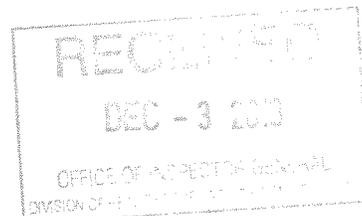
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F 441	<p>Continued From page 11 placed in sharps containers.</p> <p>Observation in the C/D shower room, on 10/29/13 at 2:30 PM, revealed an over flowing sharps container secured to the wall with greater than ten (10) razors protruding; some were handle exposed and some were blade exposed from the opening of the shapes container. In the same C/D shower room on the counter next to the sink was one (1) used razor unattended by staff.</p> <p>Observation in the C/D shower room, on 10/29/13 at 2:35 PM, revealed Housekeeper #15 walked into the shower room; removed the used razor on the sink and placed the razor in the biohazard trash can with a lid.</p> <p>Interview with Housekeeper #15, on 10/29/13 at 2:35 PM, revealed the Housekeeper stated they had placed the razor in the trash can because it looked like trash to her. The Housekeeper stated she did not know the policy on disposal of razors, but it was everybody's responsibility to keep the shower room clean. The housekeeper came to the conference room at 2:45 PM, and revealed she felt her answer she had given was wrong and stated the razor should have been disposed of in the sharps container. She further stated she should have informed the Unit Manager or Nurse on the hall the sharps container was full as they carried the key to open the locked box that held the sharps container.</p> <p>Training orientation records for Housekeeper #15 and not provided.</p> <p>Interview with Unit Manager #1, on 10/31/13 at 4:15 PM, revealed the C/D shower room sharps container was possibly missed, but should had</p>	F 441			



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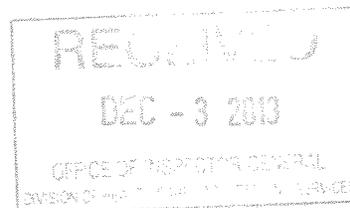
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F 441	Continued From page 12 been changed. The Unit Manager further stated all staff had been trained on sharps disposal, which included housekeeping; and the used razor, should not had been disposed of in the trash. The nurse revealed the Certified Nursing Assistants (CNA) was to let the nurse know in order to change the sharps container and revealed it was a breakdown in communication. Interview with the Staff Development Nurse, on 10/31/13 at 3:30 PM, revealed all employees were provided with class room training on bloodborne pathogens, infection control, biohazards/sharps disposal and exposure control plan and were not released to work with residents until trained and checked off. The nurse stated the risk related to poor hand hygiene and the decline in glove change included an infection risk to facility residents, staff and visitors. Interview with Director of Nursing (DON), on 10/31/13 at 3:45 PM, revealed the facility had policies that included hand hygiene, proper gloves use with skin assessment and wound care and all staff are trained and skilled before working with residents. The DON revealed infection control was something they had been working on with the Medical Director for tracking and trending in order to reduce the rate of infection within the facility. 5. Review of the facility's policy titled Cleaning and Disinfection of Resident Care Items and Equipment, dated 11/01/12, revealed resident	F 441		



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F 441	<p>Continued From page 13</p> <p>care equipment, including reusable items would be cleaned and disinfected according to current Center for Disease Control recommendations for disinfection. Reusable items are cleaned and disinfected or sterilized between residents (e.g., stethoscopes and durable medical equipment).</p> <p>Observation of Licensed Practical Nurse (LPN) #1, during medication pass with Unsampled Resident C, on 10/30/13 at 10:48 AM, revealed the LPN obtained a stethoscope from the medication cart and placed around her neck. She did not clean the stethoscope. She placed the stethoscope bell to the resident's bare chest wall and auscultated for an apical pulse without cleaning the stethoscope bell. Upon completion, she returned the stethoscope around her neck without cleaning the stethoscope.</p> <p>Observation, of LPN #1, during medication pass, on 10/30/13 at 12:00 PM, revealed Unsampled Resident B received a medication via the G-Tube. LPN #1 removed her stethoscope from around her neck and placed the stethoscope bell to the resident's bare abdomen and auscultated for G-Tube placement without cleaning the stethoscope bell. Upon completion, she returned the stethoscope around her neck without cleaning the stethoscope.</p> <p>Observation, of LPN # 1, during medication pass, on 10/30/13 at 12:15 PM, revealed Unsampled Resident A received a medication via the G-Tube and a nebulizer treatment. LPN #1 removed the stethoscope from around her neck and placed the stethoscope bell to the resident's bare abdomen and auscultated for G-Tube placement without cleaning the stethoscope bell. She returned the stethoscope around her neck. In addition, LPN</p>	F 441		



