| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155464 | A. BUILDING 00<br>B. WING | 03/13/2019 |

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| ROCKVILLE NURSING AND REHABILITATION CENTER | 768 N US HWY 41<br>ROCKVILLE, IN 47872 |

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| F 0000<br><br>Bldg. 00 | This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00288489.<br><br>Complaint IN00288489 - Substantiated. Federal/State deficiencies related to the allegations are cited at F684.<br><br>Survey dates: March 8, 11, 12, and 13, 2019.<br><br>Facility number: 000492<br>Provider number: 155464<br>AIM number: 100291360<br><br>Census Bed Type:<br>SNF/NF: 25<br>Total: 25<br><br>Census Payor Type:<br>Medicare: 5<br>Medicaid: 11<br>Other: 9<br>Total: 25<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed on March 21, 2019. | 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 and Rehabilitation Center 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. | |
| F 0580<br>SS=D<br>Bldg. 00 | 483.10(g)(14)(i)-(iv)<br>Notify of Changes (Injury/Decline/Room, etc.)<br>§483.10(g)(14) Notification of Changes.<br>(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- | | | |

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

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| | (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;<br>(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);<br>(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<br>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).<br>(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.<br>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-<br>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or<br>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.<br>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).<br><br>§483.10(g)(15)<br>Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations | | | |

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| | that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).<br>Based on record review and interview, the facility failed to ensure the physician was notified of abnormal accu-check (blood sugar testing) results and medication refusals (Resident 17) for 1 of 6 residents reviewed for medications.<br><br>Findings include:<br><br>A. Resident 17's record was reviewed on 3/11/19 at 2:47 p.m. An annual Minimum Data Set (MDS) assessment, dated 2/12/19, indicated the resident was cognitively intact.<br><br>A physician's order, dated 11/17/18, indicated accu-checks after breakfast, lunch, and at bedtime for diabetes mellitus.<br><br>A physician's order, dated 11/17/18, indicated accu-check as needed for signs and symptoms of hypoglycemia (low blood sugar) or hyperglycemia (high blood sugar).<br><br>A physician's order, dated 11/17/18, indicated insulin lispro (a hormone which regulates the amount of sugar in the blood) 100 units (u)/milliliter (ml) inject subcutaneously (SQ) (an injection into the layer between the skin and the muscle): 150-199 = 4 u, 200-249 = 6 u, 250-299 = 8 u, 300-349 = 10 u, 350-399 = 12 u, 400-999 = 14 u. Notify the physician if the accu-check is less than 60 or over 450.<br><br>A review of a Medication Administration Record (MAR) accu-check results for February and March 2019: | F 0580 | F580<br>Notification of changes<br>It is the standard of this facility to consult with the resident's physician when there is a significant change in the resident's physical, mental, or psychosocial status…<br><br>-What corrective action be accomplished for those residents found to have been affected by the deficient practice?<br>A. Resident 17's physician has been notified of her abnormal accu checks and refusal of ordered insulin dosing.<br>B. Resident 17's physician has been notified of her refusal of ordered medications.<br><br>-How will the facility identify residents having the potential to be affected by the same deficient practice?<br>A. The DON reviewed all nurse's notes on current residents for the past 90 days to ensure appropriate physician notification of abnormal accu checks and refusal of ordered insulin dosing. Concerns found were corrected immediately.<br>B. The DON reviewed all nurse's notes on current residents for the past 90 days to ensure | 04/12/2019 |

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| | a. 2/1/19, 9:00 a.m., 477, 1:00 p.m., 477, and 8:00 p.m., 498. The MAR lacked documentation the physician was notified of the accu-check being over 450.<br><br>b. 2/8/19, 1:00 p.m., 526, and 8:00 p.m., 587. The MAR lacked documentation the physician was notified of the accu-check being over 450.<br><br>c. 2/9/19, 8:00 p.m., 999. The MAR lacked documentation the physician was notified of the accu-check being over 450.<br><br>d. 2/10/19, 1:00 p.m., 500. The MAR lacked documentation the physician was notified of the accu-check being over 450.<br><br>e. 2/12/19, 8:00 p.m., 560. The MAR lacked documentation the physician was notified of the accu-check being over 450.<br><br>f. 2/13/19, 1:00 p.m., 464. The MAR lacked documentation the physician was notified of the accu-check being over 450.<br><br>g. 2/20/19, 9:00 a.m., the resident refused the accu-check. The MAR lacked documentation the physician was notified of the accu-check refusal.<br><br>h. 3/1/19, 5:18 p.m., 459. The MAR lacked documentation the physician was notified of the accu-check being over 450.<br><br>i. 3/3/19, 8:00 p.m., 460. The MAR lacked documentation the physician was notified of the accu-check being over 450.<br><br>j. 3/4/19, 8:00 p.m., 458. The MAR lacked documentation the physician was notified of the accu-check being over 450. | | appropriate physician notification of refusal of ordered medications. Concerns found were corrected immediately.<br><br>-What measure will be put into place and what systemic changes will be made to ensure that the deficient practice will not recur? The nursing staff will be inserviced on 4/8/2019 by the DON regarding notification requirements upon a resident's change of condition, including resident's abnormal accu checks, refusal of ordered insulin dosing, and refusal of ordered medications.<br><br>-How will the corrective actions be monitored to ensure the alleged deficient practice will not recur? An audit tool has been created that monitors the 24 hr report and focus charting to assure proper notifications are made to resident's physician when a resident change of condition, including resident's abnormal accu checks, refusal of ordered insulin dosing, and refusal of ordered medications 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. | |

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| | k. 3/5/19, 9:00 a.m., the resident refused the accu-check. The MAR lacked documentation the physician was notified of the accu-check refusal.<br><br>l. 3/5/19, 2:55 p.m., 465. The MAR lacked documentation the physician was notified of the accu-check being over 450.<br><br>m. 3/6/19, 9:00 a.m., the resident refused the accu-check. The MAR lacked documentation the physician was notified of the accu-check refusal.<br><br>n. 3/8/19, 9:00 a.m., 473, and 8:00 p.m., 485. The MAR lacked documentation the physician was notified of the accu-check being over 450.<br><br>o. 3/11/19, 4:26 p.m., 489. The MAR lacked documentation the physician was notified of the accu-check being over 450.<br><br>A review of nursing electronic MAR notes:<br><br>a. 2/8/19 at 3:19 p.m., The resident only allowed the nurse to administer 12 u of insulin. The accu-check was 526, and 14 u of insulin was ordered. The record lacked documentation the physician was notified of the dose of insulin administered.<br><br>b. 2/13/19 at 1:10 p.m., The resident only took 12 u of insulin. The accu-check was 464 and 14 u of insulin was ordered. The record lacked documentation the physician was notified of the dose of insulin administered.<br><br>c. 2/16/19 at 2:35 p.m., The resident only took 10 u of insulin. The accu-check was 407, and 14 u of insulin was ordered. The record lacked documentation the physician was notified of the | | -By what date the systemic changes for each deficiency will be completed?<br>April 12, 2019<br>Rockville Nursing & Rehab would like to request a desk review for compliance with this deficiency as we feel with the new training and process adopted we will obtain and maintain continued compliance. | |

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| | dose of insulin administered.<br><br>d. 2/22/19 at 1:36 p.m., The resident refused insulin. The accu-check was 284, and 8 u of insulin was ordered. The record lacked documentation the physician was notified of the resident's refusal of the insulin.<br><br>e. 2/25/19 at 2:27 p.m., The resident only allowed 6 u of insulin to be administered. The accu-check was 395, and 12 u of insulin was ordered. The record lacked documentation the physician was notified of the dose of insulin administered.<br><br>f. 2/27/19 at 10:13 a.m., The resident only allowed 5 u of insulin to be administered. The accu-check was 300 and 10 u of insulin was ordered. The record lacked documentation the physician was notified of the dose of insulin administered.<br><br>g. 3/2/19 at 2:21 p.m., The resident was given 4 u of insulin. The accu-check was 308, and 10 u of insulin was ordered. The record lacked documentation the physician was notified of the dose of insulin administered.<br><br>h. 3/4/19 at 9:26 a.m., The resident requested only 5 u of insulin. The accu-check was 315, and 10 u of insulin was ordered. The record lacked documentation the physician was notified of the dose of insulin administered.<br><br>i. 3/4/19 at 12:08 p.m., The resident refused insulin. The accu-check was 172, and 2 u of insulin was ordered. The record lacked documentation the physician was notified of the dose of insulin administered.<br><br>j. 3/5/19 at 2:55 p.m., An as needed accu-check was 465. The resident requested, and was given, | | | |

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| | 12 u of insulin. 14 u of insulin was ordered. The record lacked documentation the physician was notified of the dose of insulin administered.<br><br>k. 3/7/19 at 2:23 p.m., The resident requested, and was given, 10 u of insulin. The accu-check was 417, and 14 u of insulin was ordered. The record lacked documentation the physician was notified of the dose of insulin administered.<br><br>l. 3/8/19 at 11:00 a.m., The resident was given 12 u of insulin as requested. The accu-check was 473, and 14 u of insulin was ordered. The record lacked documentation the physician was notified of the dose of insulin administered.<br><br>m. 3/8/19 at 1:21 p.m., The resident refused insulin. The accu-check was 319, and 10 u of insulin was ordered. The record lacked documentation the physician was notified of the insulin refusal.<br><br>n. 3/11/19 at 12:38 p.m., The resident refused insulin. The accu-check was 233, and 6 u of insulin was ordered. The record lacked documentation the physician was notified of the insulin refusal.<br><br>o. 3/11/19 at 6:46 p.m., An as needed accu-check was 489. The resident requested, and was given, 12 u of insulin. 14 u of insulin was ordered. The record lacked documentation the physician was notified of the dose of insulin administered.<br><br>Nurse's notes for February and March 2019, lacked documentation the physician was notified of the refusals or insulin administered.<br><br>During an interview, on 3/12/19 at 10:29 a.m., the Regional Director of Clinical Operations (RDCO) indicated the documentation of the physician | | | |

