STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155464	A. BUILDING 00 B. WING	06/05/2017

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

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: May 30, 31, June 1, 2, and 5, 2017 Facility number: 000492 Provider number: 155464 AIM number: 100291360 Census Bed Type: SNF/NF: 24 Total: 24 Census Payor Type: Medicare: 2 Medicaid: 14 Other: 8 Total: 24 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed June 12, 2017.	F 0000	Preparation and/or execution of this plan of correction in general, or any corrective actions set forth herein, in particular, does not constitute an admission or agreement by Rockville Nursing & Rehabilitation of the facts alleged or the conclusions set forth in the statement of deficiencies. The plan of correction and specific corrective actions are prepared and/ or executed solely because of provisions of federal and/ or state laws. Rockville Nursing & Rehabilitation desires this plan of correction to be considered the facilities allegation of compliance effective 7/5/2017. Rockville Nursing & Rehab would like to request a desk review for compliance with these deficiencies as we feel with the new processes adopted we will obtain and maintain continued compliance.	
F 0157 SS=D Bldg. 00	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's			

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

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	physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.			

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	(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). Based on record review and interview, the facility failed to notify a resident's family of a choking episode for 1 of 1 residents reviewed for choking (Resident 15). Findings include: Resident 15's record was reviewed on 6/1/17 at 9:56 a.m. A review of care plans included, but was not limited to, diagnoses of dementia without behavioral disturbance and adult failure to thrive. A nurse's noted, dated 4/30/17, indicated at 12:15 p.m., Resident 15 was found "silently" coughing with a red face. The nurse leaned the resident slightly forward, patted resident on the back with a cupped hand, and resident expelled a piece of onion, and was no longer red in the face or coughing. The physician was notified and a new order was given for pureed diet until speech therapy (ST). Resident was provided a pureed diet for that meal. A physician's order, dated 4/30/17, indicated pureed diet until ST evaluation. Nurse's notes for April and May 2017,	F 0157	F157 It is the standard of this facility to notify, consistent with his or her authority, the resident representative when there is a significant change in the resident's physical, mental, or psychosocial status… A care conference has been scheduled with resident 15's representative and resident on June 28, 2017 to review the coughing episode on 4/30/17 and speech therapy's progress and recommendations. The DON reviewed all nurse's notes on current residents for the past 90 days to ensure appropriate notification. Concerns found were corrected immediately. The nursing staff was inserviced on 6/6/2017 by the DON regarding notification requirements upon a resident's change of condition. A new order tracking log has been implemented so nurses check each step required when a new order is received, including notification requirements. An audit tool has been created that monitors the 24 hr report and	07/05/2017

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	did not include any documentation of notification of Resident 15's family regarding the resident choking or the new physician's order. During an interview on 6/1/17 at 3:21 p.m., Licensed Practical Nurse (LPN) 4 indicated if a resident choked the physician and family should be notified. During an interview on 6/2/17 at 9:11 a.m., the Director of Nursing (DON) indicated a lung assessment, vital signs, speech therapy (ST) referral, physician notification, and family notification should be done if a resident choked. On 6/2/17 at 3:12 p.m., the Corporate Nurse Consultant provided a document titled, "Change in a Resident's Condition or Status," and indicated the policy was the one currently being used by the facility. The policy indicated, "...Policy Statement: Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status...Policy Interpretation and Implementation: 3. Unless otherwise instructed by the resident, the nurse supervisor/charge nurse will notify the resident's family or representative (sponsor) when: b. There is a significant change in the resident's		focus charting to assure proper notifications are made to resident's responsible party when a resident change of condition occurs. DON or designee will be responsible for auditing the above daily while on duty for 4 weeks, bi weekly for the next 4 weeks, and weekly thereafter until 100% compliance is achieved. Results will be shared monthly with the facility QAPI committee for additional recommendations. Rockville Nursing & Rehab would like to request a desk review for compliance with this deficiency as we feel with the new processes adopted we will obtain and maintain continued compliance.	

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	physical, mental, or psychosocial status...." 3.1-5(a)(2)			
F 0278 SS=D Bldg. 00	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment.			

