Have FOIA Data Base - The Law Office of Jeffrey J. Downey, serving clients in Washington D.C., Virginia and Maryland

If you have been injured in a nursing home or assisted living facility, call the Law Office of Jeffrey J. Downey for a free consultation.

Phone: 703-564-7318; email: jdowney@jeffdowney.com

The Village at Rockville (formerly National Lutheran Home)
9701 Veirs Drive
Rockville, MD 20850

Characteristics:

- Non-Profit – Church-related facility with 160 beds
- Legal Business Name – The Village at Rockville
- Director – Kyle Hreben
- Managing Employee – Donna Casner
- www.thevillageatrockville.org

Researching Nursing Homes

A note by attorney Jeffrey J. Downey:

Thank you for visiting my website. Anyone who is considering the admission of a loved one into a nursing home should undertake a review of surveys or other data that will provide a snapshot of some of the issues or problems that the facility is experiencing. Keep in mind that this information can be limited and may not reflect the actual condition of the facility when your loved one is admitted. You should consider personal visits of any facility you are evaluating.

The Maryland Department of Health inspects nursing homes including the Village at Rockville in Rockville, MD. Periodically they do inspections as complaint surveys which should be public record.

I am interested in any additional information you may have on this facility. Please call me with any question about this or any other facility you may be interested in searching or prosecuting civilly for patient neglect or abuse.

If you have a concern or complaint about a nursing facility, there are three ways to file your complaint:

1) Write to the Maryland Department of Health, Office of Health Care Quality, 7120 Samuel Morse Drive, Second Floor, Columbia, MD 21046-3422.
(linkhttps://health.maryland.gov/ohcq/docs/complaint_form.pdf)

2) Fax : 410-402-8179

3) Online - https://fs30.formsite.com/OHCQ/OnlineComplaintForm/index.html

Having already researched the Village at Rockville in Rockville, MD and obtained FOIA responses, I am posting these statements of deficiencies here, in a searchable format. Keep in mind that these surveys have been altered during the conversion process and you should update your search results.

Disclaimer: Information is built using data sources published by Centers for Medicare & Medicaid Services (CMS) under Freedom of Information Act (FOIA). The information disclosed on the NPI Registry are FOIA-disclosable and are required to be disclosed under the FOIA and the FOIA amendments to the FOIA. There is no way to 'opt out' or 'suppress' the NPPES record data for health care providers with active NPls. Some documents may not be accurately copied and some results may have changed upon appeal, which may not be noted here.

Office of Health Care Quali'l'

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	{X3) DATE SURVEY COMPLETED
	2161215	A B UILDING _____ BING	C 12/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE **VILLAGE AT ROCKVILLE**	**9701 VEIRS DRIVE ROCKVILLE, MD 208150**

(X4)1D PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCEOTOTHEAPPROPRIATE DEFICIENCY)	()(a) COMPL.ETI: DATE
S	10.07.09.08 C (5) Right to freedom from abuse .08 Resident's Rights and Services. C. A resident has the right to: (5) Be free from: (a) Physical abuse; (b) Verbal abuse; (c) Sexual abuse; (d) Physical or chemical restraints imposed for purposes of discipline or convenience; (e} Mental abuse; and (f) Involuntary seclusion; This Regulation is not met as evidenced by: See CMS 2567 F600	S6000	Refer to CMS 2567 POC F-600	
56322	110.07.09.15C (1) (b) Abuse;Report to Dept .15 Abuse of Resident.s C. Reports of Abuse. (1) A person who believes that a resident has been abused shall promptly report the alleged abuse to the: (b) Licensing and Certification Administration within the Department; or This Regulation is not met as evidenced by: See CMS 2567 F609	86322	Refer to CMS 2567 POC F-600	

Ofica

TITLE: Healthcare Administrator

(X8) DATE: 2121/2020

ATE FORM

STATEMENT OF DEFICIENCIES AND **F't.AN OF** CORRECTION	(X1) PROVIOER/SUPPIIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	216125	A BUILDING _____ B WINO	C 12/3112019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COOE
THE VILLAGE AT ROCKVILLE!	**9701 VEIRS DRIVE** ROCKVILLE, MD 20850

(X4) IO PREFIX TAO	SUMMARY STATEMENT OF DEFICIENCIES {EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEACIENCY)	(I<&) COMPLETION **DATE**
F000	INITIAL COMMENTS On December 31, 2019, a survey was conducted facflity by the Office of Health Care Quality to investigate one (1) complaint and one (1) facility reported incident (FRI}. Survey activities included review of residents' records, review of administrative records, interviews with staff, residents and resident representatives and random observations of staff practices. A finding of actual harm was cited for the facility's failure to ensure it was free from accidents. The complaint, MD00146977, and the facility reported incident, MD00149160, were substantiated. This survey identified noncompliance with Federal *of* 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities.	F000	This plan of correction is prepared and executed because it is required *by* the provisions of !he State and Federal regulations and not because The vmage at Rockville agrees with the allegations and citations listed on this statement of deficiencies. The ViUage at Rockville maintains that the **alleged** deficiencies do not, individually and collectively, jeopardize the health and safety of the residents, nor are they of such character as to limit our capacity to render adequate care as prescribed *by* regulation. The Plan of Correction shall operate as The Village at Rockville's written credible allegaUon of compliance. By submitting this Plan of CorrecUon, The Village at Rockville does not admit to the accuracy of deficiencies. The Plan of Correction is not meant to estabflsh any standard of care, contract, obligation, or position, and The **Vilage** at Rockville reserves all rights to **raise** all possible contentions and defenses In any civil or crlminal claim action, or proceeding.	
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal. mental, sexua,l or physical **abuse,** corporal punishment, or Involuntary seclusion; This REQUIREMENT Is not met as evidenced	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215126	A. BUILDING _____ B. WING	C 12/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ROCKVILLE	9701 VEIRS DRIVE ROCKVILLE, MD 20850