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| | being notified of accu-check results should have been in the nurse's notes.<br><br>During an interview, on 3/12/19 at 10:34 a.m., the RDCO indicated the physician should have been notified daily of medication refusals.<br><br>During an interview, on 3/12/19 at 11:20 a.m., the RDCO indicated the code 999 for the accu-check on 2/9/19, meant the meter read as high. That meant the resident's accu-check was over 600 at that time. The meter would show that code if the accu-check was 600 or greater. The physician should have been notified of the accu-check result, and the notification should have been documented.<br><br>During an interview, on 3/12/19 at 11:47 a.m., the RDCO indicated if a resident requested a different amount of insulin from what was ordered by the physician or refused accu-checks or insulin, the physician should have been notified. The physician notification should have been documented.<br><br>B. Resident 17's record was reviewed on 3/11/19 at 2:47 p.m. An annual Minimum Data Set (MDS) assessment, dated 2/12/19, indicated the resident was cognitively intact.<br><br>Diagnoses on the resident's profile included, but were not limited to, hypertension (high blood pressure) secondary to other renal (kidney) disorders, gastro-esophageal reflux disease (acid reflux) (GERD), other specified diabetes mellitus (a group of diseases causing too much sugar in the blood) with diabetic chronic kidney disease, end stage renal disease, other specified anxiety disorders, depression (a mental health disorder characterized by persistently depressed mood or | | | |

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| | loss of interest in activities, causing significant impairment in daily life) recurrent, and bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs) unspecified.<br><br>A physician's order, dated 11/17/18, indicated hydralazine (a medication to treat high blood pressure) 100 milligrams (mg) by mouth three times a day for hypertension.<br><br>A physician's order, dated 11/17/18, and discontinued on 2/26/19, indicated sucroferric oxyhydroxide (a medication for phosphorous levels in the blood) tablet chewable 500 mg by mouth three times a day for supplement.<br><br>A physician's order, dated 11/18/18, indicated vitamin D3 (a supplement) 50,000 units (u) by mouth every Sunday morning for vitamin deficiency.<br><br>A physician's order, dated 12/11/18 and discontinued on 2/25/19, indicated Tums (an antacid) tablets chewable, two tablets by mouth twice a day between meals.<br><br>A physician's order, dated 12/15/18, indicated clonidine (a medication to treat high blood pressure) 0.3 mg by mouth three times daily for hypertension.<br><br>A physician's order, dated 12/16/18, indicated lisinopril (a blood pressure medication) 20 mg by mouth once a day for hypertension.<br><br>A physician's order, dated 12/16/18, indicated pantoprazole (treats acid reflux) 40 mg by mouth once a day for GERD. | | | |

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| | A physician's order, dated 12/18/18, indicated docusate sodium (stool softener) 100 mg by mouth once a day for constipation.<br><br>A physician's order, dated 12/21/18, and discontinued on 2/25/19, indicated Os-Cal Calcium and D3 tablet (a supplement) 500-200 mg-u, give 500 mg by mouth three times a day for supplement.<br><br>A physician's order, dated 1/1/19, indicated Levemir (a long acting insulin) 100 u/milliliters (ml) 12 u subcutaneously (SQ) (an injection into the layer between the skin and the muscle) once a day for diabetes.<br><br>A physician's order, dated 1/5/19, indicated lorazepam (an antianxiety medication) 1 mg by mouth daily for anxiety.<br><br>A physician's order, dated 1/9/19, indicated sertraline (an antidepressant) 100 mg by mouth daily for mood.<br><br>A physician's order, dated 1/16/19, indicated calcitriol (a vitamin) 0.5 micrograms (mcg) by mouth every Monday, Wednesday, Friday, and Sunday related to kidney failure.<br><br>A physician's order, dated 1/29/19, indicated Seroquel (an antipsychotic) extended release, 200 mg by mouth once a day for bipolar.<br><br>A review of a Medication Administration Record (MAR) for February and March 2019:<br><br>a. The resident refused calcitrol 0.5 mcg, on 2/3/19, 2/4/19, 2/8/19, 2/10/19, 2/11/19, 2/13/19, 2/15/19, 2/17/19, 2/18/19, 2/20/19, 2/22/19, 2/25/19, 2/27/19, 3/1/19, 3/3/19, 3/4/19, 3/6/19, 3/8/19, 3/10/19, and | | | |

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| | 3/11/19. The MAR lacked documentation the physician was notified of the medication refusals.<br><br>b. The resident refused docusate sodium 100 mg, on 2/3/19, 2/4/19, 2/8/19, 2/10/19, 2/11/19, 2/13/19, 2/15/19, 2/16/19, 2/17/19, 2/18/19, 2/20/19, 2/22/19, 2/27/19, 3/1/19, 3/3/19, 3/4/19, 3/6/19, 3/8/19, 3/10/19, and 3/11/19. The MAR lacked documentation the physician was notified of the medication refusals.<br><br>c. The resident refused Levemir 12 u, on 2/1/19, 2/4/19, 2/9/19, 2/12/19. 2/13/19, 2/16/19, 3/6/19, and 3/12/19. The MAR lacked documentation the physician was notified of the medication refusals.<br><br>d. The resident refused lisinopril 20 mg, on 2/1/19, 2/3/19, 2/4/19, 2/13/19, 2/16/19, 2/20/19, 3/1/19, and 3/12/19. The MAR lacked documentation the physician was notified of the medication refusals.<br><br>e. The resident refused lorazepam 1 mg, on 2/1/19, 2/3/19, 2/4/19, 2/16/19, 2/20/19, 3/1/19, and 3/12/19. The MAR lacked documentation the physician was notified of the medication refusals.<br><br>f. The resident refused pantoprazole 40 mg, on 2/4/19, 2/10/19, 2/15/19, 2/18/19, 2/20/19, 2/27/19, 3/1/19, 3/4/19, 3/6/19, 3/8/19, 3/9/19, 3/10/19, and 3/11/19. The MAR lacked documentation the physician was notified of the medication refusals.<br><br>g. The resident refused Seroquel 200 mg, on 2/16/19. The MAR lacked documentation the physician was notified of the medication refusal.<br><br>h. The resident refused sertraline 100 mg, on 2/10/19, 2/18/19, 2/20/19, 2/27/19, 3/1/19, 3/4/19, 3/6/19, 3/8/19, 3/9/19, 3/10/19, and 3/11/19. The MAR lacked documentation the physician was | | | |

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| | notified of the medication refusals.<br><br>i. The resident refused Vitamin D3 50,000 u, on 2/10/19, 2/17/19, 3/3/19, and 3/10/19. The MAR lacked documentation the physician was notified of the medication refusals.<br><br>j. The resident refused Tums chewable two tablets, one dose on 2/2/19, one dose on 2/3/19, one dose on 2/4/19, two doses on 2/8/19, two doses on 2/9/19, one dose on 2/10/19, one dose on 2/13/19, one dose on 2/14/19, one dose on 2/15/19, two doses on 2/16/19, two doses on 2/17/19, two doses on 2/18/19, two doses on 2/20/19, two doses on 2/22/19, one dose on 2/23/19, and one dose on 2/25/19. The MAR lacked documentation the physician was notified of the medication refusals.<br><br>k. The resident refused clonidine 0.3 mg, one dose on 2/3/19, one dose on 2/6/19, one dose on 2/9/19, one dose on 2/10/19, one dose on 2/17/19, two doses on 2/18/19, one dose on 2/20/19, one dose on 2/22/19, one dose on 2/25/19, one dose on 2/27/19, one dose on 3/1/19, one dose on 3/4/19, one dose on 3/5/19, one dose on 3/6/19, one dose on 3/7/18, two doses on 3/8/19, one dose on 3/9/19, one dose on 3/10/19, and two doses on 3/11/19. The MAR lacked documentation the physician was notified of the medication refusals.<br><br>l. The resident refused hydralazine 100 mg, one dose on 2/1/19, one dose on 2/2/19, three doses on 2/3/19, three doses on 2/4/19, one dose on 2/5/19, one dose on 2/6/19, one dose on 2/7/19, one dose on 2/8/19, two doses on 2/9/19, one dose on 2/10/19, three doses on 2/11/19, one dose on 2/12/19, two doses on 2/13/19, two doses on 2/14/19, one dose on 2/15/19, two doses on 2/16/19, two doses on 2/17/19, one dose on | | | |