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	(2) Clinical disagreement does not constitute a material and false statement. Based on record review and interview, the facility failed to ensure accurate Minimum Data Set (MDS) coding for a resident at risk for choking and a resident that received hospice services, for 2 of 25 resident MDS assessments reviewed. (Resident 7 and 15). Findings include: 1. Resident 15's record was reviewed on 6/1/17 at 9:56 a.m. A quarterly MDS assessment, dated 5/2/17, indicated none of the above for signs/symptoms of possible swallowing disorder including coughing/choking during meals, no significant weight loss, and indicated use of mechanically altered diet. A nurse's noted, dated 4/30/17, indicated at 12:15 p.m., Resident 15 was found "silently" coughing with a red face. The nurse leaned the resident slightly forward, patted resident on the back with a cupped hand, and resident expelled a piece of onion, then was no longer red in the face or coughing. The physician was notified and a new order was given for pureed diet until speech therapy (ST). Resident was provided a pureed diet for that meal.	F 0278	F278 It is the standard of this facility to complete assessments that accurately reflect the resident's status. Immediately after the survey team identifying the concerns about R. #7's & R. #15's MDS assessment, they were corrected and resubmitted. All residents have the potential to be affected by MDS coding. All members of the facility MDS team were inserviced on 6/16/2017 by the MDS Regional Consultant regarding reviewing the resident's medical record to ensure correct coding. An audit tool has been created that monitors MSD coding. DON or designee will be responsible for auditing a random sample of 5 residents monthly for 3 months and quarterly thereafter until 100% compliance is achieved. Results will be shared monthly with the facility QAPI committee for additional recommendations. Rockville Nursing & Rehab would like to request a desk review for compliance with this deficiency as we feel with the new processes adopted we will obtain and maintain continued compliance.	07/05/2017

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A physician's order, dated 4/30/17, indicated pureed diet until ST eval and ST evaluation.

During an interview on 6/1/17 at 3:14 p.m., the MDS coordinator indicated the area for coughing and choking on the MDS had been missed in error and should have been indicated on the assessment.

2. Resident 7's record was reviewed on 6/5/17 at 9:11a.m. A Hospice Physician Certification/Order, dated 3/3/16, indicated the resident was admitted to hospice services on 2/12/16, under the diagnosis of Alzheimer's disease, and suffered from a life limiting illness and had a life expectancy of 6 months or less if the illness ran it's normal course.

A care plan, dated 2/16/16, with a revision date of 4/25/17, indicated the resident received hospice services.

Section O titled, "Special Treatments, Procedures, and Programs," of the resident's annual MDS (Minimum Data Set) assessment, dated 1/25/17, did not indicated the resident received hospice services.

During an interview, on 6/5/17 at 9:11 a.m., Hospice Aide 14 indicated she had

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	been providing services for the resident 2-3 times a week for well over a year. During an interview, on 6/5/17 at 10:52 a.m., the MDS Coordinator indicated the resident received hospice services and Section O of the annual MDS had not been coded correctly. On 6/2/17 at 3:12 p.m., the Corporate Nurse Consultant provided an document, dated April 2007, titled, "Resident Assessment Instrument," and indicated the policy was the one currently being used by the facility. The policy indicated, "Policy Statement: A comprehensive assessment of a resident's needs shall be made...Policy Interpretation and Implementation...3. The purpose of the assessment is to describe the resident's capacity to perform daily life functions and to identify significant impairments in functional capacity...4...o. Special Treatment and Procedures: Refers to treatments and procedures that are not part of basic services provided...." 3.1-31(d)			
F 0282 SS=D Bldg. 00	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the			

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	facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview, the facility failed to ensure a residents' medication was discontinued as ordered by the physician for 1 of 5 residents reviewed for unnecessary medications (Resident 31). Findings include: 1. The record for Resident 31 was reviewed on 6/1/17 at 9:39 a.m. The resident's care plan included diagnosis, but was not limited to, depression. A MAR (medication administration record) for the months of January and February 2017, included but was not limited to, sertraline (anti-depressant medication) hcl 25 mg (milligrams) tablet give 1 tablet by mouth every morning. A consultation report, dated 1/23/17, indicated on 1/25/17 the physician wrote an order to hold sertraline times 10 days and reevaluate. A MAR for January 2017, indicated the medication sertraline 25 mg was held on 1/26, 1/27, 1/28, 1/29, 1/30 and 1/31/17.	F 0282	F282 It is the standard of this facility to provide or arrange services as outlined by the comprehensive care plan… Immediately after the surveyor expressed concern over resident 31's administration of sertraline, a medication error report was completed. These reports contribute to the facility's QAPI program. All current resident's MARs have been reviewed by the DON to ensure all residents receiving medications or medications that have been discontinued as per physician orders. No other residents were affected by this alleged deficient practice. The nursing staff was inserviced on 6/21/2017 by the DON regarding receiving physician's orders. A new order tracking log has been implemented so nurses check each step required when a new order is received, processing new orders to the appropriate place (MAR, TAR, Lab book). A new order tracking log has been implemented so nurses check each step required when a new order is received, including notification requirements.	07/05/2017