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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 441	<p>Continued From page 14</p> <p>#1 proceeded with a nebulizer treatment. She removed the stethoscope from around her neck and proceeded with anterior and posterior lung field auscultation on Unsampled Resident A. Upon completion, she returned the stethoscope around her neck without cleaning the stethoscope.</p> <p>Interview with LPN #1, on 10/31/13 at 9:45 AM, revealed the stethoscope should have been cleaned before and after she used her stethoscope, since she carried the stethoscope around her neck. There was a potential for cross contamination by reuse and not cleaning between each resident use. She stated, equipment used on residents should be cleaned after each use and between resident use. She stated it slipped her mind. The lack of cleaning the stethoscope between resident uses could lead to the spread of germs to other residents.</p> <p>Interview with Unit Manager #1, on 10/31/13 at 9:48 AM, revealed all equipment used on residents must be cleaned between resident uses to prevent infection. That included stethoscopes.</p> <p>Interview with the Director of Nursing (DON), on 10/31/13 at 3:35 PM, revealed the stethoscope should have been cleaned before and after each use on each resident. She stated there was a potential for cross contamination by reuse and failure to clean between each resident use. She confirmed the facility did have a policy that spoke to the cleaning of reusable items.</p>	F 441		
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{F 000}	<p>INITIAL COMMENTS</p> <p>Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 11/28/13 as alleged.</p>	{F 000}		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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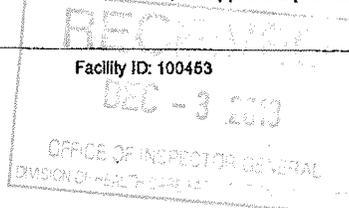
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1974</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (200)</p> <p>SMOKE COMPARTMENTS: Six (6) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system.</p> <p>GENERATOR: Type II, 55 KW generator. Fuel source is Natural Gas.</p> <p>A standard Life Safety Code survey was conducted on 10/30/13. Rockford Health and Rehab Center was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p>	K 000	The preparation of this Plan of Corrections does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set. This Plan of Correction is prepared and executed solely because it is required by the Federal and State Law.		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

[Signature] Administrator 11/20/13

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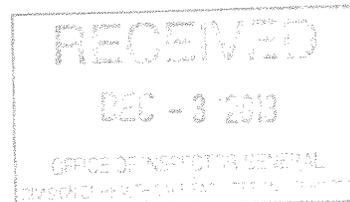


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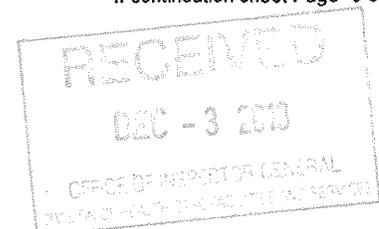
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K 000	Continued From page 1	K 000		
K 018 SS=D	<p>Deficiencies were cited with the highest deficiency identified at D level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¼ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure corridor doors would completely latch when closing, to prevent the passage of smoke in the event of an emergency, in accordance with NFPA standards. The deficiency had the potential to affect one (1) of six (6) smoke compartments, approximately twenty-five (25) residents, staff, and visitors. The facility has one-hundred and ten (110) certified</p>	K 018	<p>The door to B15 was fixed by the Maintenance Assistant on 11/19/2013 to be able to properly latch to resist the passage of smoke in the event of an emergency. All doors were checked for proper closure on 11/20/2013 by the Maintenance Assistant. There were no other doors identified to have issues with closure. All resident doors will be checked for proper latching monthly for 3 months then quarterly by the Maintenance Director or Maintenance Assistant. These audits will be completed by the Maintenance Director or Maintenance Assistant and results of the audits will be reviewed by the QA Committee. Completion Date: 11/21/2013</p>	



