

| | | | |
|--|---|--|---|
| 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 03/13/2015 |
|--|---|--|---|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER ROCKVILLE NURSING AND REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 768 N US HWY 41 ROCKVILLE, IN 47872 |
|---|---|

| (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 000 Bldg. 00 | <p>This visit was for the Investigation of Complaint IN00169303.</p> <p>Complaint IN00169303 - Substantiated. Federal/State deficiencies related to the allegations are cited at F 157 and F309.</p> <p>Survey dates: March 12, 13, 2015</p> <p>Facility number: 000492 Provider number: 155464 AIM number: 100291360</p> <p>Survey team: Connie Landman RN-TC</p> <p>Census bed type: SNF/NF: 23 Total: 23</p> <p>Census payor type: Medicare: 4 Medicaid: 14 Other: 5 Total: 23</p> <p>Sample: 3</p> <p>These deficiencies reflects state findings in accordance with 410 IAC 16.2-3.1.</p> | F 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.

| | | | |
|--|---|--|---|
| 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 03/13/2015 |
|--|---|--|---|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER ROCKVILLE NURSING AND REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 768 N US HWY 41 ROCKVILLE, IN 47872 |
|---|---|

| (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 157 SS=D Bldg. 00 | <p>Quality review completed 3/16/15 by Brenda Marshall, RN.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to immediately notify</p> | F 157 | It is the practice of Rockville Nursing & Rehab to assure that the physician and family are appropriately in | 03/27/2015 |

| | | | |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155464 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | X3) DATE SURVEY COMPLETED 03/13/2015 |
|--|---|---|---|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER ROCKVILLE NURSING AND REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 768 N US HWY 41 ROCKVILLE, IN 47872 |
|---|---|

| (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 |
|--------------------|---|---------------|--|----------------------|
| | <p>the physician of a condition change for 1 of 3 residents reviewed for change in condition (Resident B).</p> <p>Findings include:</p> <p>During an interview with CNA #3 on 3/12/15 at 11:50 a.m., she indicated she assisted Resident B with his clear liquid lunch on 3/5/15. The CNA indicated Resident B vomited a large amount of black liquid and had "rattle" sounds in his chest.</p> <p>During an interview with LPN #1 on 3/13/15 at 11:30 a.m., she indicated she was informed in "morning report" on 3/5/15 Resident B vomited during the previous night.</p> <p>During an interview with the DON (Director of Nursing) on 3/12/15 at 1:30 p.m., she indicated her expectation was if a CNA brought a problem or concern to a nurse, the nurse would immediately go and do a head to toe assessment of the resident and document her findings.</p> <p>The record for Resident B was reviewed on 3/12/15 at 10:15 a.m. His diagnosis included, but was not limited to, history of lower gastrointestinal bleed in 2009.</p> <p>A Nurses Note, dated 3/5/15 at 6:25 a.m.,</p> | | <p>accordance with guidelines related to incidents.</p> <p>I. The corrective action taken for those residents found to have been affected by deficient practice include: Resident B is no longer at facility II. Other residents that have the potential to be affected have been identified by: Residents experiencing an acute change of condition have potential to be affected by this finding. All residents that have had an acute change of condition since March 13th have been reviewed to assure that physician/families have been notified appropriately. III. The measures or systemic changes that have been put into place to ensure that the deficient practice does not recur include: A change of condition or status policy was reviewed and approved through QA. Nursing staff will be educated on new policy and importance of physician/family notification with significant changes. In addition, nurses will be inserviced on the importance of responding to CNA concerns. As the interdisciplinary team is reviewing acute changes on each business day, they are reviewing all documentation to assure the physician/family was notified appropriately. Nursing staff will also be inserviced on the use of the SBAR.</p> <p>IV. The corrective action taken to monitor performance to assure compliance through quality</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 03/13/2015 |
|--|---|--|---|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER ROCKVILLE NURSING AND REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 768 N US HWY 41 ROCKVILLE, IN 47872 |
|---|---|