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	The MAR for February 2017, indicated the sertraline hcl 25 mg was held on 2/1/17 and administered on 2/2, 2/3 and 2/4/17. A physician's order, dated 2/6/17, indicated to "discontinue the sertraline d/t (due to) no behaviors during open window of medication evaluation 1/25 through 2/6/17." A MAR for February 2017, indicated, sertraline 25 mg tablet by mouth every morning was administered on the following days 2/8, 2/10, 2/11, 2/12/17. The medication was discontinued on the MAR on 2/21/17. A care plan dated 4/27/15, included, but was not limited to, "focus: resident has dx (diagnosis) of depression/bipolar disorder. Interventions included, but were not limited to, medications per MD (Medical Director) orders." During an interview on 6/5/17 at 10:58 a.m., the DON (Director of Nursing) indicated she created a medication error report for sertraline hcl 25 mg tablet not being held after a physicians order was written on 1/25/17 to hold medication, and a separate physicians order on 2/6/17 to discontinue the medication. The DON also indicated it was brought to her		The nursing staff was inserviced to the tracking log on 6/6/2017 by the DON. Night shift is responsible for double checking that any orders received within the past 24 hrs have been transcribed to the MAR/TAR or Lab book correctly. An audit tool has been created that monitors new orders received have been transcribed to the MAR/TAR or Lab book correctly. DON or designee will be responsible for auditing the above daily while on duty for 4 weeks, bi weekly for the next 4 weeks, and weekly thereafter until 100% compliance is achieved. Results will be shared monthly with the facility QAPI committee for additional recommendations. Rockville Nursing & Rehab would like to request a desk review for compliance with this deficiency as we feel with the new processes adopted we will obtain and maintain continued compliance.	

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	attention on date survey team informed her. The DON indicated when a physicians order is written the nurse will transfer the order onto the MAR and the order will be faxed to the pharmacy. On 6/21/17 at 3:12 p.m., the Corporate Nurse Consultant provided a document titled, "Physician/Prescriber authorization and communication of orders" and indicated the policy was the one currently being used by the facility. The policy indicated, "Procedure: 1. Facility should not administer medications or biological's except upon the order of a Physician/Prescriber...." 3.1-35(g)(2)			
F 0309 SS=D Bldg. 00	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 (k) Pain Management. The facility must ensure that pain management is provided to residents who			

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	require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on record review and interview, the facility failed to properly assess a resident who choked for 1 of 1 residents reviewed for choking and to ensure implementation of physician's orders for one of 1 of 6 residents reviewed for medication accuracy (Resident 15). Findings include: 1. Resident 15's record was reviewed on 6/1/17 at 9:56 a.m. A review of care plans included, but was not limited to, diagnoses of dementia without behavioral disturbance and adult failure to thrive. A nurse's noted, dated 4/30/17, indicated at 12:15 p.m., Resident 15 was found "silently" coughing with a red face. The nurse leaned the resident slightly forward, patted resident on the back with a cupped hand, and resident expelled a piece of onion, then was no longer red in the face or coughing. The physician was notified and a new order was given for	F 0309	F309 It is the standard of this facility to provide the necessary care and service to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care… A. The DON reviewed all nurse's notes on current residents for the past 90 days to ensure appropriate assessment including complete vital signs were documented in the resident's record. Concerns found were corrected immediately. An inservice was given to nurses on 6/21/2017 by the DON to complete an assessment of a resident related to the change in condition along with a set of complete vitals and record this in the resident's medical record under the nurse's notes. An audit tool has been created that monitors the 24 hr report and	07/05/2017

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	pureed diet until speech therapy (ST). Resident was provided a pureed diet for that meal. No documentation of a respiratory assessment or vital signs was available. No further nurse's notes were observed for 4/30/17. A physician's order, dated 4/30/17, indicated pureed diet until ST evaluation and ST evaluation. Nurse's notes for 5/1/17 were reviewed, no respiratory assessment or vital signs were noted. During an interview on 6/1/17 at 3:21 p.m., Licensed Practical Nurse (LPN) 4 indicated if a resident choked the physician and family should be notified. A lung assessment and vital signs should be done. During an interview on 6/2/17 at 9:11 a.m., the Director of Nursing (DON) indicated a lung assessment, vital signs, speech therapy (ST) referral, physician notification, and family notification should be done if a resident choked. 2. Resident 15's record was reviewed on 6/1/17 at 9:56 a.m. A review of care plans included, but was not limited to, diagnoses of dementia without behavioral disturbance and adult failure to thrive.		focus charting to assure an assessment is completed of a resident related to their change in condition along with a set of complete vitals recorded in the resident's medical record. DON or designee will be responsible for auditing the above daily while on duty for 4 weeks, bi weekly for the next 4 weeks, and weekly thereafter until 100% compliance is achieved. Results will be shared monthly with the facility QAPI committee for additional recommendations. B. All current resident's new orders have been reviewed by the DON to ensure orders have been processed to the appropriate binder (MAR, TAR, LAB Book) and communication has occurred to other departments if involved.No other residents were affected by this alleged deficient. The nursing staff was inserviced on 6/21/2017 by the DON regarding receiving physician's orders. A new order tracking log has been implemented so nurses check each step required when a new order is received, processing new orders to the appropriate place (MAR, TAR, Lab book). A new order tracking log has been implemented so nurses check each step required when a new order is received, including notification requirements. The nursing staff was inserviced to the	