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| | 2/18/19, one dose on 2/19/19, three doses on 2/20/19, one dose on 2/21/19, one dose on 2/22/19, one dose on 2/23/19, two doses on 2/25/19, one dose on 2/26/19, two doses on 2/27/19, one dose on 2/28/19, three doses on 3/1/19, one dose on 3/2/19, two doses on 3/3/19, two doses on 3/4/19, two doses on 3/5/19, two doses on 3/6/19, one dose on 3/7/19, two doses on 3/8/19, one dose on 3/9/18, two doses on 3/10/19, three doses on 3/11/19, and one dose on 3/12/19. The MAR lacked documentation the physician was notified of the medication refusals.<br><br>m. The resident refused Os-Cal D3 tablet 500-200 mg-u, 500 mg, two doses on 2/2/19, three doses on 2/3/19, three doses on 2/4/19, two doses on 2/5/19, two doses on 2/7/19, three doses on 2/8/19, three doses on 2/9/19, one dose on 2/10/19, three doses on 2/11/19, one dose on 2/12/19, two doses on 2/13/19, three doses on 2/15/19, two doses on 2/16/19, three doses on 2/17/19, two doses on 2/18/19, one dose on 2/19/19, three doses on 2/20/19, one dose on 2/21/19, three doses on 2/22/19, one dose on 2/23/19, one dose on 2/24/19, and one dose on 2/25/19. The MAR lacked documentation the physician was notified of the medication refusals.<br><br>n. The resident refused sucroferric oxyhydroxide 500 mg, one dose on 2/1/19, one dose on 2/2/19, three doses on 2/3/19, three doses on 2/4/19, three doses on 2/5/19, three doses on 2/6/19, three doses on 2/7/19, two doses on 2/8/19, three doses on 2/9/19, one dose on 2/10/19, three doses on 2/11/19, one dose on 2/12/19, three doses on 2/13/19, two doses on 2/14/19, two doses on 2/15/19, three doses on 2/16/19, two doses on 2/17/19, two doses on 2/18/19, two doses on 2/19/19, three doses on 2/20/19, one dose on 2/21/19, three doses on 2/22/19, two doses on | | | |

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| | 2/23/19, one dose on 2/24/19, two doses on 2/25/19, and one dose on 2/26/19. The MAR lacked documentation the physician was notified of the medication refusals.<br><br>Nurse's notes from February and March 2019 lacked documentation the physician was notified of the medication refusals.<br><br>A care plan, target dated 6/8/19, indicated the resident was non-compliant with taking medications and refused medications at times. Interventions included, but were not limited to, inform physician of refusals.<br><br>During an interview, on 3/12/19 at 10:34 a.m., the Regional Director of Clinical Operations (RDCO) indicated the physician should have been notified daily of medication refusals. The physician notification should have been documented.<br><br>On 3/12/19 at 1:29 p.m., the Director of Nursing (DON) provided a document titled, "Change in a Resident's Condition or Status," and indicated it was the policy currently being used by the facility. The policy indicated, "Policy Statement: Our facility shall promptly notify the...Attending Physician...of changes in the resident's medical/mental condition...Policy Interpretation and Implementation: 1. The Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On-Call Physician when there has been: ...e. A need to alter the resident's medical treatment significantly; f. Refusal of treatment or medications (i.e. two (2) or more consecutive times)...."<br><br>3.1-5(a)(3) | | | |

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| F 0641 SS=D Bldg. 00 | 483.20(g)<br>Accuracy of Assessments<br>§483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the resident's status.<br>Based on record review and interview, the facility failed to ensure accurate Minimum Data Set (MDS) assessments for 1 of 14 resident MDS assessments reviewed (Resident 19).<br><br>Findings include:<br><br>Resident 19's record was reviewed on 3/11/19 at 1:13 p.m. A comprehensive five day MDS assessment, dated 12/20/18, indicated the resident was not considered a Level II Preadmission Screening and Resident Review (PASRR) (a screening to determine if a resident being admitted to a nursing home is mentally ill and/or requires specialized services).<br><br>Diagnoses on the resident's profile included, but were not limited to, bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs) unspecified and major depressive disorder recurrent (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life) unspecified.<br><br>A Level II PASRR Assessment, dated 12/11/18, indicated the resident was mentally ill, but specialized services were not required. The resident required a yearly resident review, individual or group therapy, medication review, medication adjustment, medication monitoring, and medication administration.<br><br>A physician's order, dated 2/1/19, indicated | F 0641 | F641<br>Accuracy of assessments<br><br>It is the standard of this facility to complete assessments that accurately reflect the resident's status.<br><br>-What corrective action be accomplished for those residents found to have been affected by the deficient practice?<br>Immediately after the survey team identified the concern about R. #19's MDS assessment, it was corrected.<br><br>-How will the facility identify residents having the potential to be affected by the same deficient practice?<br>All resident's MDS assessments will be audited to ensure correct coding of Level ll Preadmission Screening. No other resident was affected by this alleged deficient practice.<br><br>-What measure will be put into place and what systemic changes will be made to ensure that the deficient practice will not recur?<br>MDS Coordinator was inserviced on 4/1/19 on Section A of the RAI manual, coding of Level ll | 04/12/2019 |

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| | risperidone (an antipsychotic) 1 milligram (mg) by mouth at bedtime.<br><br>A care plan, target dated 3/27/19, indicated the resident was a Level II and did not require specialized services. The resident was mentally ill with a diagnosis of bipolar disorder.<br><br>During an interview, on 3/13/19 at 11:28 a.m., the Social Services Director (SSD) indicated the resident was considered a PASRR Level II, and was mentally ill. The resident had consented for psychiatric services while at the facility, but had not been seen yet.<br><br>During an interview, on 3/13/19 at 11:48 a.m., the MDS Coordinator indicated the PASRR Level II should have been coded on the MDS assessment, dated 12/20/18. It had been missed. The resident was a Level II PASRR.<br><br>On 3/13/19 at 12:11 p.m., the MDS Coordinator provided a copy of Section A of the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Version 3.0 Manual, and indicated it was the policy currently being used by the facility. The manual indicated, "SECTION A: IDENTIFICATION INFORMATION: ...A1500: Preadmission Screening and Resident Review (PASRR)...Code 1, yes: if PASRR Level II screening determined that the resident has a serious mental illness...."<br><br>3.1-31(c)(3) | | Preadmission Screening by the Regional MDS consultant.<br><br>-How will the corrective actions be monitored to ensure the alleged deficient practice will not recur?<br>Social Service Director will audit Level ll Preadmission Screen coding on MDS with a random sample of 5 residents monthly for 3 months and quarterly thereafter until 100% compliance is achieved. The audit results will be reported to the facility Quality Assurance (QAPI) committee.<br><br>-By what date the systemic changes for each deficiency will be completed?<br>April 12, 2019 | |
| F 0657<br>SS=D<br>Bldg. 00 | 483.21(b)(2)(i)-(iii)<br>Care Plan Timing and Revision<br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be- | | | |

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| | (i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br><br>Based on record review and interview, the facility failed to ensure comprehensive care plans were developed for residents with intravenous (IV) (access to deliver liquids directly to the vein) antibiotics, and peripherally inserted central catheters (PICC) lines (an IV that can be used for a long time) (Residents 19 and B) and a resident receiving anticoagulant (blood thinner) medication (Resident 13) for 3 of 13 residents' care plans reviewed.<br><br>Findings include: | F 0657 | F657<br>Care Plan Timing & Revision<br>It is the standard of this facility to ensure that a comprehensive care plan is developed within 7 days after completion of the comprehensive assessment.<br><br>-What corrective action be accomplished for those residents found to have been affected by the deficient practice?<br>1. Immediately after surveyor's concerns about resident 19's care | 04/12/2019 |

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| | 1. Resident 19's record was reviewed on 3/11/19 at 1:13 p.m. An admission Minimum Data Set (MDS) assessment, dated 12/20/19, indicated the resident was cognitively intact.<br><br>Diagnoses on the resident's profile included, but were not limited to, abscess of bursa (a fluid filled pad acts as a cushion at a joint) right elbow.<br><br>A nurse's assessment, dated 1/31/19, indicated the resident had returned to the facility, after a hospital stay, with a PICC line.<br><br>An interim care plan, dated 1/31/19, indicated the resident required PICC protocol, and antibiotics as ordered.<br><br>A physician's order, dated 2/1/19, indicated flush PICC line with normal saline (an IV fluid) before and after each antibiotic administration.<br><br>A physician's order, dated 2/1/19, indicated cefazolin (an antibiotic) 2 grams (gm) IV every 8 hours for osteomyelitis (an infection of the bone) until 3/8/19.<br><br>A physician's order, dated 2/8/19, indicated cefazonlin 2 gm IV every 8 hours for osteomyelitis, until 3/15/19.<br><br>The comprehensive care plans lacked documentation of a care plan for the IV antibiotic, cefazolin, or the PICC line.<br><br>During an interview, on 3/11/19 at 2:15 p.m., the Director of Nursing (DON) indicated the resident had returned after a hospital stay on 1/31/19. She had a PICC line when she returned from the hospital. She was on IV antibiotics. | | plan not addressing IV use, this was addressed in the resident's comprehensive care plan.<br>2. Immediately after surveyor's concerns about resident B's care plan not addressing PICC line use, this was addressed in the resident's comprehensive care plan.<br>3. Immediately after surveyor's concerns about resident 13's care plan not addressing anticoagulant use, this was addressed in the resident's comprehensive care plan.<br><br>-How will the facility identify residents having the potential to be affected by the same deficient practice?<br>All current resident's care plans have been reviewed by the IDT to ensure all resident's comprehensive care plans include IV, PICC Line, and anticoagulant use. Omissions were addressed immediately.<br><br>-What measure will be put into place and what systemic changes will be made to ensure that the deficient practice will not recur?<br>A re-training was provided on 4/01/19 to the IDT by the regional MDS consultant about comprehensive care plan development, including ensuring IV, PICC Line, and anticoagulant use were included in the comprehensive care plan. | |