| (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 |
|--------------------|---|---------------|--|----------------------|
| | <p>indicated Resident B had 2 episodes of emesis (vomiting) during the night shift. The record did not indicate the physician was notified of the vomiting.</p> <p>Nurses Notes did not indicate Resident B vomited at lunchtime and did not indicate the physician was notified of the change in condition on the day shift (6:00 a.m. - 2:00 p.m.) on 3/5/15.</p> <p>The next entry in the Nurses Notes, dated 3/5/15 at 2:30 p.m., indicated Resident B had vomited a small amount of light brownish liquid, no odor. His vital signs and oxygen saturation (O2 Sat) were taken and within normal limits. The physician and the responsible party were notified.</p> <p>A 6:00 p.m. entry in the Nurses Notes on 3/5/15 indicated Resident B had a large amount of dark brown emesis. The physician was present, assessed the resident, and ordered his transfer to the hospital where he was admitted with a diagnosis of "GI [gastrointestinal] bleed."</p> <p>The Emergency Medical Services report was reviewed on 3/13/15 at 11:30 a.m. The report indicated on 3/5/15 at 7:00 p.m. Resident B's blood pressure was 124/78, heart rate 116, respiratory rate 18 and equal with rales [clicking, rattling,</p> | | <p>assurance is: A performance improvement tool has been initiated that will be utilized to review acute changes to assure that the physician/family have been notified in accordance with the regulation. The tool will include acute changes. The tool will randomly review 5 residents with an acute change. DON or her designee will complete this audit 3x a week for a month, weekly for a month, and monthly for a month, and then quarterly x3. Any issues identified will be immediately corrected. The quality assurance committee will review the tool with recommendations as needed based on the outcome of the tools monthly x3. The date of systematic changes will be completed by 3/27/15</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 03/13/2015 |
|--|---|--|---|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER ROCKVILLE NURSING AND REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 768 N US HWY 41 ROCKVILLE, IN 47872 |
|---|---|

| (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 |
|--------------------|--|---------------|---|----------------------|
| | <p>bubbling breath sounds]. The report also indicated Resident B was in bed on his back with the head of the bed up approximately 30 degrees. The staff was cleaning him up, and reported he had vomited multiple times and it was dark brown. The report indicated the sheets "show coffee ground consistency." Resident B was placed in sitting position on the cot and taken to the ambulance where his vital signs were obtained, an IV was started, he vomited a small amount of coffee ground emesis and was given Zofran (medication to prevent nausea and vomiting). His abdomen was soft, non-distended, and Resident B denied any complaints. Resident B had one other emesis en route to the hospital.</p> <p>The hospital Emergency Department record was reviewed on 3/13/15 at 11:40 a.m. The notes indicated his "problem" was vomiting blood. Resident B's vital signs were B/P (blood pressure) 91/71, pulse 124, respirations 29, temperature 99 degrees and his oxygen saturation was 92% on room air. The "History of Present Illness" "presents with coffee ground emesis." "Respiratory Chest: Breath sounds not clear, rhonchi [coarse rattling sounds like snoring] present, to bilateral lower lobes, breath sounds diminished to bilateral upper lobes, bilateral lower lobes." Resident B was admitted to a</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 03/13/2015 |
|--|---|--|---|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER ROCKVILLE NURSING AND REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 768 N US HWY 41 ROCKVILLE, IN 47872 |
|---|---|

