STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155464	A. BUILDING 00 B. WING	04/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROCKVILLE NURSING AND REHABILITATION CENTER	768 N US HWY 41 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
F 0000 Bldg. 00	This visit was for Investigation of Complaint IN00291647. This visit was in conjunction with a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey and to the PSR to Investigation of Complaint IN00288489 completed on March 13, 2019. Complaint IN00291647 - Substantiated. Federal/State deficiency related to the allegations are cited at F622. Complaint IN00288489 - Corrected. Unrelated deficiency cited at F690. Survey Dates: April 16, and 17, 2019. Facility number: 000492 Provider number: 155464 AIM number: 100291360 Census Bed Type: SNF/NF: 19 Total: 19 Census Payor Type: Medicare: 3 Medicaid: 10 Other: 6 Total: 19 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.	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.	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Quality review completed on April 26, 2019.			
F 0622 SS=D Bldg. 00	483.15(c)(1)(i)(ii)(2)(i)-(iii) Transfer and Discharge Requirements §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility			

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	pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information			

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	(C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. Based on record review and interview, the facility failed to ensure an assessment was completed before a resident was transferred to the emergency room (ER), and a report (resident information communicated verbally from the facility to the receiving ER staff) was called to the ER for 1 of 3 residents reviewed for hospitalizations (Resident C). Findings include: Resident C's record was reviewed on 4/16/19 at 1:38 p.m. A quarterly Minimum Data Set (MDS) assessment, dated 1/24/19, indicated the resident was cognitively intact. Diagnoses on the resident's profile included, but were not limited to neurogenic bowel (inability to control bowels related to a nervous system problem). A physician's order, dated 2/8/19 and discontinued on 3/20/19, indicated Linzess (a medication used to treat irritable bowel syndrome) 145 micrograms (mcg) by mouth once daily for diarrhea. A physician's order, dated 3/21/19 and discontinued on 4/2/19, indicated Linzess 290 mcg by mouth once daily for constipation.	F 0622	It is the standard of this facility to permit each resident to remain in the facility and not transfer or discharge the resident from the facility unless the transfer or discharge is necessary for the resident's welfare… -What corrective action be accomplished for those residents found to have been affected by the deficient practice? Resident C's order for Linzess has been discontinued, and resident is no longer having issues with constipation. -How will the facility identify residents having the potential to be affected by the same deficient practice? The DON reviewed all ER transfers on current residents for the past 90 days to ensure 1) appropriate assessment was completed prior to the transfer & 2) a report was communicated and documented to the ER. No other concerns were found.	05/17/2019

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	A nurse's note, dated 3/24/19, indicated the resident's abdomen was distended and hard. Bowel sounds (noises made by the bowels indicate normal bowel function) were present in four quadrants. A nurse's note, dated 3/28/19, indicated an enema was administered as the resident requested. A nurse's note, dated 3/31/19 at 12:00 p.m., indicated the resident's stomach was hurting and swelling even after an enema that morning. The physician ordered to send the resident to the ER. The note lacked documentation of vital signs, a bowel assessment including bowel sounds, and report being called to the ER. A nurse's note, dated 3/31/19 at 5:30 p.m., indicated the resident returned from the hospital. A computed tomography (CT) scan of the abdomen was completed. A soap suds enema was administered at the hospital and the resident was to receive magnesium citrate (a laxative) upon return to the facility. Hospital Emergency Department discharge instructions, dated 3/31/19, indicated the resident was treated for constipation. The resident's hospital medication list did not include Linzess. A CT scan of the abdomen, dated 3/31/19, indicated no acute findings. A nurse's note, dated 4/1/19 at 3:00 p.m., indicated the resident was sent to the ER to be admitted for an upper and lower gastro intestinal (GI) evaluation. The resident's physician was to call the ER with further orders. The resident was not able to eat much or drink. Abdominal distention		-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 were inserviced on 5/2/2019 by the DON regarding documentation of resident's physical condition/ complaint, & completing a SBAR (Situation, Background, Assessment, Request) prior to giving report to the ER and sending that assessment with the resident to the hospital. -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 1) appropriate assessment was completed prior to the transfer & 2) a report was communicated and documented to the ER. 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. -By what date the systemic changes for each deficiency will be completed? May 17, 2019 Rockville Nursing & Rehab would	