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| | During an interview, on 3/11/19 at 2:38 p.m., the MDS Coordinator indicated there should have been a comprehensive care plan for the PICC line and the IV antibiotic. She was unable to find a care plan.<br><br>During an interview, on 3/11/19 at 3:20 p.m., the MDS Coordinator indicated the resident's comprehensive care plan should have been updated. She had reviewed the resident's interim care plan, and updated the comprehensive care plan, but the PICC line and IV antibiotic had been missed.<br><br>During an interview, on 3/12/19 at 9:35 a.m., the DON indicated PICC lines should have been on the comprehensive care plan.<br>2. During a random observation, on 3/8/19 at 10:46 a.m., Resident B was observed to have a peripherally inserted central catheter (PICC) line to his left upper arm.<br><br>Resident B's record was reviewed on 3/12/19 at 9:30 a.m. A nursing admission assessment, dated 2/21/19, indicated the resident had a PICC line, double lumen to his left arm.<br><br>A review of current comprehensive care plans lacked documentation the resident had a PICC line to his left arm.<br><br>A physician's order, dated 3/4/19 indicated to change PICC line dressing every week and as needed.<br><br>During an interview, on 3/13/19 at 9:17 a.m., the Minimum Data Set (MDS) Coordinator indicated the resident lacked both an interim (baseline) care plan and a comprehensive care plan for his PICC line. The resident should have been care planned | | -How will the corrective actions be monitored to ensure the alleged deficient practice will not recur?<br>The DON or designee will review the 24 hr report and focus charting to note new residents or current residents with a change in IV, PICC Line, and anticoagulant use. DON or designee will then ensure these are reflected in the resident's comprehensive care plan. 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.<br><br>-By what date the systemic changes for each deficiency will be completed?<br>April 12, 2019<br>Rockville Nursing & Rehab would like to request a desk review for compliance with this deficiency as we feel with the new training and process adopted, we will obtain and maintain continued compliance. | |

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| | as having a PICC line and was unsure why it had been missed.<br><br>3. Resident 13's record was reviewed on 3/11/19 at 1:03 p.m. An admission Minimum Data Set (MDS) assessment, dated 12/13/18, indicated the resident had received an anticoagulant medication 7 days during the look back prior.<br><br>A review of current comprehensive care plans lacked documentation the resident received an anticoagulant.<br><br>A physician's order, dated 2/20/19, indicated Coumadin (anticoagulant) 5 milligram (mg) tablet, give 5 mg by mouth one time a day every Monday, Tuesday, Wednesday, Thursday, Friday, and Saturday for hypertension.<br><br>A physician's order, dated 2/24/19, indicated Coumadin 5 mg tablet, give 2.5 mg by mouth one time a day every Sunday for hypertension.<br><br>During an interview, on 3/11/19 at 3:13 p.m., the MDS Coordinator indicated the resident lacked an anticoagulant care plan. A comprehensive care plan should have been developed within 7 days of the completion of the resident's comprehensive assessment.<br><br>On 3/11/19 at 3:11 p.m., the MDS Coordinator provided a document titled, "Care Plans-Comprehensive," and indicated it was the policy currently being used by the facility. The policy indicated, "Policy Statement: An individualized Comprehensive Care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. Policy Interpretation and | | | |

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| ROCKVILLE NURSING AND REHABILITATION CENTER | 768 N US HWY 41<br>ROCKVILLE, IN 47872 |

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| | Implementation: 1. Our facility's Care planning/Interdisciplinary team, in coordination with the resident, his/her family or representative (sponsor), develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain...4. The resident's Comprehensive Care Plan is developed within seven (7) days of the completion of the resident's comprehensive assessment (MDS)...."<br><br>3.1-35(b)(1)<br>3.1-35(c)(1) | | | |
| F 0684<br>SS=D<br>Bldg. 00 | 483.25<br>Quality of Care<br>§ 483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br>Based on record review, and interview, the facility failed to ensure a resident's accu-check (blood glucose reading) was retested after an error reading and the physician was notified in a timely manner for 1 of 4 resident's reviewed for hospitalization (Resident B).<br><br>Findings include:<br><br>Resident B's record was reviewed on 3/12/19 at 9:30 a.m. Diagnoses from the resident's profile included, but were not limited to, diabetes mellitus (DM) (disease that results in too much sugar in the blood, high blood glucose). | F 0684 | F684<br>Quality of Care<br>It is the standard of this facility to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive care plan, and the resident's choices.<br><br>Rockville Nursing & Rehab Requests an IDR of this tag due to the nurse acting appropriately for the resident's care during a non-responsive episode on | 04/12/2019 |

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| | A progress note, dated 2/24/19 at 8:00 a.m., indicated the resident was in the dining room slumped over to his right side. He was taken to his room and laid down in bed. An accu-check was obtained and an error reading displayed, glucagon (treats severe low blood sugar) 1 milligrams (mg) subcutaneous (SQ) was administered. The resident began to respond to stimuli and answered questions after 30 minutes. The resident was found again to be falling over and unable to set up and physician was called, ambulance arrived to the facility at 9:20 a.m. The progress note lacked documentation the resident's accu-check was retested after the error reading and the physician was notified of the glucagon administration and the first episode of hypoglycemic symptoms.<br><br>A Medication Administration Record (MAR), dated 2/24/19 at 8:00 a.m., indicated insulin glargine solution (a long acting insulin) 100 unit/ml, inject 20 units (SQ) in the morning for diabetes. The resident's insulin lacked documentation it had been administered on 2/24/19 at 8:00 a.m.<br><br>A MAR, dated 2/24/19, indicated accu check before meals and at bedtime for DM. The resident's blood sugar reading indicated 151 on 2/24/19 at 6:00 a.m.<br><br>During an interview, on 3/13/19 at 11:16 a.m., the Director of Nursing (DON) indicated when an error reading displayed on a glucometer the test should be redone. The physician should be notified promptly when there was a change of condition with a resident.<br><br>On 3/12/19 at 11:39 a.m., the Regional Director of | | 2/24/29.<br><br>Documentation during this episode on 2/24/19 include R. # B's accu check being 151 at 6:00 am. Resident was slumped over to his rt side in the dining room at 8:00 am. When resident B's accu check was taken, it registered as an error. Following her assessment and vitals taken, knowledge of earlier accu check, knowledge the resident had not eaten yet in the day, and knowledge of resident the Nurse then administered 1 mg glucagon. After 5 mins R. #B is being more responsive & accu check was 187. After 30 mins Resident #B requests to eat morning meal, and accu check and vitals are taken, his blood sugar is 214. Nurse documents that resident is unable to sit up, slumping over. Nurse obtains order to send resident B to the hospital, and documents ambulance arrives at 9:20. Administrator's phone records the call to inform R. is going out to hospital at 9:08 am, after Physician, Ambulance, and DON was called. It should also be noted that the facility was experiencing a power outage (reported to ISDH) during this timeframe, and charge nurse was responding to power outage concerns in the facility as well. Nurse documents this entire episode in one entry, obviously | |

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| | Clinical Operations provided an untitled instructions manual for the glucometer and indicated it was the insert that would be used to troubleshoot an error reading on the glucometer. The instructions indicated if an error message displayed to retest.<br><br>On 3/12/19 at 1:29 p.m., the DON provided a document titled, "Change in A Resident's or Status," and indicated it was the policy 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(e.g., changes in level of care, billing/payments, resident rights, etc.). Policy Interpretation and Implementation: 1. The Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or on-call Physician when there has been: ...d. A significant change in the resident's physical/emotional/mental condition...."<br><br>On 3/12/19 at 2:22 p.m., the DON provided a document titled, "Nursing Care of the Resident with Diabetes Mellitus," and indicated it was the policy currently being used by the facility. The policy indicated, "Management of Hypoglycemia: ...12. For symptomatic and unresponsive residents with hypoglycemia (<70 mg/dl or less than the physician-ordered parameter): a. immediately administer oral glucose paste to the buccal mucosa, intramuscular glucagon...per facility protocol and notify the physician for further orders; b. if resident remains unresponsive, call 911...."<br><br>This Federal Tag relates to Complaint IN00288489.<br><br>3.1-37(a) | | after resident has left the facility.<br><br>-What corrective action be accomplished for those residents found to have been affected by the deficient practice?<br>A. Resident B was transported to the hospital after the above episode.<br><br>-How will the facility identify residents having the potential to be affected by the same deficient practice?<br>The DON reviewed all nurse's notes on residents for the past 90 days to ensure appropriate action and notification of error accu checks were made. Concerns found were addressed immediately.<br><br>-What measure will be put into place and what systemic changes will be made to ensure that the deficient practice will not recur?<br>The nursing staff will be inserviced on 4/8/2019 by the DON regarding appropriately rechecking an accu check that reads as an error, & notification requirement upon a resident's change of condition.<br><br>-How will the corrective actions be monitored to ensure the alleged deficient practice will not recur?<br>An audit tool has been created that monitors the 24 hr report and focus charting to assure proper notifications are made to | |