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 1 by: Based on the review of clinical records, administrative documents. and facility staff interviews, it was determined that the facility's staff neglected to use the proper technique when transferring a resident using a mechanical lift device. This finding was evident in 1 of 3 residents **reviewed** for transfers with **a** mechanical lift during a complaint survey (Resident #3). The findings include: This finding was identified during the investigation of complaint M000146977. On 12-31-2019, a review of Resident #3's clinical record revealed the resident is at risk for falls. According to the resident's care plan the facility's intervention to address this risk included a hayer 11ft with two-person assist for all transfers. A review of Resident #3's annual minimum data set (MDS} assessment, date 05-11-19, Section G0110 revealed the resident required a minimum of two-persons to physical assist for transfers. The minimum data set (MOS) is part of the U.S. federally mandated process for clinical assessment of all residents in Medicare or Medicaid certified nursing homes that evaluates each resident's functional capabilities and helps nursing home staff Identify health problems. Further review of Resident #3's clinical rP.cord revealed a nursing progress note on where the nurse documented a geriatric nursing assistant (GNA) reported that during a transfer to the bed with a mechanical lift device, Resident #3 fell and the resident's head hit the floor (Refer to **F689).**	F6001	tis The Village at Rockv;lle's practice lo transfer residents usmg the proper technique when using a mechanical lift. 1. Referenced incident occurred in this lime Residenl#3	since 12/31/2019
			2. A review of long-term care residents with orders for mechanical ritt transfers was completed 2/17/2020. No eVidence of Improper transfer techniques were identified.	2/17/2020
			3 Geriatric Nursing Assistant's will be re-educated by the Educabon Director by 2/29/2020 on proper mechanical lift transfer requirements. GNA's on lea'l or PRN, will have education completed prior working next shift.	2129/2020 2/2912020
			4. The nurse superv sor or OAPI Manager will perform random observations of 20% of residents with orders for mechanical lift transfers weekly x4, then, monthly x2, then quarte y x3. Observation findings will be presented to the Quality Assurance Performance Improvement Committee for furthei recommendations.	

STATEMENT OF DEFICIENCIES ANO PLAN OF COARECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3} DATE SURVEY COMPLETED
	216125	A. BUILDING _____ B. WING	C 12/31/2919

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS. CITY, STATE, ZIP CODE
THE VILLAGE AT ROCKVILLE	9701 VEIRS DRIVE ROCKVILLE, **MD 20850**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	10 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD 8E CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X! COMPLETION DATE
F 600	I Continued From page 2 On 12-31-19 at 10:00 AM the Administrator was interviewed. The Administrator stated an internal Investigation was completed on Resident #3's fall and a statement from the GNA was obtained. The GNA admitted to using a mechanical lift device to transfer the resident without the assistance from a second staff member. In addition, the Administrator stated there must always be two staff members using a mechanical lift device to transfer residents. On 12-31-19 at 10:30 AM a review of the facUity's mechanical lift machine policy states at least two nursing assistants are needed to safely move a resident with a mechanical lift. On 12-31-19 at 11:00 AM a reviewofGNA's statement revealed the GNA stated she used a mechanical lift device without a second staff member present to transfer Resident #3 to the bed and during the transfer the resident fell hitting their head on the floor. On 12-31·19 at 1:00 PM surveyor interview with the Director of Nursing stated that during the annual competency training the staff complete return demonstration for the use of mechanlcal lifting machines with the *unit* managers. No additlonalinformation was provided.	F800		
F 609 SS=D	Reporting of Alleged Violations CFR(s): **483.12(c)(1)(4)** §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the faci ty must: §483.12(c)(1) Ensure that all alleged violations	F609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2151215	A. BUILDING _____ B. WING _____	C 12/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ROCKVILLE	9701 VEIRS DRIVE ROCKVILLE, MD 20850

(X-1) PROVIDER PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 3 involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported Immediately, but not later than 2 hours after the allegation Is made, if the events that cause the allegation Involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through **established** procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken This REQUIREMENT Is not met as evidenced by: Based on the review of the clinical records, the facility's policy, and facility staff interview, it was determined that the facility failed to investigate an incident of possible neglect to the Office of Health **Care** Quality (OHCQ). This finding was evident for 1 of 3 residents selected for review during a complaint survey (Resident #3}. The findings Include: This finding was identified during the investigation of complaint MD00146977.	F 609	It is The ViUage al Rockvine's practice to report alleged violations of abuse, neglect, exploitation or mistreatment. 1. The Village at Rockvile completed a thorough investigation at the time of the incident and took appropriate action based on common understanding of self-report requriements. 2. A 100% audit of resident falls resulting m serious bodily injury between 1/1/2020-2/17/2020 was conducted. Results of audit were compliant with transfer orders and care plan interventions. 3. Nursing supervisors, ADON. and DON were re-educated by the LNHA on F-609 to ensure the reporting of alleged violations of abuse, neglect, exploitation or mistreatment on 2/13/2020. 4. An audit of 50% of incidents resulting in injury will be conducted by the QAPI Manager or Clinical supervisor weekly x4 then monthly x2, then quarterly x3 to ensure compllance with reporting requirements. The result of the audit will be presented to the Quality Assurance Perfonnance Improvement Committee for further recommendations.	12131/2019 2/17/2020 2/13/2020 2/22(2020