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	A basic metabolic panel (BMP), dated 5/5/17, included, but was not limited to, a sodium level of 127 with a normal range of 135-145. A note was written at the bottom of the lab indicating the resident did not drink much each day, averaging 350 milliliters(ml) to 850 ml each day. A duplicate BMP, dated 5/5/17, indicated a physician's order of decrease water intake to meals. An undated physician's order, on the same page as a physician's order, dated 5/8/17, indicated decrease water intake to meals. A BMP, dated 5/12/17, included, but was not limited to, a sodium level of 128 with a normal range of 135-145. A review of physician's orders for May and June 2017, did not include any further follow up with physician regarding labs or medication changes. A review of nurse's notes for May and June 2017, did not include any further follow up with physician regarding labs or medication changes. A care plan, dated 12/2/16, indicated a focus of resident had a potential		tracking log on 6/6/2017 by the DON. Night shift is responsible for double checking that any orders received within the past 24 hrs have been transcribed to the MAR/TAR or Lab book correctly. The nursing staff was inserviced on 6/21/2017 by the DON about communicating with other departments if involved when a new order is received. The facility communication form will be used for these communications. An audit tool has been created that monitors new orders received have been transcribed to the MAR/TAR or Lab book correctly, and communication has occurred to other departments if involved. DON or designee will be responsible for auditing the above daily while on duty for 4 weeks, bi weekly for the next 4 weeks, and weekly thereafter until 100% compliance is achieved. Results will be shared monthly with the facility QAPI committee for additional recommendations. Rockville Nursing & Rehab would like to request a desk review for compliance with this deficiency as we feel with the new processes adopted we will obtain and maintain continued compliance.	

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	nutritional problem related to diagnosis of failure to thrive and a body mass index (BMI) of 19.5. Interventions included, but were not limited to, "...obtain and monitor lab/diagnostic work as ordered. Report results to doctor and follow up as indicated, provide and serve diet as ordered, and monitor intake and record each meal...." During an interview on 6/1/17 at 2:20 p.m., the Dietary Manager indicated drinks were passed in the dining room prior to the meal service by the aides and managers. There were no residents on restricted fluids. New dietary orders were communicated by nursing to dietary with a communication slip. During an interview on 6/1/17 at 2:29 p.m., Certified Nursing Assistant (CNA) 6 indicated CNAs passed drinks in the dining room, and no residents were on restricted fluids. During an interview on 6/1/17 at 2:47 p.m., CNA 7 indicated CNAs passed drinks in the dining room, and no residents were on restricted fluids. During an interview on 6/2/17 at 9:03 a.m., CNA 1 indicated no residents were on restricted fluids.			

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	On 6/2/17 at 3:12 p.m., the Corporate Nurse Consultant provided a document titled, "Change in a Resident's Condition or Status," and indicated the policy was the one currently being used by the facility. The policy indicated, "Policy Interpretation and Implementation: 6. 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...." On 6/2/17 at 3:12 p.m., the Corporate Nurse Consultant provided a document titled, "Interdepartmental Notification of Diet (Including Changes and Reports)," and indicated the policy was the one currently being used by the facility. The policy indicated, "Policy Statement: Nursing Services shall notify the Food Services Department of a resident's diet orders, including any changes in the resident's diet, meal service, and food preferences. Policy Interpretation and Implementation: 1. When a new resident is admitted, or a diet has been changed, the nurse supervisor shall ensure that the Food Services Department receives a written notice of the diet order...." 3.1-37(a)			
F 0323	483.25(d)(1)(2)(n)(1)-(3)			

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SS=E Bldg. 00	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. Based on observation, interview, and record review, the facility failed to ensure the resident's side rails were secure while in the upright position for 4 of 4 beds observed with half side rails installed (Residents 6, 15, 20, and 27).	F 0323	F323 It is the standard of this facility to ensure it is free of accident hazards – if a bed rail is used, the facility must ensure correct installation, use, and maintenance of bed rails…	07/05/2017