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| | | | resident's physician when there is a resident change of condition, and that accu checks are retaken when an error message is received. 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.<br><br>-By what date the systemic changes for each deficiency will be completed?<br>April 12, 2019<br>Rockville Nursing & Rehab would like to request a desk review for compliance with this deficiency as we feel with the new training and process adopted, we will obtain and maintain continued compliance. | |
| F 0757<br>SS=D<br>Bldg. 00 | 483.45(d)(1)-(6)<br>Drug Regimen is Free from Unnecessary Drugs<br>§483.45(d) Unnecessary Drugs-General.<br>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-<br><br>§483.45(d)(1) In excessive dose (including duplicate drug therapy); or<br><br>§483.45(d)(2) For excessive duration; or | | | |

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| | §483.45(d)(3) Without adequate monitoring; or<br><br>§483.45(d)(4) Without adequate indications for its use; or<br><br>§483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or<br><br>§483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.<br>Based on record review and interview, the facility failed to ensure labs for medication monitoring were obtained for a Vancomycin (an antibiotic) trough (a blood test to monitor the levels of the antibiotic) (Resident B), and a Hemoglobin A1C was drawn (Resident 5) for 2 of 6 residents reviewed for medications.<br><br>Findings include:<br><br>1. Resident B's record was reviewed on 3/12/19 at 9:30 a.m. A baseline care plan, dated 2/26/19, indicated the resident had an infection post surgery and received Vancomycin (antibiotic) intravenously.<br><br>A review of current physician's orders, lacked documentation for a Vancomycin trough level to be obtained.<br><br>A physician's order, dated 3/5/19, indicated Vancomycin 1.25-0.9 grams (gm)/250 milliliters (ml), use 1.25 ml intravenously one time a day for infection until 4/5/19.<br><br>A Medication Administration Record (MAR), dated March 2019, indicated Vancomycin 1.25-0.9 | F 0757 | F757<br><br>Drug Regimen is Free from Unnecessary Drug Use<br>It is the standard of this facility to ensure that each resident's drug regimen is free from unnecessary drugs.<br><br>-What corrective action be accomplished for those residents found to have been affected by the deficient practice?<br>1. Immediately after surveyor's concerns about resident B's trough not being drawn for their Vancomycin use, an order was obtained, and the trough was drawn.<br>2. Immediately after surveyor's concerns about resident 5's AIC not being drawn, arrangements were made for it to be obtained.<br><br>-How will the facility identify residents having the potential to | 04/12/2019 |

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| | (gm)/250 (ml), use 1.25 ml intravenously. The MAR indicated the antibiotic was administered on 3/5/19, 3/6/19, 3/7/19, 3/8/19, 3/9/19, 3/10/19, 3/11/19, 3/12/19, and 3/13/19.<br><br>A review of current labs, lacked documentation the recommended lab test of Vancomycin trough levels had been completed from 3/5/19 through 3/13/19.<br><br>Diagnoses from the resident's profile included, but were not limited to, wound infection.<br><br>During an interview, on 3/13/19 at 11:16 a.m., the Director of Nursing (DON) indicated the resident returned from the hospital on 3/4/19 and the admission nurse should have followed up with the physician on lab monitoring for Vancomycin. She could not find where a trough had been obtained from 3/5/19 through 3/13/19. She followed up with pharmacy and was guided a Vancomycin trough would typically be obtained after the fourth dose and monitored weekly after. At the same time, a drug information insert was provided, and indicated lab and/or medical tests such as Vancomycin blood levels should be done while you are using this medication.<br><br>During an interview, on 3/13/19 at 1:24 p.m., Physician 11 indicated a Vancomycin trough should have been obtained after the 3rd dose and he was unsure why it was missed, but felt "the ball had been dropped." It was not necessary to obtain a peak level, but a trough level should be obtained after the 3rd dose and from there he would let pharmacy take over the monitoring of the medication.<br><br>On 3/13/19 at 1:38 .m., the DON provided a document titled, "Infusion Therapy Procedures: | | be affected by the same deficient practice?<br>1. No other residents have orders for Vancomycin.<br>2. All current resident's lab orders have been reviewed by the DON to ensure orders have been processed to the Lab Book and are completed as ordered. No other residents were affected by this alleged deficient.<br><br>-What measure will be put into place and what systemic changes will be made to ensure that the deficient practice will not recur?<br>1. The nursing staff will be inserviced on 4/8/2019 by the DON regarding trough levels needing drawn for Vancomycin use.<br>2. The nursing staff was inserviced on 3/27/2019 by the DON regarding receiving and following physician's orders. A Lab book has been implemented so nurses check process new lab orders, and ensure the order is completed. The nursing staff will be inserviced to the Lab book on 3/27/2019 by the DON.<br><br>-How will the corrective actions be monitored to ensure the alleged deficient practice will not recur?<br>1. The DON or designee will review the 24 hr report and focus charting to note new residents or current residents with a Vancomycin and ensure that a trough level is | |

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| | Anti-Infective Therapy," and indicated it was the policy currently being used by the facility. The policy indicated, "Purpose: To provide for the safe and effective administration of anti-infective therapy...Recommended Lab test: ...Vancomycin peak/trough levels as needed...."<br><br>2. Resident 5's record was reviewed on 3/11/19 at 1:23 p.m. The profile indicated the resident's diagnoses included, but were not limited to, diabetes mellitus (a group of metabolic disorders in which there are high blood sugar levels over a prolonged period) with hyperglycemia (a condition in which an excessive amount of glucose circulates in the blood plasma).<br><br>The resident's Medication Administration Record (MAR), dated March 2019, indicated the resident received insulin Glargine solution (used to control high blood sugar in people with diabetes) 100 units per milliliter (ml), inject 22 units subcutaneous (also known as, SQ, situated or applied under the skin) one time a day, and Humalog solution (Insulin), 100 units per ml, inject per sliding scale (refers to the progressive increase in pre-meal or nighttime insulin doses) SQ two times a day every 2 day(s) for diabetes mellitus. The MAR also indicated an order for accu-check (blood glucose monitoring) twice daily at varying times, two times a day every two day(s).<br><br>A lab order, dated 1/15/18, indicated Hemoglobin (Hg) A1c (a test that shows an average level of blood sugar over the past 2 to 3 months) every 90 days for diabetes mellitus.<br><br>Review of lab documents, dated April 2018 through February 2019, indicated HgA1c's had been completed in September 2018 and February | | ordered.<br>2. The DON or designee will review the 24 hr report and focus charting to note new residents or current residents with lab orders and ensure they have been transcribed to the Lab book correctly, and orders are completed.<br><br>DON or designee will audit 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.<br><br>-By what date the systemic changes for each deficiency will be completed?<br>April 12, 2019<br>Rockville Nursing & Rehab would like to request a desk review for compliance with this deficiency as we feel with the new training and process adopted, we will obtain and maintain continued compliance. | |

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| | 2019. No other completed HgA1c's were observed, during the time period.<br><br>During an interview, on 3/12/19 at 9:09 a.m., the Director of Nursing (DON) indicated the resident's HgA1c's had been overlooked every 90 days and had not been completed as ordered.<br><br>During an interview, on 3/12/19 at 3:23 p.m., the Regional Director of Clinical Operations (RDCO) indicated the expectation was that medications would be administered and labs should be completed as the physician's order indicated.<br><br>On 3/12/19 at 3:30 p.m., the RDCO provided a document, dated June 2004, titled, "Physician's Orders," and indicated it was the policy currently being used by the facility. The policy indicated, "Policy Statement: Physician's orders must...be managed in accordance with applicable laws and regulations...."<br><br>3.1-48(a)(3) | | | |
| F 0758 SS=D Bldg. 00 | 483.45(c)(3)(e)(1)-(5)<br>Free from Unnec Psychotropic Meds/PRN Use<br>§483.45(e) Psychotropic Drugs.<br>§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:<br>(i) Anti-psychotic;<br>(ii) Anti-depressant;<br>(iii) Anti-anxiety; and<br>(iv) Hypnotic<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that--- | | | |

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| | §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;<br><br>§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;<br><br>§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and<br><br>§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.<br><br>§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.<br><br>Based on record review and interview, the facility failed to ensure documented physician rationale for the declination of recommended Gradual Dose Reductions (GDR), for 2 of 5 residents reviewed for unnecessary medication. (Residents 5 and 18). | F 0758 | F758<br>Free from Unnecessary Psychotropic Meds<br><br>It is the policy of this facility to ensure each Resident who uses | 04/12/2019 |

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| | Findings include:<br><br>1. Resident 5's record was reviewed on 3/11/19 at 1:23 p.m. The profile indicated the resident's diagnoses included, but were not limited to anxiety disorder unspecified (characterized by excessive, uncontrollable and often irrational worry).<br><br>The resident's Medication Administration Record (MAR), dated March 2019, indicated a physician's order for lorazepam (a medication which affects chemicals in the brain that may be unbalanced in people with anxiety) 0.5 milligram (mg), by mouth at bedtime for anxiety disorder.<br><br>The resident's annual Minimum Data Set (MDS) assessment, dated 1/11/19, indicated the resident received an anti-anxiety medication.<br><br>A care plan, dated 2/23/18, indicated the resident had a diagnosis of anxiety.<br><br>A care plan, dated 1/17/18, indicated the resident used anti-anxiety medications related to diagnosis of anxiety disorder.<br><br>A Consultation Report, dated 5/23/18, indicated to consider a GDR of lorazepam from 0.5 mg at bedtime to 0.25 mg at bedtime. The physician declined the recommendation and placed a checkmark next to the statement which indicated the GDR would be clinically contraindicated. No written documented rationale was observed, by the physician, to justify the declination of the GDR.<br><br>During an interview, on 3/11/19 at 2:40 p.m., the Director of Nursing (DON) indicated there was no | | psychotropic drugs receives gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.<br><br>This facility wishes an Informal Dispute Resolution for this tag based on the surveyor's own findings. Under 483.45(e)(2) the requirement states Residents who use psychotropic drugs receives gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;<br><br>This is in contrast to 483.45(e)(4) which states PRN orders for psychotropic drugs are limited to 14 days. Except as provided in 483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document the rationale in the resident's medical record and indicate the duration for the PRN order.<br><br>Only in 483.45(e)(4) for PRN orders to be extended must the physician document the rationale.<br><br>For resident 5, upon recommendation to consider a GDR for lorazepam, the physician declined the recommendation and placed a checkmark next to the | |