STATEMENT OF DEFICIENCIES ANO PL.AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	216125	A. BUILDING _____ 8.WINI3	C 12/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE **VILLAGE AT ROCKVILLE**	**9701 VBRS DRIVE ROCKVILLE, MD 20850**

(X4)1D PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE
F 609	Continued From page 4 On 12-31-2019, the review of Resident #3's clinical record revealed a comprehensive care plan for at risk for falls with an intervention of a hayer lift with a two-person assist for all transfers. A review of Resident's #3's annual minimum data set (MDS) assessment, dated 05-11-19, revealed that Section G0110 Indicates the resident's requires transfers a minimum of two-persons physical assist the resident. On 12-31-2019, further review of Resident #3's clinical record revealed a nursing progress note, dated 06 2-2019, where the nurse documented a geriatric nursing assistant (GNA) reported that during a transfer to the bed with a mechanical lift device, Resident #3 fell and the resident's head hit the floor (Refer to F689). on 12-31-2019 at 10:00 AM, the Administrator and the Director of nursing were interviewed. The interview revealed they that the facility did not report this incident to Office of Health Care Quality because the event invloved a witnessed fall, the facility did not believe the incident was possible neglect. No additlonal information was provided.	F609		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Eachresident receives adequate supervision and assistance devices to prevent accidents This REQUIREMENT Is not met as evidenced	F689		

STATEMENT OF OEFICIENCJES ANO PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215125	A 8UILOING _____ B.WINO	C 12/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ROCKVILLE	9701 VEIRS DRIVE ROCKVILLE, MD 20850

(X4)1D PREFIX TAG	SUMMARY STATEMENT OF **DEFICIENCIES** (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING **INFORMATION}**	ID **PREFIX** TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THEAPPROPRIATE DEFICIENCY)	(X5) COl.f'I.ETION OA'll,
F 689	Continued From page 5 by: Based on clinical record review, the review of administrative documents, and facility staff Interviews, it was determined that the facility's staff falled to use the proper technique when transferring a resident using a mechanical lift **device.** This finding was evident in 1 of 3 residents reviewed for transfers with a mechanical lift during a complaint survey (Resident #3). This facility's failure resulted in actual harm related to the resident. The findings include: This finding was identified during the investigation of complaint MD00146977. On 12-31-2019, review of the c nical record for Resident #3 revealed a comprehensive care plan for at risk for falls with an intervention of a hoyer lift with two-person assist for all transfers. Also, the review of the annual minimum data set (MDS) assessment date 05-11-19 Section G0110 transfers was coded for two-persons physical **assist.** The minimum data set {MDS) is part of the U.S. federaHy mandated process for clinical assessment of all residents in Medicare or Medicaid certified nursing homes. This process provides a comprehensive assessment of each reslden rs functional capabilities and helps nursing home staff identify health problems. MDS assessments are required for residents on admission to the nursing facility and then periodically, within specific guidelines and time frames. On 12-31-2019 further review of Resident #3's	F 689[I	ts The Village at Rockvile 's practice lo provide an environment that remains as free of accident hazards as is possible. 1. Referenced incident occurred in since this time Resident #3 2. An audit of falls from 1/1/2020-2/17/2020 was completed on 2/20/2020. Results of the audit indicate falls did not occur during mechanical lift transfers. 3 Geriatric Nursir,g Assistant's will be re-educated by !he Education Director by 2/29/2020 on proper mechanical lift transfer requirements. GNA's on leave or PRN, will have education completed prior working next shift. 4. The nurse supervisor or OAPI Manager wiU perform random observations of 20% of residents with orders for mechanical lift transfers weekly x4, then, monthly x2, then quarterly x3 Observation findings wil be presented to the Quality Assurance p erformance Improvement Committee for further r ecommendations.	2/12/2020 2/20/2020 2/29/2020 2/29/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215125	A. BUILDING _____ B. WING	C 12/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE **VILLAGE AT ROCKVILLE**	**9701 VEIRS DRIVE ROCKVILLE, MD 20850**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page a **cli vealed** a nursing progress note **on---** where the nurse documented the geriatric nursing assistant (GNA) reported that during a transfer to the bed with a mechanical lift device, the resident fell and hit their head on the floor. The nurse went to assess the resident who was already beck in bed but sustaineda laceration to the forehead. The nursing assessment revealed the resident needed stitches. The resident was sent to the emergency room for further care. The continued review of the Resident's clinical record revealed a provider follow-up progress note, dated• [redacted] that Resident #3 received 18 stiches to the left **side** of the forehead. On 12-31-2019 at 10:00 AM In an Interview, the Administrator stated an internal investigation was completed on Resident #3's fall and a statement from the GNA was obtained. The GNA admitted to using a mechanical lift device to transfer the resident without the assistance from a second staff member. In addition, the administrator stated there must always be two staff members using a mechanical lift device to transfer residents, On 12-31-2019 at 10:30 AM surveyor **review** of the facility's mechanical lift machine policy states at least two nursing assistants are needed to safely move a resident with a mechanical lift. On 12-31-2019 at 11:00 AM surveyor **review** of the GNA's statement revealed the GNA **stated** she used a mechanical lift device without a second staff member present to transfer resident #3 to the bed and during the transfer the resident fell hitting their head on the floor.	F689		