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	Findings include: 1. On 05/31/17 at 11:32 am, during the initial environmental tour, bilateral half side rails for Resident 20 were observed to be loose. On 06/01/17 at 3:13 pm, the left side rail of Resident 20's bed was loose and pulling away from the bed while in the upright position. The side rail, in the upright position, wobbled back and forth and was not secure. On 6/02/17 at 10:31 am, CNA 11 provided a demonstration of Resident 20's left side rail. The side rail was loose and wobbled back and forth while in the upright position. CNA 11 indicated, "[Resident 20] does wiggle a lot." CNA 11 indicated there was too much room between the bed and the side rail because of it's loose and wobbling condition. She could see how Resident 20 could get wedged in between the bed and the rail, and that Resident 20 was not capable of raising the rail herself. On 06/02/17 at 10:37 am, the Maintenance Director indicated that he would need to replace the left side rail for Resident 20 because it was not latching securely. The width between the mattress and the side rail when pushed outward		It should be noted that at no time during the survey, or previous bed rail checks was any resident bed rail loose enough to exceed the safety recommendation of a gap of 4 ¾". Bedrails for the 4 residents cited have been removed or upgraded by adding an additional metal washer to the bracket that attaches the bedrail to the bed. This has tightened the bedrails so they cannot wobble back and forth. Physician orders have been obtained for residents 6 and 15 to use half bed rails. Their care plans have been updated to reflect bedrail usage. There was a potential for all Residents with bedrails to be affected by this alleged deficient practice. An all staff inservice was held on 6/8/17 by the administrator about reporting loose side rails to maintenance through the maintenance log, and reporting it to the administrator or DON if the rail remains loose, wobbly, or or exceeded a 4 ¾ inch gap. All bedrails in use at the facility will be upgraded by adding an additional metal washer to the bracket that attaches the bedrail to the bed if they are found to wobble back and forth by 7/5/2017.	

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	measured 4 inches. On 06/02/17 at 10:53 am, the Maintenance Director provided copies of the "Bed List" and "Room Inspection Forms" for the months of April and May. He indicated that the check marks mean the item/room was "in good repair, and in working order." Resident 20's room and bed checks were checked off as in good and working order for the months of April and May. On 06/02/17 at 11:37 am, Administrator indicated there was no current bed rail policy or procedure and the Maintenance Directors monthly rounds were sufficient. On 06/03/17 record reviews for Resident 20 was completed to include: A quarterly MDS (Minimum Data Set) dated 5/6/17 indicated Resident 20's Bed Mobility for self-performance was coded a 3, "extensive assistance" and staff support was coded a 2, "limited assistance." Transfers for self-performance was coded a 3, "extensive assistance" and staff support was coded 2 "limited assistance." MDS indicated resident had two or more falls since admission. Review of Physician's orders indicated		An audit tool has been created that monitors bedrails. Administrator or Environmental Service Manager will be responsible for auditing bedrails to check if they are loose, wobbling, or exceeded a 4 ¾ inch gap 3 times weekly for 4 weeks, 2 times weekly for the next 4 weeks, and weekly thereafter until 100% compliance is achieved. Results will be shared monthly with the facility QAPI committee for additional recommendations. Rockville Nursing & Rehab would like to request a desk review for compliance with this deficiency as we feel with the new processes adopted we will obtain and maintain continued compliance.	

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	diagnosis' to include but not limited to: Parkinson's Disease, history of falling, Dementia in other diseases classified elsewhere with behavioral disturbances, other reduced mobility. Care plan for Resident 20 dated 12/2/2016 indicated, "...the resident needs a safe environment with: Slide fails [side rails] as ordered..." Fall Risk Assessment dated 04/16/17 indicated Resident 20's score of 17, "...a score of 10 or more represents high risk of falls..." Bed Rail Assessment dated 3/16/17 indicated Resident 20 used bed rails for support and positioning. Because of history of falls, bed rails are used for safety to help with mobility. Additional comments indicates, "...assist of 1 for bed mobility, transfers, and toileting, due to impaired mobility related to Parkinson's and cognition...." 2. On 5/31/17 at 10:08 a.m., Resident 6 was observed to have half side rails on both sides of the bed. Half side rails on each side of the bed were loose, moved back and forth when pulled on. On 5/31/17 at 1:43 p.m., the half side rails of Resident 6's bed were noted to be loose.			

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On 6/2/17 at 10.12 a.m., Resident 6 was observed to be asleep in bed and half side rails were noted to be loose.