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| | documented rationale related to the declination of the GDR by the physician. At the same time, a physician progress note, dated 6/27/18, was observed. The progress note contained no documentation to justify the physician's declination for the GDR.<br><br>2. Resident 18's record was reviewed on 3/11/19 at 3:01 p.m. The profile indicated the resident's diagnoses included, but were not limited to anxiety disorder unspecified (characterized by excessive, uncontrollable and often irrational worry).<br><br>The resident's Medication Administration Record (MAR), dated March 2019, indicated a physician's order for lorazepam (a medication which affects chemicals in the brain that may be unbalanced in people with anxiety) 0.5 milligrams (mg), by mouth in the morning for anxiety disorder.<br><br>A significant change Minimum Data Set (MDS) assessment, dated 2/12/19, indicated the resident received an anti-anxiety medication.<br><br>A care plan, dated 2/22/18, indicated the resident used an anti-anxiety medication related to anxiety disorder<br><br>A Consultation Report, dated 6/19/18, indicated the resident had been prescribed lorazepam 0.25 mg at bedtime, since January 2018. The report recommended to consider discontinuing the resident's lorazepam 0.25 mg QHS. The physician declined the recommendation and placed a checkmark next to the statement which indicated continued use is in accordance with the current standard of practice and a GDR attempt at this time is likely to impair the individual's function. No written documented rationale was observed, by | | statement which indicated the GDR would be clinically contraindicated. This meets the requirement under 483.45(e)(2) to indicate the GDR was clinically contraindicated.<br><br>For resident 18, upon recommendation to discontinue lorazepam, the physician declined the recommendation and placed a checkmark next to the statement which indicated continued use is in accordance with the current standards of practice and a GDR attempt at this time is likely to impair the individual's function. This meets the requirement under 483.45(e)(2) to indicate the GDR was clinically contraindicated.<br><br>-What corrective action be accomplished for those residents found to have been affected by the deficient practice?<br>For resident 5, the physician declining the recommendation has been contacted for a statement which indicated the GDR would be clinically contraindicated, and rational for same.<br>For resident 18, the physician declining the recommendation has been contacted for a statement which indicated the GDR would be clinically contraindicated, and rational for same.<br><br>-How will the facility identify residents having the potential to | |

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| | the physician, to justify the declination of the GDR.<br><br>During an interview, on 3/12/19 at 2:22 p.m., the Director of Nursing (DON) indicated there was no documented rationale related to the declination of the GDR by the physician. At the same time, she indicated the Consultation Report document required patient-specific rationale as to why the the GDR attempt would be declined.<br><br>3.1-48(b)(2) | | be affected by the same deficient practice?<br>The Social Service Designee has reviewed all residents with current psychotropic GDR recommendations to ensure the physician has provided contraindication if the GDR was refused.<br><br>-What measure will be put into place and what systemic changes will be made to ensure that the deficient practice will not recur?<br>All physician responses to GDR recommendations will be brought to daily QA and reviewed to ensure the physician has provided contraindication and rational if the GDR was refused. If the physician has not provided contraindication and rational, The Social Service Designee will initiate contact with the physician to provide contraindication & rational.<br><br>Physician Education was provided to facility physicians reviewing GDR recommendations.<br><br>-How will the corrective actions be monitored to ensure the alleged deficient practice will not recur?<br>An audit tool has been created that monitors Physician Response to GDR Recommendations. SSD or designee will be responsible for auditing the above daily while on duty for 4 weeks, bi weekly for the | |

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| | | | next 4 weeks, and weekly thereafter until 100% compliance is achieved. Results will be shared monthly with the facility QAPI committee for additional recommendations.<br><br>-By what date the systemic changes for each deficiency will be completed?<br>April 12, 2019 | |
| F 0759<br>SS=D<br>Bldg. 00 | 483.45(f)(1)<br>Free of Medication Error Rts 5 Prcnt or More<br>§483.45(f) Medication Errors.<br>The facility must ensure that its-<br><br>§483.45(f)(1) Medication error rates are not 5 percent or greater;<br>Based on observation, record review, and interview, the facility failed to ensure a medication error rate of less than 5% based on medication errors observed during 2 of 29 opportunities for errors during random medication administration observations, resulting in a medication error rate of 6.9% (Resident 5).<br><br>Findings include:<br><br>During a random medication administration observation, on 3/12/19 at 11:25 a.m., Registered Nurse (RN) 9 administered Humalog (a rapid acting insulin) KwikPen (pre-filled insulin pen) 100 units (u)/milliliter (ml) 4 units subcutaneously (SQ), and insulin glargine solution (a long acting insulin) KwikPen 100 units/ml 22 units SQ to Resident 5. The KwikPens were not observed to be primed prior to use.<br><br>Resident 5's record was reviewed on 3/12/19 at | F 0759 | F759<br>Free of Medication Error Rates 5 Percent or More<br>It is the standard of this facility to ensure that its medication error rates are not 5 percent or greater.<br><br>-What corrective action be accomplished for those residents found to have been affected by the deficient practice?<br>R # 5 was monitored for signs and symptoms of irritation at the KwikPen injection sites with no irritation noted. RN #9 was provided 1:1 education regarding priming KwikPens prior to administering subcutaneous injections. Resident #5 is receiving KwikPen injections according to manufacturer's | 03/13/2019 |

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| | 11:45 a.m. Diagnoses from the resident's profile included, but were not limited to, diabetes mellitus (DM) (disease that results in too much sugar in the blood, high blood glucose).<br><br>A physician's order, dated 1/31/18, indicated Humalog solution 100 unit/ml, inject per sliding scale (SQ) two times a day for DM.<br><br>A physician's order, dated 2/2/18, indicated insulin glargine solution 100 unit/ml, inject 22 units (SQ) one time a day for DM.<br><br>During an interview, on 3/12/19 at 1:41 p.m., the Director of Nursing (DON) indicated that the Humalog KwikPen and insulin glargine KwikPen should have been primed prior to use.<br><br>On 3/12/19 at 12:11 p.m., the DON provided a document titled, "Humalog KwikPen," and indicated it was the instructions for use that were currently being used by the facility. The insert indicated, "Instructions for use: ...Priming your pen. Prime before each injection. Priming your pen means removing the air from the needle and cartridge that may collect during normal use and ensures that the pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin. Step 6: To prime your pen, turn the dose knob to select 2 units. Step 7: Hold your pen with the needle pointing up. Tap the cartridge holder gently to collect air bubbles at the top. Step 8: Continue holding your pen with needle pointing up. Push the dose knob in unit it stops, and "0" is seen in the dose window. Hold the dose knob in and count to 5 slowly. You should see insulin at the tip of the needle. If you do not see insulin, repeat priming steps 6 to 8, no more than 4 times. If you still do not see insulin, change the needle and repeat | | instructions.<br><br>-How will the facility identify residents having the potential to be affected by the same deficient practice?<br>All residents receiving KwikPen injections have the possibility of being affected by this alleged deficient practice.<br><br>-What measure will be put into place and what systemic changes will be made to ensure that the deficient practice will not recur?<br>An in-service was provided on 3/12/19 that included education for all nursing staff regarding following the KwikPen manufacturer's instructions that it must be primed prior to administering injections.<br><br>-How will the corrective actions be monitored to ensure the alleged deficient practice will not recur?<br>The Director of Nursing will randomly observe KwikPen injection administration bi-weekly for 4 weeks, weekly for 4 weeks, monthly for 2 months and monthly thereafter until 100% compliance is achieved. The Director of Nursing will report findings to Quality Assurance (QAPI) monthly.<br><br>-By what date the systemic changes for each deficiency will be completed?<br>March 13, 2019 | |

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| | priming steps 6 to 8...."<br><br>On 3/12/19 at 12:11 p.m., the DON provided a document titled, "Insulin Glargine," and indicated it was the instructions for use that were currently being used by the facility. The insert indicated, "Instructions for use: ...Priming your pen. Prime before each injection. Priming your pen means removing the air from the needle and cartridge that may collect during normal use and ensures that the pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin. Step 6: To prime your pen, turn the dose knob to select 2 units. Step 7: Hold your pen with the needle pointing up. Tap the cartridge holder gently to collect air bubbles at the top. Step 8: Continue holding your pen with needle pointing up. Push the dose knob in unit it stops, and "0" is seen in the dose window. Hold the dose knob in and count to 5 slowly. You should see insulin at the tip of the needle. If you do not see insulin, repeat priming steps 6 to 8, no more than 4 times. If you still do not see insulin, change the needle and repeat priming steps 6 to 8...."<br><br>3.1-25(b)(9) | | Rockville Nursing & Rehab would like to request a desk review for compliance with this deficiency as we feel with the new training and process adopted we will obtain and maintain continued compliance. | |
| F 0812<br>SS=F<br>Bldg. 00 | 483.60(i)(1)(2)<br>Food<br>Procurement,Store/Prepare/Serve-Sanitary<br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. | | | |