Offic c,f H® lth CareQuallt\

STATEMENT *OF* DEFICIENCIES AND PLAN OF CORRECTION	()(1) PROVIOE:R/SUPPLIER/CLIA IDENTIFICATION NUMBER:	CX2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215125	A BUILDING; _____ B WING	C 12/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE **VILLAGE AT ROCKVILLE**	**9701 VEIRS DRIVE ROCKVILLE. MD 20850**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD SE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPIETE DATE
S 000	S 000: Initial Comments On December 31, 2019, a suivey was conducted facility by the Office of Health Care Quality to investigate one (1) complaint and one (1) facility reported Incident (FRI), Survey activities included review of residents' records, **review** of administrative records, interviews with staff, residents and resident representatives and random observations of staff practices. A finding of actual harm was cited for the facility's failure to ensure it **was free** from accidents. The complaint. M000146977, and the facility i reported incident, MD00149160, were [substantiated. This survey Identified noncompUance with 10.07.02 of COMAR requirements for Long Term Care Facilities.	S 000	This plan of correction is prepared and executed because it is required by the provisions of the State and Federal regulations and not because The Village at Rockville agrees with the allegations and citatioos listed on this statement of deficiencies. The Village at Rockville maintains that the alleged deficiencies do not, individually and collectively, jeopardize the health and safety or the residents, nor are they of such character as to limit our capacity to render adequate care as prescribed by regulation. The Plan of Correction shall operate as The Village at Rockville's written credible allegallon of compliance. By submitting this Plan of Correction, The Village at Rockville does not admit to the accuracy of deficiencies. The Plan of Correction is not meant to establish any standard of care, contract, obligation, or position, and The Village al Rockville reserves all rights to raise all possible contentoins and defenses in any civil or crim'nal da im action, or proceeding.	
S 580;	10.07.02.18 C Nursing Services - Care 24 Hours a Day .18 Nursing Services. C. Nursing Care 24 Hours a Day. The administrator shall employ sufficient and satisfactory licensed nursing service personnel and support personnel to: (1) Be on duty 24 hours a day; (2) Provlde appropriate bedside care; and (3) Ensure that a resident: (a) Receives treatments, medications, and diet as prescribed; (b) Receives rehabilitative nursing care as	S 580	**Refer** to CMS 2567 POC F-689	

OHCQ
LABORATORY DIRECTOft,'.S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE **TITLE** **(XG)OATE**

Healthcare Administrator

TATE-FORM **LKWP11**

Off!CEI *Of* Health Care Qualitv

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIERICLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A.BUIL DING _____	(X3) OATf SURVEY COMPLETED
	215125	8,WING	C 12/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ROCKVILLE	9701 VEIRS DRIVE ROCKVILLE, MD 20850

(X4)10 PREFIX TAG	SUMMARY STATEMENT Of DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGUIATORV OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	{) COMPleTE DATE
S 580	Continued From page 1 needed; (c) Receives proper care to prevent pressure ulcers and deformities: (d) Is kept comfortable, clean, and well-groomed: (e) Is protected from accident, injury, and infection: (f) Is encouraged, assisted, and trained in self-care and group activities; and (g) Receives prompt and appropriate responses to requests for assistance. This Regulation is not met as evidenced by: SeeCMS2567 F689	S 580		

STATEMENT OF DEFICIENCIES ANO PLAN OF CO!'!RECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY C OMPLETED
	215125	A. BUILDING _____ 8.WING	C 08/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ROCKVILLE	9701 VEIRS DRIVI! ROCKVILLE, MD 20850

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTON (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F626	Continued From page 1 who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply wlth the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2)Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part {as defined In § 483.5}, the resident must be permitted to return to an available bed in the partlcular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. This REQUIREMENT is not met as evidenced by: Based on record review and Interviews with staff and residents, it was determined that the facility failed to aUow resident #2 to return to the facility following a hospitalization. Thls finding was evident for 1 of 6 residents (#2) reviewed during the complaint survey and resulted in actual harm and was related to complaint #MD00141855. The findings included: On 08-16-19, record review of resident #2's clinical record at the facility revealed that he/she was admitted to the facility on with diagnoses including, but not limited to: malignant neoplasm of the cerebeNum, neoplasm of unspecified part of the bronchus or Jung, and mild cognitive impairment. The resident exhibited behavioral disturbances such as shouting and repeatedly calling staff for assistance on 05-10-19, 05-15-19, 05-18-19, 05-19-19, 05-20-19, 05-23-19, 05-24-19, 05-25-19, and 05-30-19Review of the facility assessment	F626		