On 6/2/17 at 11:34 a.m., Resident 6 was observed to be sleeping in bed, half side rails were loose.

During an environmental round with the Maintenance Supervisor on 5/31/17 at 1:52 p.m., the Maintenance Supervisor indicated Resident 6's half side rails were loose.

During an interview on 5/31/17 at 1:52 p.m., the Maintenance Supervisor indicated side rails were checked monthly. Side rails were checked for looseness, distance from mattress to side rails, and making sure they are functioning properly. Side rails are normally loose, but when side rails get very loose the rubber washer would be replaced. The rubber washer needed replaced on Resident 6's side rails.

During an interview on 6/2/17 at 11:34 a.m., the Maintenance Supervisor indicated the rubber washer was changed in Resident 6's side rails the previous day.

During an interview on 6/2/17 at 2:23 p.m., Certified Nursing Assistant (CNA)

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	1 indicated Resident 6 required assistance from one staff member to transfer from the bed to the wheelchair. Resident 6 did use the side rails for transfers. During an interview on 6/5/17 at 11:33 a.m., the Director of Nursing (DON) indicated side rails should have a physician's order, be added to the care plan, and a side rail assessment should be done prior to the side rails being installed on the bed. Resident 6's record was reviewed on 6/2/17 at 9:37 a.m. Diagnosis included, but were not limited to, hemiplegia affecting left dominant side, cerebral infarction due to unspecified occlusion or stenosis of basilar arteries, and muscle weakness generalized. A quarterly nursing assessment, dated 5/11/17, included, but was not limited to, half length bed rails used for support and positioning, bed rails were properly installed and bed rails were firmly attached to the bed frame and were easily raised and lowered. A physician's orders for April, May, and June 2017 did not include an order for side rails. The resident's care plans did not include a			

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	care plan for side rails. A May bed list provided by the Maintenance Supervisor on 6/2/17 at 10:45 a.m., indicated Resident 6's side rail needed a new washer. 3. On 5/31/17 at 10:05 a.m., Resident 15 was observed to have a quarter side rail to the left side of the bed and a half side rail to the right side of the bed. Both side rails were noted to be loose, moved back and forth when pulled on. On 5/31/17 at 11:56 a.m., Resident 15's quarter side rail and half side rail were noted to be loose. On 6/2/17 at 9:02 a.m., Resident 15's quarter side rail and half side rail were noted to be loose. On 6/2/17 at 12:25 p.m., Resident 15's quarter side rail and half side rail were noted to be loose. During an environmental round with the Maintenance Supervisor on 5/31/17 at 1:52 p.m., the Maintenance Supervisor indicated Resident 15's half side rails were loose. During an interview on 6/2/17 at 9:03 a.m., CNA 1 indicated Resident 15 was			

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	normally dependent for activities of daily living (ADL's). Resident used side rails and gait belt for transfers from bed to chair. Resident 15's record was reviewed on 6/1/17 at 9:56 a.m. Diagnosis included, but were not limited to, dementia without behavioral disturbance, muscle weakness generalized, unspecified lack of coordination, and other reduced mobility. A quarterly nursing assessment, dated 5/2/17, included, but was not limited to, half length bed rails used for support and positioning, bed rails were properly installed and bed rails were firmly attached to the bed frame and were easily raised and lowered. A physician's orders for April, May, and June 2017 did not include an order for side rails. The resident's care plans indicated there was no care plan for side rails. A May bed list provided by the Maintenance Supervisor on 6/2/17 at 10:45 a.m., indicated Resident 6's side rail needed a new washer. 4. On 5/31/17 at 10:44 a.m., Resident 27 was observed with half side rails on both sides of the bed. Both rails to bed were			

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	loose, moved back and forth when pulled on. On 6/2/17 at 11:10 a.m., the half side rails on the bed were observed to be loose. On 6/5/17 at 9:03 a.m., the half side rails on the bed were observed to be loose. During an interview on 6/1/17 at 3:03 p.m., Resident 27 indicated she may use the side rail to position herself in bed. During an interview on 6/2/17 at 11:33 a.m., CNA 1 indicated the resident was encouraged to use the side rails for bed mobility and she had noticed the side rails to be loose and squeaky. She indicated when the resident was assisted in bed, the resident would use the side rails to help pull herself over. During an interview on 6/5/17 at 11:33 a.m., the Director of Nursing (DON) indicated side rails should have a physician's order, be added to the care plan, and a side rail assessment should be done prior to the side rails being installed on the bed. Resident 27's record was reviewed on 6/2/17 at 10:32 a.m. Diagnosis included, but were not limited to, generalized			

