

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 09/25/2014
--	---	--	---

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
--------------------	--	---------------	---	----------------------

F000000	<p>This visit was for the Investigation of Complaints IN00156200, IN00150951, and IN00152171.</p> <p>Complaint IN00156200 - Substantiated. Federal/State deficiencies related to the allegations are cited at F441.</p> <p>Complaint IN00150951 - Substantiated. Federal/State deficiencies related to the allegations are cited at F441.</p> <p>Complaint IN00152171 - Substantiated. Federal/State deficiencies related to the allegations are cited at F441.</p> <p>Survey Date: September 25, 2014.</p> <p>Facility Number: 000492 Provider Number: 155464 AIM Number: 100291360</p> <p>Survey Team: Lora Brettnacher, RN-TC Kewanna Gordon, RN</p> <p>Census Bed Team: SNF/NF: 26 Total: 26</p> <p>Census Payor Type:</p>	F000000		
---------	--	---------	--	--

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 09/25/2014
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	
F000441 SS=E	<p>Medicare: 6 Medicaid 16 Other: 4 Total: 26</p> <p>Sample: 7</p> <p>This deficiency reflects state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed 9/26/14 by Brenda Marshall, RN</p> <p>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.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to</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 09/25/2014
--	---	--	---

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>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 Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on record review and interview, the facility failed to implement isolation policies to prevent the spread of infection for 3 of 7 residents reviewed for infection control (Residents M, K, and X).</p> <p>Findings include:</p> <p>1. Resident M's record was reviewed on 9/25/14 at 1:30 p.m. An untimed physician's order, dated 9/15/14, indicated an order for "Tape Skin Sample" to rule out a contagious skin condition. The record did not indicate isolation precautions were implemented to prevent the spread of infection when the facility suspected Resident M had contagious skin condition.</p> <p>2. Resident K's record was reviewed on 9/25/14 at 1:45 p.m. A nurse's note,</p>	F000441	<p>By submitting the enclosed material we are not admitting 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 October 10, 2014 to the complaint survey conducted on September 25, 2014. We respectfully request a paper review. We will provide you with any additional information to confirm compliance per your request.</p> <p>F441 It is the practice of the facility that Standard Precautions shall be used when caring for residents at all times regardless of their suspected or confirmed infection status. Transmission-based Precautions shall be used when caring</p>	10/08/2014

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 09/25/2014
--	---	--	---

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>dated 9/16/14 at 4:30 p.m., indicated a "skin sample scraping" was obtained and sent to the lab to rule out a contagious skin condition. The record did not indicate isolation precautions were implemented to prevent the spread of infection when the facility suspected Resident K had contagious skin condition.</p> <p>3. Resident X's record was reviewed on 9/25/14 at 2:00 p.m. A physician's order, dated 9/15/14 at 2:00 p.m., indicated an order for "Tape Skin Sample" to rule out a contagious skin condition. The record did not indicate isolation precautions were implemented to prevent the spread of infection when the facility suspected Resident X had contagious skin condition.</p> <p>During an interview, on 9/25/14 at 9:30 a.m., the Director of Nursing (DON) indicated over the past several months the facility had been dealing with a contagious skin condition. She indicated several residents had a rash. She indicated after a resident had been unsuccessfully treated for months due to a rash she was tested for a contagious skin condition and results were positive.</p> <p>During an interview, on 9/25/14 at 1:50 p.m., Licensed Practical Nurse (LPN) #1</p>		<p>forresidents who are documented or suspected to have communicable diseases orinfections that can be transmitted to others. In addition, if there is a reason to believe that a resident has an infectious or communicable disease, thecharge nurse shall notify the resident's attending physician for appropriateisolation instructions.</p> <p>The corrective action taken for those residents found to be affected bythe by the deficient practice include:Residents M, K, and X all had negative results for the tape skin sample sono residents were currently affected by the deficient practice.</p> <p>Other residents that have the potential to be affect have beenidentified by:All residents have been reviewed to assure that there is no reason tobelieve that a resident has an infectious or communicable disease in whichisolation would be necessary. No additional residents were identified.</p> <p>The measures or systematic changes that have been put into place toensure that the deficient practice does not recur include:Re=education for all of the staff was completed on 10/8/2014. The staff wasinserviced on the facility's isolation policies. Director of Nursing reviewed 2policies with the staff: 1) Isolation – Categories of Transmission-BasedPrecautions and 2) Isolation, Initiating. Staff is now</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 09/25/2014
--	---	--	---

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 isolation precautions were not implemented for the residents suspected to have a contagious skin condition unless the lab results were positive.</p> <p>During an interview, on 9/25/14 at 2:30 p.m., with the Administrator present, the DON indicated isolation precautions were not implemented for Resident M, K, and X because the results of their lab tests were negative.</p> <p>A policy regarding a contagious skin condition, identified as current by the DON, on 9/25/14 at 11:35 a.m., indicated, "...[skin condition named] is an itching skin irritation caused by the microscopic human itch mite... [skin condition named] is spread by skin-to-skin contact with the infected area, or through contact with bedding, clothing, privacy curtains and some furniture. Prevention is possible with good hygiene... Affected residents should remain on Contact Isolation until twenty-four (24) hours after last treatment...Protective clothing should be worn as established by the facility's infection and exposure control program..."</p> <p>A policy titled "Isolation, Initiating" identified as current by the DON, on 9/25/14 at 11:35, indicated, "...Isolation</p>		<p>aware that they are to initiate isolation procedures even if a resident is <i>suspected</i> of having an infectious or communicable disease.</p> <p>The corrective action taken to monitor performance to assure compliance through quality assurance is:DON or designee will continue to monitor all infection control in the facility and report on infection control in monthly Quality Assurance meetings to assure compliance.</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 09/25/2014
--	---	--	---

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>precautions will be initiated when there is reason to believe that a resident has an infectious or communicable disease.</p> <p>Policy Interpretation and Implementation</p> <p>1. Should there be reason to believe that a resident has an infectious or communicable disease, the nurse shall notify the resident's attending physician for appropriate isolation instructions. 2. The charge nurse shall enter the physician's order on the Physician's Order Sheet. The physician's orders must be carried out as quickly as practical. .. isolation precautions shall remain effect until discontinued by the attending physician or when criteria are met..."</p> <p>This Federal tag relates to Complaints IN00156200, IN00150951, and IN00152171.</p> <p>3.1-18(a)</p>			