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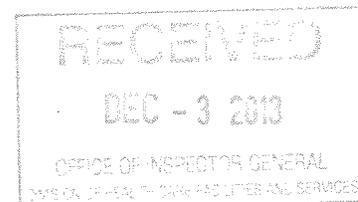
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K 018	<p>Continued From page 2</p> <p>beds and the census was ninety-five (95) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 10/30/13 at 10:23 AM, with the Maintenance Director revealed the door to resident room B15 would not latch when tested.</p> <p>Interview, on 10/30/13 at 10:23 AM, with the Maintenance Director revealed he was unaware of the door not being able to latch when closing and acknowledged it would not be able to resist the passage of smoke in the event of an emergency.</p> <p>19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors.</p> <p>Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials.</p> <p>Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors</p>	K 018		



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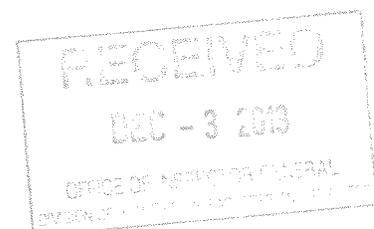
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K 018	Continued From page 3 shall be constructed to resist the passage of smoke. 19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.5.2. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: Existing roller latches demonstrated to keep the door closed against a force of 5 lbf (22 N) shall be permitted to be kept in service.	K 018			
K 029 SS=D	19.3.6.3.3* Hold-open devices that release when the door is pushed or pulled shall be permitted. NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are	K 029	A self-closing device was added to the door to the boiler room on 11/7/2013 by the Maintenance Assistant. All other doors in the facility were checked to verify self-closing devices were placed on required areas by 11/6/2013 by the Maintenance Director. No other doors were identified to need a self-closing device. Maintenance Director and Assistant Maintenance Director received re-education by the Administrator on 11/1/2013 regarding self-closing devices and safety to protect hazardous areas. Maintenance Director or Assistant Maintenance Director to check doors for proper closure and self-closing devices quarterly. Results of the audits will be reviewed by the QA committee. Completion Date: 11/9/2013		



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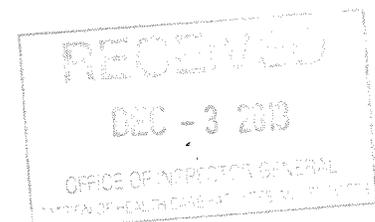
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185311	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 10/30/2013
NAME OF PROVIDER OR SUPPLIER ROCKFORD HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4700 QUINN DR. LOUISVILLE, KY 40216		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 029	Continued From page 4 permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements for Protection of Hazards, in accordance with NFPA standards. The deficiency had the potential to affect one (1) of six (6) smoke compartments, residents, staff and visitors. The facility has one-hundred and ten (110) certified beds and the census was ninety-five (95) on the day of the survey. The findings include: Observation, on 10/30/13 at 9:17 AM, with the Maintenance Director revealed the door to the Boiler Room did not have a self-closing device installed on the door. The door closer had been removed. Interview, on 10/30/13 at 9:17 AM, with the Maintenance Director revealed he was not aware of the door to the Boiler Room not being equipped with a self-closing device or why it had been removed. Reference: NFPA 101 (2000 Edition). 19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided	K 029			



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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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K 029	Continued From page 5 with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029			



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185311	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED R 12/03/2013
NAME OF PROVIDER OR SUPPLIER ROCKFORD HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4700 QUINN DR. LOUISVILLE, KY 40216		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{K 000}	INITIAL COMMENTS Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 11/21/13 as alleged.	{K 000}			

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

TITLE

(X6) DATE

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.