

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155464	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/27/2015
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NAME OF PROVIDER OR SUPPLIER ROCKVILLE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 768 N US HWY 41 ROCKVILLE, IN 47872
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F 000 Bldg. 00	<p>This visit was for a recertification and state licensure survey.</p> <p>This visit was in conjunction with a Post Survey Revisit (PSR) to the Investigation of Complaint IN00169303 completed on March 13, 2015.</p> <p>Survey dates: April 21 - 24, 2015 and April 27, 2015.</p> <p>Facility Number: 000492 Provider Number: 155464 AIM Number: 100291360</p> <p>Census bed type: SNF/NF: 24 Total: 24</p> <p>Census payor type: Medicare: 2 Medicaid: 15 Other: 7 Total: 24</p> <p>These deficiencies reflect state findings cited in accordance with 10 IAC 16.2-5.</p>	F 000	By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective May 18th, 2015 to the annual licensure survey conducted April 21st– 24th and April 27th.	

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.

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F 164 SS=D Bldg. 00	<p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>Based on observation and record review, the facility failed to ensure the residents right for personal privacy during medication administration for 2 of 2 residents reviewed for privacy during medication administration. (Resident #23 and #27).</p>	F 164	<p>How will the corrective action be accomplished for those residents who are affected by this alleged deficient practice? Resident #27 and #23 will have door shut and/or curtain closed when receiving insulin injection</p> <p>How will the facility identify residents having the potential to be affected by the same</p>	05/18/2015
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	<p>Findings include:</p> <p>1. On 4/22/15 at 12:00 p.m., LPN #1 administered insulin to Resident #27. With the resident sitting in his wheel chair and facing the hallway, the nurse lifted the resident's shirt, exposing the resident's abdomen from below the chest to below the navel to administer the insulin. The door to the resident's room was open and Resident #23 was observed sitting in his wheelchair in the hallway outside of the room.</p> <p>On 4/25/15 at 11:54 a.m., review of the significant change Minimum Data Set (MDS), dated 12/31/14, indicated the resident had a moderate cognitive deficit.</p> <p>2. On 4/22/15 at 11:35 a.m., LPN #1 administered insulin to Resident #23. With the resident sitting in his wheelchair, the nurse administered the insulin in the back of the resident's left arm. The resident's door was open and the privacy curtain was not pulled, and the resident could be fully viewed from the hallway. The resident's roommate (Resident #15) was in the room at the time of the injection.</p> <p>On 4/24/15 at 12:03 p.m., review of the Quarterly Minimum Data Set (MDS), dated 1/20/15, indicated the resident had</p>		<p>deficient practice? All residents have the potential to be affected by this finding. What measure will be put into place or systematic changes made to ensure that the deficient practice does not recur? Directed inservice training will be completed for the nursing staff including but not limited to Resident's Rights, especially in regards to privacy. How will facility monitor its corrective actions? The director of nursing will observe insulin injections 3x a week for a month, weekly for a month, and then quarterly x3. In addition, the administrator will interview residents to ensure that preferences in regards to privacy are being met. Administrator will complete these rounds 3x a week for a month, weekly for a month, monthly for a month, and then quarterly x3. The Quality Assurance committee will oversee compliance</p>		

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F 242 SS=D Bldg. 00	<p>a moderate cognitive deficit.</p> <p>During review of a current document titled, "Resident Rights" provided by the Director of Nursing (DON) on 4/24/15 at 10:37 a.m., documentation was noted, under the title of "Privacy and confidentiality," The resident has the right to personal privacy...Personal privacy includes...medical treatment..."</p> <p>3.1-3(u)(1)</p> <p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Based on interview and record review, the facility failed to ensure resident's preferences for showering was maintained for 1 of 3 residents reviewed who met the criteria for choices (Resident #8).</p> <p>Findings include:</p>	F 242	<p>How will the corrective action be accomplished for those residents who are affected by this alleged deficient practice?</p> <p>Resident #8 was interviewed again and indicated she would like shower three times a week. Resident #8 is still on the shower schedule to receive showers 3 times a week in the evenings.</p> <p>How will the facility identify residents having the potential</p>	05/18/2015