DEPARTMENT OF HEALTH **AND HUMAN SERVICES**
CENTERS FOR ME:O.ICAB_E.&MEDICAID SERVIC fS_

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDERISIJPPIIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	()(3) DATE SURVEY COMPLETED
	2111125	A. BUILDING _____ a WING _____	C 08121/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE **VILLAGE AT ROCKVILLE**	**9701 VEIRS DRIVE ROCKVILLE, MD 20850**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEI"ICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS·REFERENCEO TO THE APPROPRIATE DEFICIENCY)	) COMPLETION DATE
F 626	[Continued From page 2 revealed that the facility had the capability to admit residents with dementia and behavioral disturbances. **on11••1** resident #2 was transferred to the acute hospital for a medical procedure. The transfer was necessary for the resident's welfare and the res1dent's needs could not be met by the facility at the time. The resident was private pay status at the time of transfer and the family declined the facility's bed hold. Review of the facility bed hold policy revealed that, if the resident or responsible party does not wish to pay to hold a bed, they can request discharge from the facility and would need to reapply for admission upon return. Surveyor review of the bedhold agreement **signed by** resident #2's Power of Attorney O" revealed that the bedhold was declined. Furthermore, the bedhold agreement stated that, if the resident declines the bedhold but chooses to return to the facility after their absence, the facility will readmit the resident and assign the next avallable appropriate bed, unless the facility **car** meet the resident's needs. **O.** a written notice of transfer was signed by the resident and his/her medical power of attorney acknowledging the transfer. The notice did not state that the resident was discharged from the facility. Review of the Minimum Data Sheet (MDS) discharge **as t,** with an assessment reference date **of—** revealed the resident was discharged with return anticipated. MDS is part of the U.S. federally mandated process for clinical assessment of all residents in Medicare or **Medicaid** certified nursing homes. This process provides a comprehensive assessment of each resident's functional capabilities and helps nursing home staff identify health problems MDS assessments are required for residents on admission to the nursing facility and then	F **6261**	It is The V llage at Rockville's practice to permit residents to return to the facility . 1. Resident 112 2. A rev ew of residents request in g admission after a resId ent-in.t ated discharge was completed for 8/1/19-9/15/19. The results were 100% compliance . 3. Staff will be re-educated by the Nursing Home Administrator or the Quali ty Assurance Manager by 10/5/19 on the importance of clear and thorough documentation regarding resident-in tiated d'scharge, d'scharge planning, and pre-adm ission acceptance determination . 4.The LNHA or QA Manager will review 100% resident -initiated discharge documentation includmg discharge planning, for 30 days, then 50% for the next 60 days, then 10% for the next quarter. The LNHA or DON will audit ten (10) pre-admission determination documentation weekly x4 weeks, then monthly x3 months, then quarterly x2 quarters. Review and audit findings wil be presented to the Quality Assurance Performance Improvement Committee for further recommendations .	9/16 / 19 10/5/19 10/5/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(Xt) PROVIOER/SUPPUER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3} DATE SURVEY COMPLETED
	215125	A. BUILOING _____ B. WING	C 08/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADORESS. CITY, STATE, ZIP CODE
THE VILLAGE AT ROCKVILLE	9701 VEIRS DRIVE ROCKVILLE, MD 20850

(X4)10 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IOENTIl'YING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN Of CORRECTION [EACH CORRECTIVE ACTION SHOULO BE CROSS-REFERENCEO TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLIITION DATE
F 626	Continued From page 3 periodically, within specific guidelines and time frames. On [redacted] resident #2's family submitted an application for Medicaid to the facility staff after the resident was hospitaHzed and no longer in the facility. On 08-21-19, surveyor review of the acute ase management notes, written on revealed that the facUity denied resident #2 for readmission because they felt that resident #2 required a bed in the dementia unit, which was full at the Ume. There was no evidence that the facility conducted an assessment of the resident's clinical condition at the hospital. Review of the facility census report on [redacted] revealed 4 empty beds, including 1 empty bed on the dementia unit. Review of resident #2's medical record revealed no diagnosis of dementia and resident #2 previously stayed in a non-dementia unit at the facilio/" Case management notes, written on , revealed that resident #2 requested to see the hospital case manager because he/she wanted the case manager to see that he/she was "normal." Resident #2 stated that no one wanted him/her. Additionalcase management notes, written on • • • „stated the resident's family were eager to have the resident readmitted back to the facility, however, the facility declined the resident for readmission with the reason being that Resident #2. required a bed In the demen!i!..Y.!liL...Beview of the facility census report on [redacted] evealed there were 5 empty beds in the facility and no avaYable beds in the dementia unit. Review of the hospital psychiatrist notes on • • • revealed that the resident's behavioral disturbances improved after their medical procedure and the resident was calm and cooperative. Previous behavioral disturbances were attributed to delirium	F626		

STATEMI!NT OF DEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215125	A. BUILDING _____ B.WING	C 08/21/2019

NAME OF PROVIDER DR SUPPLIER	STREET AODRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ROCKVILLE	9701 **VEIRS** DRIVE ROCKVILLE, **MD 20850**