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	(swelling) was noted. The note lacked documentation of vital signs, a bowel assessment including bowel sounds, and a report being called to the ER. A nurse's note, dated 4/1/19 at 7:45 p.m., indicated the resident returned to the facility. The ER had not received a call from the resident's physician to admit the resident to the hospital. The resident was given a soap suds enema and had a large bowel movement in the ER. The CT scan noted no acute issues. Hospital Emergency Department discharge instructions, dated 4/1/19, indicated the resident was treated for constipation. The resident's medication list did not include Linzess. A note written on the first page, by facility staff, for the resident's facility physician indicated the resident's Linzess was not listed on the hospital medication list. The hospital was not aware he was taking Linzess. Abdominal pain, swelling, and abdominal distention had been noted. A nurse's note, dated 4/2/19, indicated the physician visited the resident and discontinued the Linzess. A nurse's note, dated 4/3/19, indicated the resident's stomach felt better. During an interview, on 4/17/19 at 10:15 a.m., Licensed Practical Nurse (LPN) 6 indicated when a resident was sent to the hospital a medication list should have been sent with the resident. A report should have been called to the ER with each transfer, and documented in the nurse's notes. She had sent the resident to the hospital on 4/1/19 because the physician had requested the resident be directly admitted. She was not sure why the		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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	resident had not been admitted to the hospital. If she had called a report to the ER, she would have documented it in the nurse's notes. Transfer forms were not used for communication with the hospital. During an interview, on 4/17/19 at 10:24 a.m., the Administrator indicated the hospital reported to the facility the medical director (resident's physician) had not called the hospital back to admit the resident on 4/1/19. The resident returned to the facility. During an interview, on 4/17/19 at 10:30 a.m., the Director of Nursing (DON) indicated when a resident was transferred to the hospital a report should have been called to the hospital. This should have been documented in the nurse's notes. During an interview, on 4/17/19 at 1:14 p.m., the DON indicated there were no vital signs recorded at the time of the transfers on 3/31/19 and 4/1/19. She also checked 24 hour report sheets, and was unable to find vital signs recorded there for the resident. Bowel sounds should have been assessed and documented at the time of the transfers on 3/31/19 and 4/1/19. A lot of the resident's symptoms seemed to be related to the Linzess, and he had felt better since it was discontinued. On 4/17/19 at 1:53 p.m., the DON provided a document titled, "Making an Emergency Transfer or Discharge," and indicated it was the policy currently being used by the facility. The policy indicated, 'Policy Statement: Our facility shall make an emergency transfer or discharge when it is in the best interest of the resident. Policy Interpretation and Implementation: 1. Should it			

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	become necessary to make an emergency transfer or discharge to a hospital or other related institution, our facility will implement the following procedures: ...b. Notify the receiving facility that the transfer is being made...d. Prepare a transfer form to send with the resident...." This Federal tag relates to Complaint IN00291647. 3.1-12(a)(3)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.			

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	§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on record review and interview, the facility failed to ensure an antibiotic was initiated as ordered by a nurse practitioner (NP) for a resident with a urinary tract infection (UTI) for 1 of 3 residents reviewed for hospitalizations (Resident C). Findings include: Resident C's record was reviewed on 4/16/19 at 1:38 p.m. A quarterly Minimum Data Set (MDS) assessment, dated 1/24/19, indicated the resident was cognitively intact. Diagnoses on the resident's profile included, but were not limited to, neuromuscular dysfunction of the bladder (a bladder problem related to a problem with the nervous system). A nurse's note, dated 3/15/19 at 1:00 p.m., indicated the physician was notified the resident's urine had a strong odor. The physician ordered a urinalysis (UA) (lab test of the urine to check for infection). A nurse's note, dated 3/19/19 at 11:00 a.m., indicated the results from the resident's UA were faxed to the physician. A urine culture report, dated 3/19/19, indicated proteus mirabilis (a bacteria) was detected in the resident's urine. An order, written by the NP,	F 0690	It is the standard of this facility to ensure that a resident who is continent of bladder on admission receives services and assistance to maintain continence unless his clinical condition I or becomes such that continence is not possible to maintain… -What corrective action be accomplished for those residents found to have been affected by the deficient practice? Resident C's order for Bactrim was started on 3/29/19. -How will the facility identify residents having the potential to be affected by the same deficient practice? The DON reviewed all current resident's charts for unprocessed orders. a report was communicated and documented to the ER. No other concerns were found. -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 were in serviced	05/17/2019

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	dated 3/19/19, indicated Bactrim DS (an antibiotic) twice daily for ten days, was observed handwritten by the NP on the culture report. The report had been faxed to the facility on 3/19/19. A Medication Administration Record (MAR), for March 2019, indicated a physician's order, dated 3/29/19, Bactrim DS , one tablet by mouth twice daily for UTI for ten days. The first dose of the antibiotic was administered on 3/29/19. A nurse's note, dated 3/29/19, indicated an order was clarified and the resident was started on Bactrim related to the UA results. A medication error report, dated 3/29/19, indicated a faxed order was received for Bactrim DS, one tablet by mouth twice daily for ten days on 3/19/19, but the order was not processed. The faxed order was filed in the resident's chart and resulted in a delay in treatment for the resident. The antibiotic order was processed when the error was discovered. During an interview, on 4/17/19 at 11:00 a.m., the Director of Nursing (DON) indicated a UA was done on 3/15/19, and a faxed order for an antibiotic was received on 3/19/19. The antibiotic was not started, as it was ordered, on 3/19/19. The issue was found during an audit on 3/29/19, and the physician was notified. The antibiotic was then started. The faxed order should have been processed on the day it was received, but it had been missed. On 4/17/19 at 1:53 p.m., the 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		on 5/3/2019 by the DON regarding faxed orders received. The nurse receiving the order is responsible for processing the order, receipt of the fax must be noted in the 24 hr report, a nurse note must be made indicating the new order, and then the fax will be placed in the DON mailbox. DON will review to ensure the order is processed correctly. -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 for faxed orders to ensure they are processed correctly. DON or designee will be responsible for auditing the above daily while on duty for 4 weeks, bi weekly for the next 4 weeks, and weekly thereafter until 100% compliance is achieved. Results will be shared monthly with the facility QAPI committee for additional recommendations. -By what date the systemic changes for each deficiency will be completed? May 17, 2019 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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	shall promptly notify the resident, his or her 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: ...d. A significant change in the residents physical...condition...5. The nurse supervisor/charge nurse will record in the resident's medical record information relative to changes in the resident's medical...condition or status.... 3.1-41(a)(2)			