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| | (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.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br><br>Based on observation and interview, the facility failed to ensure staff personal items were not stored in the refrigerator and food temperatures were not completed prior to food service. This had the potential to affect 25 of 25 residents who received food from the kitchen.<br><br>Findings include:<br><br>On 3/8/19 at 9:58 a.m., during an initial kitchen observation, a stryofoam cup (with gas station name on the side), and an open cloth lunch bag with grapes, cheese, a bottle of juice, and a bottle of over-the-counter anti-diarrheal medication with the medicine cup exposed from the bag. The Dietary Manager (DM) indicated, the lunch bag belonged to her and was in the kitchen refrigerator, because the facility did not have a staff break room.<br><br>On 3/12/19 at 12:05 p.m., Cook 5 was observed, without checking the food temperatures, plating the Residents' food for lunch.<br><br>On 3/12/19 at 1:17 p.m., Cook 5 indicated she should have taken food temperatures before plating the food. | F 0812 | F812<br><br>Food Procurement, Store/ Prepare/ Serve-Sanitary<br><br>It is the standard of this facility to store, prepare, distribute, and serve food in accordance with professional standards for food service safety.<br><br>It should be noted that The Indiana Retail Food Establishment Sanitation Requirements provided to the surveyor on 3/13/19 does not state that employees may not keep their lunches in the kitchen refrigerator. The requirements list proper food storage and handling instructions. The employee lunch bag was insulated plastic, and an insulated cup. These items were not in contact with other food in the refrigerator.<br><br>-What corrective action will be accomplished for those residents found to have been affected by the | 04/12/2019 |

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| | On 3/13/19 at 1:27 p.m., the DM indicated the facility did not have a policy, but followed the Indiana Retail Food Establishment Sanitation Requirements. Staff were not to have personal items in the kitchen and food temperatures should have been checked prior to plating the Resients' food.<br><br>3.1-21(i)(3) | | deficient practice?<br>1. Immediately upon the surveyor's report of concern, the employee lunch was removed from the kitchen refrigerator.<br>2. Immediately upon the surveyor's report of concern, cook 5 received 1:1 education about checking food temperatures prior to plating resident's food.<br><br>-How will the facility identify residents having the potential to be affected by the same deficient practice?<br>All residents served meals from the kitchen had the potential but were not affected by this alleged deficient practice as there were no reports of residents with GI issues in the week following survey observations 3/8/19 – 3/13/19, nor resident complaints about food temperature.<br><br>-What measure will be put into place and what systemic changes will be made to ensure that the deficient practice will not recur?<br>All dietary staff will be in serviced on storage, distribution and serving food under sanitary conditions on 4/8/2019.<br><br>-How will the corrective actions be monitored to ensure the alleged deficient practice will not recur?<br>1. The administrator or designee will check the kitchen refrigerator to ensure food is stored | |

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| | | | appropriately.<br>2. The Dietary Manager or designee will monitor to ensure food temps are completed prior to resident's food being plated during varied meals.<br><br>The above will be completed daily for 2 weeks, 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.<br><br>-By what date the systemic changes for each deficiency will be completed?<br>April 12, 2019<br>Rockville Nursing & Rehab would like to request a desk review for compliance with this deficiency as we feel with the new training and process adopted, we will obtain and maintain continued compliance. | |
| F 0880<br>SS=D<br>Bldg. 00 | 483.80(a)(1)(2)(4)(e)(f)<br>Infection Prevention & Control<br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control | | | |

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| | program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin | | | |

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| | lesions from direct contact with residents or their food, if direct contact will transmit the disease; and<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary. | | | |
| | Based on observation, record review, and interview, the facility failed to ensure a resident's personal glucometer (blood glucose monitoring device) was used during an accu-check (blood glucose reading) and the glucometer used was disinfected before use for 1 of 1 residents observed for an accu check reading during a medication administration observation (Resident 5).<br><br>Findings include:<br><br>During an accu check observation, on 3/12/19 at 11:21 a.m., Registered Nurse (RN) 9 was observed to obtain an accu check reading for Resident 5. The glucometer used was not observed to be disinfected prior to use. The glucometer had Resident 17's name printed on the back of the device and was placed back into the medication | F 0880 | F880<br>Infection Control<br><br>It is the standard of this facility to 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 communicable disease and infection.<br><br>-What corrective action be accomplished for those residents found to have been affected by the deficient practice?<br>Immediately upon surveyor's concern, Resident 17's glucometer was disinfected, and | 04/12/2019 |

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| | cart next to Resident 5's glucometer device after used and was not disinfected. At the same time, RN 9 indicated each resident had their own personal glucometer and he had accidentally used the wrong glucometer for Resident 5's accu check reading. The glucometers were not disinfected before or after use unless soiled because each resident had their own. The glucometer should have been cleaned before and after use since the wrong device had been used.<br><br>Resident 5's record was reviewed on 3/12/19 at 11:45 a.m. Diagnoses from the resident's profile included, but were not limited to, diabetes mellitus (disease that results in too much sugar in the blood, high blood glucose).<br><br>A physician's order, dated 2/1/18, indicated accu-check twice daily for DM.<br><br>A Medication Administration Record, dated 3/12/19, indicated the resident's noon accu check had been obtained.<br><br>A care plan, initiated on 1/17/18 and revised on 2/11/9, indicated the resident had DM. Interventions included, but were not limited to, fasting serum blood sugar as ordered by doctor.<br><br>During an interview, on 3/12/19 at 11:40 a.m., the Regional Director of Clinical Operations indicated each resident had a personal glucometer device and should only be used for the resident indicated.<br><br>On 3/12/19 at 1:40 p.m., the Director of Nursing (DON) provided a document titled, "Glucometer Disinfection," and indicated it was the policy currently being used by the facility. The policy indicated, "Purpose: The purpose of this | | each resident's glucometer was placed in individual bags. Resident 5's accu check site was monitored with no signs of infection noted. RN 9 was provided 1:1 education regarding using each resident's individual glucometers.<br><br>-How will the facility identify residents having the potential to be affected by the same deficient practice?<br>One resident was affected by this alleged deficient practice. All Residents receiving accu checks were identified and considered to be at risk.<br><br>-What measure will be put into place and what systemic changes will be made to ensure that the deficient practice will not recur?<br>An in-service was provided on 3/15/19 that included education for all nursing staff regarding the following of facility policies and procedures regarding using resident's individual glucometer for accu checks.<br><br>-How will the corrective actions be monitored to ensure the alleged deficient practice will not recur?<br>The Director of Nursing will randomly observe accu checks bi-weekly for 4 weeks, weekly for 4 weeks, monthly for 2 months and monthly thereafter until 100% compliance is achieved. The | |

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| ROCKVILLE NURSING AND REHABILITATION CENTER | 768 N US HWY 41<br>ROCKVILLE, IN 47872 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (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 |
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| | procedure is to provide guidelines for the disinfection of capillary-blood sampling devices (Glucometers) to prevent transmission of blood borne diseases to residents and employees...Procedure: 1. Obtain and gather equipment and supplies: Disinfectant wipe, Glucometer, Gloves as indicated...Recommended disinfectant wipe: Gluco chlor 10. Cleanse the glucometer with the disinfectant wipe...Guidelines: The CDC has developed specific infection control recommendations pertaining to diabetes care in health care and group residence settings. Those recommendations include, but are not limited to: ...assign separate glucometers to individual residents. If glucometers are shared, the device must be cleaned and disinfected between each patient use...."<br><br>3.1-18(a)<br>3.1-18(b)(5) | | Director of Nursing will report findings to Quality Assurance (QAPI) monthly.<br>for 4 weeks, monthly for 2 months and monthly thereafter until 100% compliance is achieved. The Director of Nursing will report findings to Quality Assurance (QAPI) monthly.<br><br>-By what date the systemic changes for each deficiency will be completed?<br>April 12, 2019 | |
| F 0908<br>SS=F<br>Bldg. 00 | 483.90(d)(2)<br>Essential Equipment, Safe Operating Condition<br>§483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition.<br><br>Based on observation and interviews, the facility failed to ensure the kitchen equipment functioned properly for 2 of 2 kitchen observations. This had the potential to affect 25 of 25 residents who received food from the kitchen.<br><br>Findings include:<br><br>On 3/8/19 at 9:55 a.m., during an initial kitchen tour, the following was observed:<br><br>- Standing areas of water were observed on the | F 0908 | F908<br>Essential Equipment, Safe Operating Condition<br><br>It is the policy of this facility to ensure that all mechanical, electrical, and patient care equipment is maintained in safe operating condition.<br><br>The facility notes these discrepancies on the 2567. The surveyor was told by the dietary | 03/13/2019 |

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| | 155464 | A. BUILDING 00<br>B. WING | 03/13/2019 |