(X4)10 PREFIX TAO	**SUMMARY** STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGUI.ATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
F 626	Continued From page 4 secondary to a medical condition which was resolving. The psychiatrist further stated that the primary care team at the hospital reported that the resident had been very calm since the medfcaf procedure, and there were no episodes of agitation or behavior disturbances. A case management note, dated [redacted] **l tated** the resident was evaluated by the psychiatrist and cleared from a psychiatric standpoint The note further documented that the facility stated they were unable to readm the resident and the **case** was closed. There was no evidence that the facility reviewed hospital notes or conducted an assessment of the resident's clinlcal condition at the hospital bef- resident #2's readmission on Review of the facility census report on revealed that there were 4 empty beds in the facility but none in the dementia unit. FL hospital transfer summary, written on revealed documenatlon that resident #2 remained in the acute care hospital because the resident was still pending placement. Resident #2 was discharged from the acute hospital to another facility on or skilled nursing facllity services and physical therapy needs. ReviewofCOMAR 10.07.09.120 revealed that residents, whose hospitalization or therapeutic leave **exceeded** the bed•hold period under the State Medicaid Plan, have a right to be readmitted to the nursing facillty immediately upon the first availability of a bed In a semiprivate room If the resident requires the services provided by the nursing facility and is eligible for Medicaid coverage for the nursing facility's services. On 08-16·19 at 10;50 AM, interview with the Director of Nursing and Administrator revealed that the resident was not denied readmission for	F626		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	()(1) PROVIDER/SUPPUER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215125	A.BU|LD|NG _____ B. WING	C 08/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, COY, STATE, ZIP CODE
THE VILLAGE AT ROCKVILLE	9701 VEIRS DRIVE ROCKVILLE, MD 208150

(XA)ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDfD BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	10 PREFIX TAG	PROVIDER'S PLAN Of CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 626	Continued From page 5 behavioral issues. The Administrator stated the facility felt they could not meet resident #2's **needs,** but was not able to elaborate. There was no documentation to verify the reasons the facility could not meet resident #2's needs. On 08-21-19 at 11:1O AM, interview with resident #2 revealed that he/she remembered being ln the hospital and being told that the facility would not accept them back. The resident started crying and stated that he/she felt depressed and anxious at the time because they worked all their life and felt no one wanted them. The resident felt he/she was back to normal after the medical procedure and was no longer exhibiting behavioral disturbances. Resident #2 stated he/she still feels depressed whenever they think about it. On 08-21-19 at 1 PM, interview with the Administrator and Executive Director revealed that resident #2 was private pay status at the time of transfer to the hospital and the family declined the bed hold. Per facility bed hold policy, the resident was discharged from the facility and would need to reapply for admissionto the facility. When the hospital contacted the facility for readmission, the facility denied **resident#2's** read missionbecause they felt they could not meet his/her **needs,** howev hospital case management note on -- the facility told the hospital that the resident was denied because there were no beds available on the dementia unit.	F 626		

Offir-A.1:ll Health Cara Quallhl

STATEMENT OF DEFICIENCIES ANO PIAN OF CORRECTION	(X1) PRO\IIDER/SUPPUER/CIIA 1DENTIFICATION NUMBER.	(X2) MULTIPIE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	215125	A BUILDING: _____ B.WING	C 0812_1/20.19

NAME OF PROVIOER OR SUPPLIER	STREET AODRESS, CITY, STATE. ZIP CODE
THE **VILLAGE AT ROCKVILLE**	**9701 VEIRS DRIVE ROCKVILLE, MD 20850**

(X4)I0 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	10 PREFIX TAG	PROVIDER'S PLAN Of CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCEDTO THE APPROPRIATE DEFICIENCY)	IX5) COMP ETE DATE
S 000	Initial Comments I The following deficiencies are the result of a complaint survey that was conducted on August 16 & 21, 2019 to investigate complaints #MD00141780and MD00141855 andfaclHty reported incidents MD00141146 & MO0014164.2 Survey activities consisted of a review of 6 resident records and interviews with residents, residents' family members, and facltlty staff. Additionally, administrative records and resident care policies were reviewed. A finding of actual harm was cited related to complaint #MD00141855 for the facility's failure to allow residents to return to the facility following hospitalization resulting in psychosocial harm to resident #2.	S000		
S6220	10.07.09.12 D·Res reloc/bed hold;permit res return .12 Resident Relocation and Bed Hold. D. Permitting a Resident to Return to the Nursing Facility. When a resident's hospitalization or therapeutic leave exceeds the bed-hold period under the State Medicaid plan, the resident has a right to be readmitted to the nursing facility immediately upon the first availability of a bed in a semiprivate room if the resident: (1) Requires the services provided by the nursing facility; and (2) Is eligible *tor* Medicaid coverage for the nursing facility's services. This Regulation is not met as evidenced by: Refer to CMS 2567 F626	S6220	t s The Village at Rockville's practice to permit residents to return to the facili ty. 1. Res dent 112 2 A revrew of residents req ues ting ad mission after a res dent - nitiated dischar ge was completed for 8/1/19-9/15/19 . The results were 100% complia nce. 3. Staff will be re-educated by the Nursing Home Administrator or the Quality Assurance Manager oy 10/ 5/ 19 on the import ance of clear an d thorough documentation regarding res dent-in tiated discharge, discharge p ann ing , and pre-adm ission acceptan ce determ •"tat on 4. The INHA or QA Manager will review 100% resd ent -,nti ated discharge documentation including discharg e plannin g, for 30 days, then 50% for the nex t 60 days, then 10% for the next quarter. Th e INHA or DON wil• aud it ten (10) pre-admissi on determination documentation weekly x4 weeks, the n month :y x3 months, then quarterly x2 quarters . Review and audit findings w II be presented to the Qual ity Assurance Performance Improv ement Committee for furt her ecommenda ti on s	9/16/19 10/5/19 10/5/19