| (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 309 SS=G Bldg. 00 | <p>medical/surgical unit after being stabilized with intravenous fluids and medications in the Emergency Department.</p> <p>A current facility policy, dated 04/12, titled "Change in a Resident's Condition or Status" was provided by the DON on 3/13/15 at 3:05 p.m. It indicated: "...1. The Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On-Call Physician when there has been:...e. A significant change in the resident's physical/emotional/mental condition; f. A need to alter the resident's medical treatment significantly...5. The Nurse Supervisor/Charge Nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status...."</p> <p>This federal tag relates to Complaint IN00169303.</p> <p>3.1-5(a)(2)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and</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 03/13/2015 |
| NAME OF PROVIDER OR SUPPLIER ROCKVILLE NURSING AND REHABILITATION CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 768 N US HWY 41 ROCKVILLE, IN 47872 | | |
| (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 | |
| | <p>services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to ensure a timely and thorough assessment and failed to ensure adequate monitoring of of a resident with a change in health condition and failed to immediately notify the physician of a condition change for 1 of 3 residents reviewed for change in condition (Resident B).</p> <p>Findings include:</p> <p>During an interview with CNA #3 on 3/12/15 at 11:50 a.m., she indicated she assisted Resident B with his clear liquid lunch on 3/5/15. The CNA indicated Resident B vomited a large amount of black liquid and had "rattle" sounds in his chest. CNA #3 indicated CNA #4 assisted her in cleaning the emesis and CNA #4 remained with the resident while she reported the emesis to LPN #1. The CNA indicated she asked LPN #2 to check the resident because LPN #1 had not been observed to assess the resident's change in condition.</p> <p>In a follow up interview on 3/13/15 at 1:45 p.m., CNA #3 indicated Resident B vomited a large amount of black, clear,</p> | F 309 | <p>It is the practice of Rockville Nursing & Rehab to assure that our residents receive appropriate services to attain or maintain the highest practicable physical, mental and psychosocial well-being.</p> <p>I. the corrective action taken for those Residents found to be affected by the deficient practice include: Resident B is no longer at facility II. Other residents that have the potential to be affected have been identified by: All Residents who experience acute change of condition or status have the potential to be affected by this finding. All residents that have had an acute change of condition since March 13, 2015 have been reviewed to assure that Physician/Families have been notified and appropriate treatments have been obtained. III. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include: A change of condition or status policy was reviewed and approved through QA. Nursing staff will be educated on the new policy and the importance of Physician/Family notification with significant changes. In addition, nurses will be inserviced on the importance of responding to CNA concerns. As the interdisciplinary</p> | 03/27/2015 | |

| | | | |
|--|---|--|---|
| 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 03/13/2015 |
|--|---|--|---|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER ROCKVILLE NURSING AND REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 768 N US HWY 41 ROCKVILLE, IN 47872 |
|---|---|

| (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 |
|--------------------|--|---------------|---|----------------------|
| | <p>mucous-like emesis into a napkin and on his shirt. She indicated she informed LPN #1 Resident B had black, liquid emesis and had "rattle" sounds in his chest.</p> <p>During an interview with LPN #2 on 3/12/15 at 2:50 p.m., she indicated CNA #3 approached her "just before shift change" at 2:00 p.m. on 3/5/15 and requested she assess Resident B. LPN #2 indicated CNA #3 indicated Resident B vomited but did not report the emesis was black. The LPN indicated she did not have her stethoscope available when she assessed Resident B. She indicated the resident sounded " a little congested" but was not in distress.</p> <p>During an interview with LPN #1 on 3/13/15 at 11:30 a.m., she indicated she was informed in "morning report" on 3/5/15 Resident B vomited during the previous night. LPN #1 indicated she was the only staff monitoring the dining room during the noon meal when CNA #3 informed her Resident B was congested. LPN #1 indicated she did not ask another nurse to assess Resident B and did not ask to be relieved from her duties in the dining room so she could immediately assess Resident B. LPN #1 indicated she did not assess Resident B after she finished her dining duties</p> | | <p>team is reviewing acute changes on each business day, they are reviewing all documentation to assure that Physician/Family was notified appropriately. Nursing staff will also be inserviced on the use of the SBAR.IV. The corrective action taken to monitor performance to assure compliancethrough quality assurance is:A performance improvement tool has been initiated that will be utilized toreview acute changes to assure that the physician/family have been notified in accordance with the regulation. The tool will include acute changes. The toolwill randomly review 5 residents with an acute change. DON or her designee willcomplete this audit 3x a week for a month, weekly for a month, and monthly fora month, and then quarterly x3. Any issues identified will be immediatelycorrected. The quality assurance committee will review the tool withrecommendations as needed based on the outcome of the tools monthly x3.The dateof the systematic changes will be 3/27/15</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 03/13/2015 |
|--|---|--|---|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER ROCKVILLE NURSING AND REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 768 N US HWY 41 ROCKVILLE, IN 47872 |
|---|---|