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	<p>During an interview of Resident #8, on 4/22/15 at 2:01 p.m., the resident indicated she had requested three showers a week, but could not remember, due to short term memory loss, if she actually had gotten three showers a week.</p> <p>On 4/24/15 at 11:31 a.m., CNA #2 indicated Resident #8 was scheduled for three showers per week, on Sundays, Tuesdays and Thursdays, and needed assistance of one person. CNA #2 indicated Resident #8 had not received three showers a week.</p> <p>On 4/24/15 at 11:43 a.m., the Director of Nursing (DON) indicated Resident #8 was assigned showers on Sundays, Tuesdays and Thursdays, but had not received three showers weekly.</p> <p>On 4/24/15 at 3:09 p.m., CNA #5 indicated Resident #8 was scheduled for three showers per week and needed assistance with showers of one person.</p> <p>Resident #8's clinical record was reviewed on 4/24/15 at 10:27 a.m. A Quarterly Minimum Data Set (MDS) assessment, dated 1/28/15, indicated the resident was moderately cognitive impaired and required one person physical assist for showers.</p>		<p>to be affected by the same deficient practice? All residents have the potential to be affected by this finding. What measure will be put into place or systematic changes made to ensure that the deficient practice does not recur? Directed inservice training will be completed for nursing staff including but not limited to the facility's procedure regarding shower sheets. This is the current process regarding shower sheets 1. Shower sheets are to be picked up by CNA at beginning of shift 2. Shower sheets are to be turned into Charge Nurse after shower has been completed 3. Showers are to then be documented on Resident's ADL record. 4. Charge Nurse is to sign off on shower sheet and put in DON mailbox If resident refuses shower, this should also be noted on shower sheets and still turned in. If resident #8 is LOA during the time of her scheduled shower, CNA is to note that on her shower sheet as well. How will facility monitor its corrective actions? All residents have been interviewed by the Social Services Director on their shower preferences using the "Resident Preference" worksheet to make sure their preferences are up to date. All care plans have also been updated accordingly. A performance improvement tool has been initiated that will be utilized to audit showers. The tool</p>		

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	<p>A form, dated June 12, 2014, titled, "PREFERENCES FOR CUSTOMARY ROUTINES," was received from the DON on 4/24/15 at 11:45 a.m. The form indicated, but was not limited to, Resident #8 preferred showers, three evenings a week.</p> <p>Documentation, titled, "ADL Flow Sheet," provided by the DON on 4/24/15 at 11:45 a.m., indicated Resident #8 failed to receive three showers per week on the following weeks:</p> <p>a. The first week of March, 2015, the resident received showers on March 1st and March 5th.</p> <p>b. The second week of March, 2015, the resident received a shower on March 12th.</p> <p>c. The third week of March, 2015, the resident received a shower on March 19th.</p> <p>d. The fourth week of March, 2015, the resident did not receive any showers.</p> <p>e. The first week of April, 2015, the resident received a shower on April 2nd.</p> <p>f. The second week of April, 2015, the resident received showers on April 7th</p>		<p>will randomly review residents to make sure their shower preferences from the "Resident Preference" sheet are being followed. DON or designee will audit 3x a week for a month, weekly for a month, and monthly for a month, then quarterly x3. The Quality Assurance committee will oversee compliance</p>	

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	<p>and April 9th.</p> <p>g. The third week of April, 2015, the resident received a shower on April 15th.</p> <p>h. The fourth week of April, 2015, the resident received a shower on April 23rd.</p> <p>The DON provided on 4/24/15 at 10:37 a.m., a policy and procedure titled, "Resident Rights," which indicated, "...Self-determination and participation. The resident has the right to; (1) Choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care...(3) Make choices about aspects of his or her life in the facility that are significant to the resident...."</p> <p>3.1-3(v)(1)</p>			