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(XII) OATE 9./q,,,

TATE FORM DIRH11

conu"ijation **sheet** 1 or 1

Office of Health Care Oualit\

STATEMENf OF DEACIENCIEI MID PlAN OF CORRECTION	OC1) PROVIDERIIUPPLIERICUA IDENTIFICATIONNUMBER:	(X3) MULT1PL&CON8TRUCT10N	CDDATE SURVEY COMPLETED
	211121	A. MILOJNQ: •••••••• B,WING_____	C . 07119/2018

NAME OF PRO\IIDER OR SUPPU!It	STREET ADDRESS. CITY, STATE, ZIP CODE
THE VILLAGE AT ROCKVILLE	8701 VEIRS DRIVE ROCKVILLE. MD ZC85C

CX4)1D PREFIX TAO	SUMMARY STATUo£NT OF DlflCliHCIE8 (EACH DEFICIENCY MUST IE PRECEDED BY FULL REGUlATORV OR L8CID!NTIl'VING INFORMATION)	ID PREFIX TAG	PROVl0ER'S PIAN OF CORAECllOH (&ACH CORRiCT1'IE ACT10H SHOULD BE CR088-IIUIRENCED TO THE APPROPRIATE DEPICIDICY)	DATE
S0001	Inttial comments	S000		

The foffowing deficiencies are the reawt of the annual survey conducted by the office of Health Care Quality on July 16, 17, 18 and 19, 2018, to detennlne the facility's compliance with State COMAR requirements. survey activities con1llted of a review of 48 residents' records, observation or resident care and staff practices. lntSNlewe of raldente, residents' famlly members, the ombudsman, and facllity's etaff.

Additionally, admlnfstrative records and l'elldent care pollcles were reviewed.

In addiUon to **standard** survey protocola, facfftty **repo,ted** Incident MD 00128823, MO **00128826,** MO 00127873 **and an** addltlanal feclity reported **fnclident wtxch W88 provided to the lUIV8Y team** were reviewed.

This survey did not Identify noncompliance with COMAR requirements that **were reviewed** In ralatlonahlp to these facUlty reported lncldanta.

The facility Is llcenaed for 180comprehenaive beds. At time of this survey the facllltycensua **WIIII 155 beds.**

s 320110.07.02.08 E Admission and Discharge — Is... ◆ **refer to 1'921 of POC** — a.10.1a

.08 Admission and OJacharge

E. Notification of Responsible Persons When Patrent **Mcwet. The** administrator or the admlnlstrator'a deslgnte shall notify the pflvata or public agency or relative reeponalbla for the patient when the patient la transfe"8d trom the facllity for any reason or at time of death. The attending physician shell alto be notified.

m.

OfRe11 of Health Car111 Ou111lltv

STATEMENT 01' DEFICIENCEI AND Pl.AN 0, COfUIECTION	(.ICIJ **PROVIDEMUPPI.** IDEN11F1CATIONNUM8ER:	CX2)MUI.TIPLE CON81RUC110N	(l(J) **T! SUINEY C0fafi.E'T!D**
	21&121	A. IUILIIING,: - - • • • • • 11.NNG .. - - - - - - - - -	C 07/lf/2018

NAME! OF PROVIDER OR SUPPLIER	STR&Er ADDRES8. CffY, STATE, ZP C00I
THE VILLAOE AT ROCKVILUi	9701 **VEIRSDRIVE** **ROCKVILLE. MD 208IO**

(X4J ID PREFIX TAG	**SUMMNtY ITA'l&IENT** OF DEFICIENCES (IACH DUICIINCY WST BEPR&CiDID IV FULL A£Gut.ATORY 011LIC IDENTIPYING IN,oJUMTION)	ID PRI!I'II(TAO	**PRDVmP'S PLM MCORMCTION** (EACH COMI!CTIVE **ACn0N SHOULD** BE CR0S8-REFERENCEDTO1HI APPROPRIATE DUICDCYJ	DATIi
s 320	Continued Fram page 1 Thia Regulation Is not mat as evidenced by; Refer to CMS 2587 F623	S320		
S512	10.07.02.12 R Nag Svea; Charge Nurse Daly Rounds .12 Nursing Services. **R. Charge NU1181'** DaUy Rounds. **The charge** nurse a, nurses shell make dally rounds to all nut81ng units for which reaponelble, pelformlng such functions as: **(1)** Visiting **each patient;** (2) Reviewing cllnfcaf record&, medlcatlan orders, pallent care plans, and staffa&&lgnments; (3) To the degree possible, accompanying physicians whenvtsltln9 pa1lent8. This Regulation 11 not **met es** evidenced by: Refer to CMS 2587 F757 and F758	$512	Please refer to F767 and F768 of roe 1	.10.18
S1119	10.07.02.21 G Inf Control Program; Prevent Spread of lnfec .21 lnf•cllon Control Program. G. Preventing Spread of Infection. (1) The facility **Shall 11sea** any residents with signs and aymptoma of anInfectious lllne11for the posslbllity of tranamlalon to another resident oremployN. (2) The facllity ahall take appraprfate Infection control steps to prevent the transmission of a communlcable dlsea• to residents. employeea,	s1119	tuae refer to F880 of POC	8.10.18

Office *of* Health Cara · -...