| (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 |
|--------------------|--|---------------|---|----------------------|
| | <p>because LPN #2 had already assessed the resident.</p> <p>During an interview with the DON (Director of Nursing) on 3/12/15 at 1:30 p.m., she indicated her expectation was if a CNA brought a problem or concern to a nurse, the nurse would immediately go and do a head to toe assessment of the resident and document her findings.</p> <p>The record for Resident B was reviewed on 3/12/15 at 10:15 a.m. His diagnosis included, but was not limited to, history of lower gastrointestinal bleed in 2009.</p> <p>A Nurses Note, dated 3/5/15 at 6:25 a.m., indicated Resident B had 2 episodes of emesis (vomiting) during the night shift. The record did not indicate the physician was notified.</p> <p>Nurses Notes did not indicate Resident B vomited at lunchtime and did not indicate if nursing assessments were completed on the day shift (6:00 a.m. - 2:00 p.m.) on 3/5/15 and did not indicate the physician was notified of the emesis.</p> <p>The next entry in the Nurses Notes, dated 3/5/15 at 2:30 p.m., indicated Resident B had vomited a small amount of light brownish liquid, no odor. His vital signs and oxygen saturation (O2 Sat) were</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 03/13/2015 |
|--|---|--|---|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER ROCKVILLE NURSING AND REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 768 N US HWY 41 ROCKVILLE, IN 47872 |
|---|---|

| (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 |
|--------------------|---|---------------|---|----------------------|
| | <p>taken and within normal limits. The physician and the responsible party were notified.</p> <p>A 6:00 p.m. entry in the Nurses Notes on 3/5/15 indicated Resident B had a large amount of dark brown emesis. The physician was present, assessed the resident, and ordered his transfer to the hospital where he was admitted with a diagnosis of "GI [gastrointestinal] bleed."</p> <p>The Emergency Medical Services report was reviewed on 3/13/15 at 11:30 a.m. The report indicated on 3/5/15 at 7:00 p.m. Resident B's blood pressure was 124/78, heart rate 116, respiratory rate 18 and equal with rales [clicking, rattling, bubbling breath sounds]. The report also indicated Resident B was in bed on his back with the head of the bed up approximately 30 degrees. The staff was cleaning him up, and reported he had vomited multiple times and it was dark brown. The report indicated the sheets "show coffee ground consistency." Resident B was placed in sitting position on the cot and taken to the ambulance where his vital signs were obtained, an IV was started, he vomited a small amount of coffee ground emesis and was given Zofran (medication to prevent nausea and vomiting). His abdomen was soft, non-distended, and Resident B</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 03/13/2015 |
|--|---|--|---|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER ROCKVILLE NURSING AND REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 768 N US HWY 41 ROCKVILLE, IN 47872 |
|---|---|

| (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 |
|--------------------|---|---------------|---|----------------------|
| | <p>denied any complaints. Resident B had one other emesis en route to the hospital.</p> <p>The hospital Emergency Department record was reviewed on 3/13/15 at 11:40 a.m. The notes indicated his "problem" was vomiting blood. Resident B's vital signs were B/P (blood pressure) 91/71, pulse 124, respirations 29, temperature 99 degrees and his oxygen saturation was 92% on room air. The "History of Present Illness" "presents with coffee ground emesis." "Respiratory Chest: Breath sounds not clear, rhonchi [coarse rattling sounds like snoring] present, to bilateral lower lobes, breath sounds diminished to bilateral upper lobes, bilateral lower lobes." Resident B was admitted to a medical/surgical unit after being stabilized with intravenous fluids and medications in the Emergency Department.</p> <p>A current facility policy, dated April 2005 and revised December 2005, titled "Standards of Nursing Practice" was provided by the DON on 3/13/15 at 10:53 a.m. The policy indicated: "...We believe the use of the nursing process ensures appropriate care and services for each resident....The delivery of nursing care in the facility is based on a thorough assessment of the resident to identify his or her care needs...."</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 03/13/2015 |
|--|---|--|---|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER ROCKVILLE NURSING AND REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 768 N US HWY 41 ROCKVILLE, IN 47872 |
|---|---|

| (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 |
|--------------------|--|---------------|---|----------------------|
| | <p>A current facility policy, dated 04/12, titled "Change in a Resident's Condition or Status" was provided by the DON on 3/13/15 at 3:05 p.m. It indicated:</p> <p>"...1. The Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On-Call Physician when there has been...e. A significant change in the resident's physical/emotional/mental condition; f. A need to alter the resident's medical treatment significantly...5. The Nurse Supervisor/Charge Nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status..."</p> <p>This federal tag relates to Complaint IN00169303.</p> <p>3.1-37(a)</p> | | | |