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F 318 SS=D Bldg. 00	<p>483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Based on observation, interview, and record review, the facility failed to provide range of motion services for 1 of 3 residents reviewed for limited range of motion (Resident #2).</p> <p>Finding includes:</p> <p>On 4/22/15 at 11:16 a.m., Resident #22 was observed in the dining room having a snack. The resident's hands were observed with contractures (constrictor of muscle/joints). The Activity Director was interviewed at that time. She indicated the resident could not easily open her hands. No splints were observed in place.</p> <p>On 4/24/15 at 10:00 a.m., CNAs (Certified Nurse Aides) #2 and #3 were interviewed. The CNAs indicated only CNA #2 was trained on providing range of motion services. CNA #2 indicated she</p>	F 318	<p>F318How will the corrective action be accomplished for those residents who are affected by this alleged deficient practice? Resident #2 was evaluated by therapy and is currently receiving therapy services for limited range of motion. How will the facility identify residents having the potential to be affected by the same deficient practice? 22 residents were rescreened by therapy to determine if there is a need for range of motion services What measure will be put into place or systematic changes made to ensure that the deficient practice does not recur? Residents determined to benefit from range of motion will be identified, care planned and added to current CNA assignment sheet How will facility monitor its</p>	05/18/2015
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	<p>did not do restorative nursing. The staff indicated residents were encouraged to raise their arms during dressing and bathing. The CNAs indicated they thought residents who required splinting devices or range of motion for contractures were referred to therapy. The CNA's indicated Resident #22 developed contractures of the hands in the last couple of days.</p> <p>The Director of Nursing was interviewed on 4/27/15 at 12:01 p.m. The DON indicated the lead CNA (CNA #2) was responsible for training other CNAs on range of motion services during orientation. The DON indicated part of the certification curriculum for CNAs included how to provide range of motion services.</p> <p>The Physical Therapist was interviewed on 4/28/15. He indicated he had evaluated the resident on that date and indicated the resident had declined thirty degrees in range of motion of lower extremities since discharge from therapy 8/7/14.</p> <p>The resident's clinical record was reviewed on 4/27/15 at 10:45 a.m. A physician's order, dated 4/21/15, for a rehabilitation evaluation and treatment.</p>		<p>corrective actions?Residents receiving ROM services will be reviewed in the weekly Medicare meeting. In addition, a performance improvement tool has been initiated that randomly reviews and verifies residents receiving range of motion services. The DON or designee will complete this tool 3x a week for 3 weeks, weekly for a month, monthly for a month, then quarterly x3.</p>	

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F 323 SS=D Bldg. 00	<p>The Annual Minimum Data Set (MDS) assessment, dated 2/25/15, coded the resident with bilateral upper and lower extremity limitations.</p> <p>A nursing passive range of motion care plan was noted for resident at risk for further contractures related to dementia and limited mobility. The goal was to tolerate five repetitions of PROM bilateral upper and lower extremities six days per week. Documentation of the service being provided was lacking for March and April.</p> <p>3.1-42(a)(2)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure side rails were securely fastened to a</p>	F 323	How will the corrective action be accomplished for those residents who are affected by	05/18/2015

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	<p>resident's bed for 1 of 6 residents reviewed with side rails (Resident #15).</p> <p>Finding includes:</p> <p>On 4/21/15 at 2 p.m., Resident #15 was observed in bed with two 1/2 siderails raised that were loosely attached to the bed.</p> <p>On 4/21/15 at 3 p.m., a maintenance staff moved the side rail and indicated it was loose and needed fixed.</p> <p>On 4/27/15 at 1 p.m., the administrator indicated maintenance staff did not check side rails. The administrator indicated the staff were supposed to document concerns in a log book kept at the nurses' station.</p> <p>Resident #15's clinical record was reviewed on 4/22/15 at 2 p.m. A "Bed Rail Safety Assessment," dated 2/18/15, indicated, "....Bed rails are firmly attached to the bed frame and are easily raised and lowered."</p> <p>A quarterly assessment, dated 2/18/15, identified the resident was cognitively impairment and required extensive assistance with bed mobility.</p> <p>A facility policy and procedure titled</p>		<p>thisalleged deficient practice?Resident #15's siderails were adjusted and tightened on 4/21</p> <p>How will the facilityidentify residents having the potential to be affected by the same deficientpractice?All residents who use siderails have the potential to be affected by thisfinding</p> <p>What measure will beput into place or systematic changes made to ensure that the deficient practicedoes not recur?A Bed Entrapment Assessment has been put into place to monitor siderails as part of a preventative maintenance program.</p> <p>How will facility monitorits corrective actions?All beds will be checked to ensure the rails are in placeand firmly attached. Any changes to side rails will be completed and signed offby maintenance director. The Bed Entrapment Assessment will be completed by theMaintenance Director as part of a preventative maintenance program. In addition, staff will monitor via guardian angel rounds,5x a week.</p>	