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	muscle weakness, history of falling, unspecified lack of coordination, difficulty in walking, reduced mobility, and cognitive communication deficit. A quarterly nursing assessment, dated 3/9/17, indicated 1/2 length bed rails were used for support and positioning, bed rails were properly installed and bed rails were firmly attached to the bed frame and were easily raised and lowered. Physician's orders dated April, May, and June 2017, did not include an order for side rails. No side rail care plans were observed during review of the resident's care plans. 3.1-45(a)(1)			
F 0333 SS=D Bldg. 00	483.45(f)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS (f)(2) Residents are free of any significant medication errors. Based on record review and interview, the facility failed to ensure medications were initiated as ordered by the physician for 1 of 6 residents reviewed for medication accuracy (Resident 15). Findings include:	F 0333	F333 It is the standard of this facility to ensure that its residents remain free of any significant med errors. All current resident's new orders have been reviewed by the DON to ensure orders have been processed to the appropriate	07/05/2017

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	Resident 15's record was reviewed on 6/1/17, at 9:56 a.m. A review of care plans included, but was not limited to, diagnoses of dementia without behavioral disturbance, transient cerebral ischemic attack, depression, muscle weakness, and adult failure to thrive. A basic metabolic panel (BMP), dated 5/5/17, included, but was not limited to, a sodium level of 127 with a normal range of 135-145. A note was written at the bottom of the lab indicating the resident did not drink much each day, averaging 350 milliliters(ml) to 850 ml each day. A duplicate copy of the same BMP, dated 5/5/17, included, but was not limited to, an order from the physician for demeclocylcine, a tetracycline antibiotic, 150 milligrams (mg) related to the low sodium. A review of physician's orders for May and June 2017 did not indicate demeclocycline had been initiated, changed, or stopped. A physician's order, dated 5/8/17, included, but was not limited to, "Recheck BMP on 5/12/17, and consult with physician upon results about possible medication change."		binder (MAR, TAR, LAB Book). No other residents were affected by this alleged deficient practice. The nursing staff was inserviced on 6/21/2017 by the DON regarding receiving physician's orders. A new order tracking log has been implemented so nurses check each step required when a new order is received, processing new orders to the appropriate place (MAR, TAR, Lab book). A new order tracking log has been implemented so nurses check each step required when a new order is received, including notification requirements. The nursing staff was inserviced to the tracking log on 6/6/2017. Night shift is responsible for double checking that any orders received within the past 24 hrs have been transcribed to the MAR/TAR or Lab book correctly. An audit tool has been created that monitors new orders received have been transcribed to the MAR/TAR or Lab book correctly. DON or designee will be responsible for auditing the above daily while on duty for 4 weeks, bi weekly for the next 4 weeks, and weekly thereafter until 100% compliance is achieved. Results will be shared monthly with the facility QAPI committee for additional recommendations. Rockville Nursing & Rehab would like to request a desk review for compliance with this deficiency as	

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	155464	A. BUILDING 00 B. WING	06/05/2017

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	A BMP, dated 5/12/17, included, but was not limited to, a sodium level of 128 with a normal range of 135-145. A review of physician's orders for May and June 2017 did not include any further follow up with physician regarding labs or medication changes. A review of nurse's notes for May and June 2017 did not include any further follow up with physician regarding labs or medication changes. A care plan, dated 12/2/16, indicated a focus of resident has a potential nutritional problem related to diagnosis of failure to thrive and a body mass index (BMI) of 19.5. Interventions included, but were not limited to, obtain and monitor lab/diagnostic work as ordered. Report results to doctor and follow up as indicated. During an interview on 6/1/17, at 2:00 p.m., the Director of Nursing (DON) indicated she could not find where demeclocycline had been started. During an interview on 6/1/17, at 2:08 p.m., the DON indicated when an order came in on a lab from the fax machine the nurse should write the order, process the order, contact the family, add it to the		we feel with the new processes adopted we will obtain and maintain continued compliance. Rockville Nursing & Rehab would like to request a desk review for compliance with this deficiency as we feel with the new processes adopted we will obtain and maintain continued compliance.	

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	medication administration record (MAR), and fax the order to the pharmacy. On 6/2/17 at 3:12 p.m., the DON Corporate Nurse Consultant provided a document titled, "Physician/Prescriber Authorization and Communication of Orders to Pharmacy," and indicated the policy was the one currently being used by the facility. The policy indicated "...PROCEDURE: 2. For hard-copy medical records, facility should ensure that all medications and biological orders are written, dated, and signed...." 3.1-25(a)			
F 0371 SS=D Bldg. 00	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.			