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| | kitchen floor and the kitchen floor drain was observed covered in standing water.<br><br>- All three compartments of the three compartment sink were observed to be partially full of water with brown/tan debris floating on top of the water.<br><br>During an interview, on 3/8/19 at 9:58 a.m., the Dietary Manager (DM) indicated the dishwasher had not functioned, since the motor caught fire on 3/1/19. The three compartment sink was stopped up and the kitchen floor drain was clogged. The maintenance man was working with a plumbing company to fix the drains in the kitchen. The plumbing company had been here on 2/28/19 to work on the drains, but the kitchen drains were clogged again.<br><br>During an interview, on 3/8/19 at 10:36 a.m., the Maintenance Director indicated the floor drains and the three compartment sink in the kitchen were clogged. He had contacted a plumbing company for the drainage issues in the kitchen and the plumbing company was supposed to come that day. The facility has had issues from the water not draining in the kitchen for about of month. The kitchen floor drain did not have a grease trap. The water and debris had went down the drain, clogged up the drain, and then backed up the water into the kitchen. He had ordered parts for the dishwasher on 3/2/19 and the parts were scheduled arrive any day.<br><br>During an interview, on 3/8/19 at 11:21 a.m., the Administrator (ADM) indicated the dishwasher motor had caught fire on 3/1/19. A dishwasher repairman had been to the facility on 3/01/19 and ordered a new motor that should arrive any day. A plumbing company had been here on 2/28/19 to auger the clogged kitchen drains. The | | manager, maintenance director, and administrator that a fire had occurred on 3/1/19, and a mechanical vendor came to the facility immediately and removed the motor that caught fire, and the surveyor was provided proof of that visit, and that the part was ordered on 3/2/19 due to it being late on 3/1/19. The 2567 incorrectly states that a dishwasher repair man had been to the facility on 3/2/19.The surveyor was also told by the dietary manager, maintenance director, administrator, and contracted plumber that the kitchen floor drain was cemented closed. The 2567 states incorrectly that the floor drain was clogged.<br><br>This facility wishes an Informal Dispute Resolution for this tag based on the surveyor's own findings. During observations on 3/8/19 & 3/12/19 the kitchen dish machine was not operating and dietary staff were washing dishes using the 3-bay sanitation process. Due to the extra grease and debris in the sink's drain, it backed up. When that occurred, dietary staff used bins to continue to wash and sanitize dishes. There were no observations by the surveyor of unsanitary practice during this process. Facility administrator specifically asked the surveyor if she had observed poor sanitation during the process | |

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| | maintenance director had worked on the kitchen drains last night and had contacted the plumbing company to auger the kitchen drains again.<br><br>On 3/12/19 at 10:55 a.m., during a second kitchen observation, the following was observed:<br><br>- Standing areas of water were observed on the kitchen floor and the floor drain was observed covered in standing water.<br><br>- Wet blankets were on the floor by the dishwasher floor drain.<br><br>-All three compartments of the three compartment sink were observed to be partially full of water with brown/tan debris floating on top of the water.<br><br>On 3/12/19 at 11:11 a.m., Cook 5 was observed to wash her hands at the kitchen hand washing sink. At the same time, she indicated the water from the handwashing sink was backing up into the three compartment sink, the dishwasher drain, and the kitchen floor drain.<br><br>The ADM, on 3/12/19 at 12:32 a.m., indicated the kitchen floor drain, the dishwasher floor drain, and the three compartment sink were still not draining properly. A plumbing company had been to the facility to auger the blocked kitchen drains.<br><br>3.1-19 (bb) | | and the surveyor stated she did not.<br><br>The surveyor was provided with service reports for repairs to the dish machine. The facility maintenance director attempted to resolve the drain issue, and contacted the facility's plumber when he could not correct it. The surveyor was provided with all recent plumber invoices showing service on the kitchen drain. The surveyor was provided with preventive maintenance on the dish machine, as well as monthly inspections of kitchen equipment by Eco Lab, the facility's contracted provider. The surveyor was provided with a statement from the DON that no outbreak of GI infection had occurred this year.<br><br>Proof of preventative maintenance, and appropriate response to equipment malfunction meets the guidelines for F908.<br><br>-What corrective action will be accomplished for those residents found to have been affected by the deficient practice?<br>Both the dish machine and kitchen drain has been repaired.<br><br>-How will the facility identify residents having the potential to be affected by the same deficient practice? | |

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| | | | All residents served meals from the kitchen had the potential but were not affected by this alleged deficient practice as there were no reports of residents with GI issues in the week following survey observations 3/8/19 – 3/13/19.<br><br>-What measure will be put into place and what systemic changes will be made to ensure that the deficient practice will not recur? Preventative maintenance will continue to be performed on dish machine. Monthly kitchen equipment inspections will continue to be performed by Eco Lab.<br><br>-How will the corrective actions be monitored to ensure the alleged deficient practice will not recur? Monthly preventive maintenance and kitchen equipment inspection reports will be reviewed monthly by administrator or designee. Administrator will bring the reports to The Quality Assurance (QAPI) committee monthly for 3 months, and quarterly thereafter as the QAPI team deems necessary.<br><br>-By what date the systemic changes for each deficiency will be completed?<br>March 12, 2019 | |
| F 0921<br>SS=C<br>Bldg. 00 | 483.90(i)<br>Safe/Functional/Sanitary/Comfortable Environ<br>§483.90(i) Other Environmental Conditions | | | |

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| | The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.<br><br>Based on observation and interview, the facility failed to ensure sanitary conditions for staff were in place during 2 of 2 kitchen observations.This had the potential to affect 25 of 25 residents who received food from the kitchen.<br><br>Findings include:<br><br>On 3/8/19 at 9:55 a.m., the following was observed in the kitchen:<br><br>-Areas of standing water were observed, in the kitchen prep area, by the dish machine, and the floor drain.<br><br>- Dietary staff were observed, during lunch meal prep, standing in pooled water. At the same time, the Dietary Manager (DM) indicated the floor was slippery.<br><br>- All three compartments of the three compartment sink were observed to be partially full of water with brown/tan debris floating on top of the water.<br><br>During an interview, on 3/8/19 at 9:58 a.m., the DM indicated they had been using tubs for washing pots and pans due to the three compartment sink not draining properly and the dishwasher was broken.<br><br>On 3/12/19 at 10:55 a.m., during a second kitchen observation, the following was observed:<br><br>-Cook 5 was observed, during lunch meal prep, standing in pooled water and stepping over wet blankets, clear liquid was observed to bubble up | F 0921 | F921<br>Safe/ Functional/ Sanitary/ Comfortable Environment<br><br>It is the policy of this facility to ensure that it provides a safe, functional, sanitary, and comfortable environment for residents, staff, and the public.<br><br>The facility notes this discrepancy on the 2567. The surveyor was told by the dietary manager, maintenance director, administrator, and contracted plumber that the kitchen floor drain was cemented closed. The 2567 states that the floor drain was not draining properly.<br><br>This facility wishes an Informal Dispute Resolution for this tag based on the surveyor's own findings. During observations on 3/8/19 & 3/12/19 the kitchen dish machine was not operating and dietary staff were washing dishes using the 3-bay sanitation process. Due to the extra grease and debris in the sink's drain, it backed up. When that occurred, dietary staff used bins to continue to wash and sanitize dishes. There were no observations by the surveyor of unsanitary practice during this process. Facility administrator specifically asked | 03/13/2019 |

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| | from the blanket, when stepped on.<br><br>On 3/12/19 at 11:11 a.m., Cook 5 was observed to wash her hands at the kitchen hand washing sink. At the same time, she indicated the maintenance director had used blankets to ensure the pooled water was contained.<br><br>The ADM, on 3/12/19 at 12:32 a.m., indicated the dishwasher should be repaired today and the kitchen floor drain, the dishwasher floor drain, and the three compartment sink were still not draining properly. A plumbing company had been to the facility to auger the blocked kitchen drains on multiple occasions and they had been contacted to come to the facility again.<br><br>3.1-19(a)(4)<br>3.1-19(f) | | the surveyor if she had observed poor sanitation during the process and the surveyor stated she did not.<br><br>The dietary staff wear and are required to wear non slip shoes as the floor in the kitchen becomes wet at times. The surveyor was provided with service reports for repairs to the dish machine. The facility maintenance director attempted to resolve the drain issue, and contacted the facility's plumber when he could not correct it. The surveyor was provided with all recent plumber invoices showing service on the kitchen drain. The surveyor was provided with preventive maintenance on the dish machine, as well as monthly inspections of kitchen equipment by Eco Lab, the facility's contracted provider. The surveyor was provided with a statement from the DON that no outbreak of GI infection had occurred this year.<br><br>Proof of preventative maintenance, and appropriate response to equipment malfunction meets the guidelines for F921.<br><br>-What corrective action be accomplished for those residents found to have been affected by the deficient practice?<br>Both the dish machine and kitchen drain has been repaired. | |

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| | | | -How will the facility identify residents having the potential to be affected by the same deficient practice?<br>All residents served meals from the kitchen had the potential but were not affected by this alleged deficient practice as there were no reports of residents with GI issues in the week following survey observations 3/8/19 – 3/13/19.<br><br>-What measure will be put into place and what systemic changes will be made to ensure that the deficient practice will not recur?<br>Preventative maintenance will continue to be performed on dish machine. Monthly kitchen equipment inspections will continue to be performed by Eco Lab.<br><br>-How will the corrective actions be monitored to ensure the alleged deficient practice will not recur?<br>Monthly preventive maintenance and kitchen equipment inspection reports will be reviewed monthly by administrator or designee. Administrator will bring the reports to The Quality Assurance (QAPI) committee monthly for 3 months, and quarterly thereafter as the QAPI team deems necessary.<br><br>-By what date the systemic changes for each deficiency will be completed? | |

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