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F 371 SS=E Bldg. 00	<p>"Bed Safety", dated 10/2012, was received from the administrator on 4/27/15 at 12:30 p.m. The policy indicated, " ...2. a. Inspection by maintenance staff of all beds and related equipment as part of our regular bed safety program to identify risks and problems including potential entrapment risks...."</p> <p>3.1-45(a)(1)</p> <p>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 Based on observation, interview, and record review the facility failed to ensure foods were stored and/or prepared under sanitary conditions in 2 of 2 kitchen observations.</p> <p>Findings include:</p> <p>1. During observation of the Kitchen and food storage area on, 4/21/15 at 10:15 a.m., the following items were observed:</p>	F 371	<p>F371 How will the corrective action be accomplished for those residents who are affected by this alleged deficient practice? Cook #1 was given disciplinary action and education for improper handwashing and lack of cleanliness in the kitchen. How will the facility identify residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected</p>	05/18/2015

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	<p>Food debris was on the bottom of the freezer and refrigerator.</p> <p>Floors in the kitchen and food storage had dust and debris through out.</p> <p>Three white containers were dirty on the handles, lids, and outside of the containers. They contained flour, sugar, and individually wrapped crackers.</p> <p>The tops of 6 out of 20 cans had heavy amounts of dust.</p> <p>The stove had a build up of grease on the left side. A white storage shelf in the kitchen that held pots, pans, and a coffee pot had chipping paint on the bottom of shelf.</p> <p>2. On 4/22/15 at 11:30 a.m. during an observation of puree food preparation, Cook # 4 had a 1/2 cup spoon in her hand and was preparing puree peas. After Cook # 4 was done with the peas, she placed the puree container in the dishwasher. Cook # 4 went to the sink and washed her hands for 10 seconds. She proceeded to put clean utensils in drawers and opened cabinets to put away clean dishes. Cook # 4 then removed the puree container from dishwasher and began to puree sweet potatoes.</p>		<p>although none wereaffected.</p> <p>What measure will beput into place or systematic changes made to ensure that the deficient practicedoes not recur?All dietary staff is to be inserviced on the handwashing policy for kitchenemployees as well as proper storage, preparation, distribution and serving foodunder sanitary conditions. The Dietary Manager's Daily Sanitation checklist hasbeen revised.</p> <p>How will facilitymonitor its corrective actions?A performance improvement tool has been initiated that randomly reviewskitchen observations. The Administrator will complete this tool weekly x3, monthly x3 and quarterly x3. Any identified issues will be immediatelyaddressed. The Quality Assurance Committee will review the tool at the scheduledmeetings with recommendations for additional interventions as needed. Using a performance improvement tool, dietary manager willobserve kitchen employee handwashing. Audit will be completed 3x a week for 3weeks, weekly for a month, monthly for a month, then quarterly x3.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155464	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/27/2015
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NAME OF PROVIDER OR SUPPLIER ROCKVILLE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 768 N US HWY 41 ROCKVILLE, IN 47872
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	<p>On 4/27/15 at 12:20 p.m., the Administrator provided the policy, "Food Storage" dated April 2006, the policy indicated, " 1. ...Food Services, or other designated staff, will maintain clean food storage areas at all times. ... 2. All package food, canned foods, or food items stored will be kept clean and dry at all time. ... 3. All foods will be stored on shelves, racks, dollies, or other surfaces that facilitate thorough cleaning. ..."</p> <p>On 4/27/15 at 12:20 p.m., the Administrator provided the policy, " Hand Washing and Glove Use for Food Workers" dated October 2005, the policy indicated, "... All employees involved with food preparation must wash their hands and exposed portions of their arms with soap and water. ...Vigorously rubbing together the surfaces of lathered hands and arms for at least 20 seconds. ..."</p> <p>3.1-21(i)3</p>			