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	(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. Based on observation and interview the facility failed to serve food under sanitary conditions by touching food with bare hands for 2 of 14 residents. Findings include: On 06/01/17 at 12:15 pm, LPN 4 was observed using her bare hands to pull apart and serve bread to Resident 35. On 06/01/17 at 12:17 pm LPN 4 was observed pulling bread from plastic wrap with bare hands and placed on Resident 20's plate. On 06/02/17 at 12:20 pm, LPN 9 was observed using bare hands to remove baked potato from aluminum foil, pushed it open, and served it to Resident 35. On 06/05/17 at 1:03 pm, the DON (Director of Nursing) indicated that it was not appropriate to touch food with bare hands. She indicated that forks, knifes, and spoons should be used at all	F 0371	F371 It is the standardof this facility to store, prepare, distribute, and serve food under sanitary conditions. Resident #20 & resident #35 are no longer served food that has been touched with bare hands. No other resident was observed to be affected by this alleged deficient practice. All staff have been inserviced on serving food under sanitary conditions by the administrator. This training include instruction on serving meals, as well as risks of not following sanitary serving guidelines. An audit tool has been created that monitors dining room service. Administrator or Dining Service Manager will be responsible for observing dining room service 3 times weekly for 4 weeks, 2 times weekly for the next 4 weeks, and weekly thereafter until 100% compliance is achieved. Results will be shared monthly with the facility QAPI committee for additional recommendations.	07/05/2017

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	times, and that if food were needed to be touched, there was a box of gloves kept in the dining room for that purpose. On 06/05/17 at 1:33 pm, the Administrator indicated there was no current dining policy in place and indicated "staff should absolutely not have used bare hands on food." 3.1-21(i)(3)		Rockville Nursing & Rehab would like to request a desk review for compliance with this deficiency as we feel with the new processes adopted we will obtain and maintain continued compliance.	
F 0465 SS=D Bldg. 00	483.90(h)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON (h) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. (h)(5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents. Based on observation and interview, the facility failed to ensure living environments were functional and comfortable for 4 of 22 rooms reviewed for comfortable living environments (Rooms 2, 14, 12, and 4). Findings include: On 6/5/17 at 10:03 a.m., during environmental rounds with the	F 0465	F465 It is the standard of this facility to provide a safe, functional, sanitary, comfortable environment for residents, staff, and the public. Resident rooms cited with gouges or unpainted areas in the wall have been repaired and repainted. The hanging phone jack in room 2A has been removed, and the	07/05/2017

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	Maintenance Supervisor and Administrator, the following issues were observed: a. Room 2: A phone jack was observed hanging out of wall at the head of bed A. b. Room 4: A gouged area in the wall to the right of the head of bed B, measured as 1.5 inches long. A white area needing painted to the right of the gouged area, measured 9 inches long. The area measurements were completed by the Maintenance Supervisor. c. Room 12: A white area on a yellow wall, measured as 14 inches long. The area measurement was completed by the Maintenance Supervisor. d. Room 14: Gouged areas were observed behind the recliner on the A side of the room, measured as three 1 inch gouges, one 2 inch gouge, and one 1.5 inch gouge. A gouged area was observed on the B side of the room, measured 0.5 inches. Area measurements were completed by the Maintenance Supervisor. During an interview at the same time as the environmental rounds, the Maintenance Supervisor indicated rooms were checked at least monthly.		area patched and painted. There was a potential for all Residents to be affected by this alleged deficient practice. All resident rooms will be inspected and repaired and repainted if needed by 7/5/2017. An all staff inservice was held on 6/8/17 by the administrator about reporting gouges or unpainted patch areas in resident's rooms or around the facility to maintenance through the maintenance log, and reporting it to the administrator or DON if the issue is not corrected. An audit tool has been created that monitors gouges and unpainted patch areas in resident rooms. Administrator or Environmental Service Manager will be responsible for monitoring resident rooms for gouges or unpainted areas 3 times weekly for 4 weeks, 2 times weekly for the next 4 weeks, and weekly thereafter until 100% compliance is achieved. Results will be shared monthly with the facility QAPI committee for additional recommendations. Rockville Nursing & Rehab would like to request a desk review for compliance with this deficiency as we feel with the new processes adopted we will obtain and maintain continued compliance.	

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	Maintenance log books were kept at the nurse's station for staff to write down concerns. The log books were checked once to twice daily by the Maintenance Supervisor. He was aware of the phone jack in room 2, and it was noted on the log book 2 months ago. Rooms 4 and 12 needed re-painted. Resident would be moved to a different room temporarily and painting would be completed. He was aware it needed done, just had not been completed yet. 3.1-19(a)(4)(f)(5)			