STATI!MENT *01* DSFICIENCJES AND PLAN OF CORRECTIOH	(OU) PROVIDERISUPPLIEIUCUA IDENTIFICATION Nl.lllBEA:	CU,,MULTI'LECOHS1RUCTJON A. BUILDING:- • • • • •	(X3) IMTE SURVEY' COMIUTED
	211121	I.WIG - - - - - - - - -	C 07/lSt/2111

NAME*OF*PROVIOER 0RIUMJ!R	STREET ADORE81, CITY, STATE, ZIP CODE
THE VILLAGE AT ROCKVILLE	9701 VI!Hl8 DIWI ROCKVILLE, MD 201&0

(OU)D SUMMARY STATDIINT 0, DI!FICIINCI!I ID **PROVIDliR'8 PLAN** OJI COIUIECTION

PRUIX TAG	(EACH DEFICIENCY MUSTII PMCIDED IY fULL REGUIATORY OA LSC ID&NTIF'YING INFORM.\TION)	PREFIX TAG	(EACH COMEC'I'IV£ ACTION SHOULD BE CAOSS,REFEAENCEDTO THE **APPROPRIAT&** DS'ICIENCY)	**DATE**
S1119	I Continued From page 2 and visitors as outDned In the followfng guidelines: (a) Guldeflne,forlaolatlon Ptecautfona In Haapttals; and (b) Guldallne for Infection Control InHealth Care Peracnnel. (3) The facllty **ahaD** prohibit **employHt** with a communicable **disease** or with Infected akin lesions from direct contact with residents orthelr food If direct contact could ttan1mlt the dlaeaaa. (4) The facility 1halraqulre employees toperform hand hygiene after eGh dlracl resident contact for which hand hygiene fa Indicated by eccepted profenlonal practice. (5) The faclUty ahalJ handle, atore, process, and transport linens so as to prevent the ap,ead of Infection. Thia Regulation Isnot mat as evidenced by: Refer to CMS 2887 F880	S11111		8.10.18
s1aa&1	10.07.02.38 o Reslident Status Aaael&ment; assessments .38 RNldent status Aaaessment D. The facility shall complete all Bllla&8menl8 In ecconfance with the provlsfona of 42 CFR §§483.20 and 413.343. This Regulation la not met as evidenced by: SeeCMS2587 F841	**81818**	**[Plaase refer** to F841 of POC	8.10.18

Office of Hultb care Cualty

STATEMENT OF DEFICIENCIIS AND PLAN OF CORRECTION	(X1) PROVIDEAISUPPLIERICIM IDENTIFICATION NUMBER:	CU,MULTPI.E CONSTRUCTION	CXI) DATE 8UJNEY C0MPLETED
	215121	A. BULDING,; • **8.ININ**G_ - - -	C 07/1912018

NAME OFPROVIDER OR SUPPLER	STREET ADDRE88. CITY, STA-ra, ZIP CODE
THE VILLAGE AT ROCKVILLE	87D1 **VEIR.8 DRIVE** ROCKVILLE. **MD 2088D**

0(4)1D PREFIX TAG	SUMMARY STATEMENT *OF* DEFICENCIE8 (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDEN11FYl.'fG INFORMATION)	ID PREFDC TAG	PROVIDER'8 PLAN 0, CORRECTIDH (EACH CORRECTIVE ACTION SHOULD IE CROSI-REFEAENCEDTO1HE APPROPRIATE DEFICIENCY)	col;t6 DATE
S18851	Continued From page 3	81885		
S1885	10.07.02.48 Posting of Staffing .48 P08ting of Staffing. A A nursing home shall post on each floor or unit of the nursing home, for each shift, a notice that explain• the ratio of licensed and unllcenaed ataff to residents. B. The posting on eacl'I floor shall Include: (1) Names of the staff members on duty and the room numbers of the residents that each Is aaslgned; (2) Name of the charge nurse or person Incharge of the unit;and (3) Name of the medicine aide or parson responsible *fOt* medication administration. C. The posting thall be on a form provided or approved by the Department. This RagulaUon la not met as evidenced by: Based on suNeyor observation, It was detennlned that the fachlty etaff faJled to post staffing ratios. This finding was evident on 5 of 5 nursing units. The flndlngs Include: On 07•18-17 at 9:00 /W, during lnitlal rounds, It was noted that the facllity staff failed to **poet the** ratio of licensed and unRcenaad staff to residents on any of the nurelng units. On 07-17-18 at 4:20 PM, aurveyor observation agafn revealed no ratio of lk:enaad and unlicensed staff posted for residents and vieltors Information. On 07-18--18 at2:50 PM, Interview with the director of nursing revealed the facility had previously provided ratios, but changed the	S1885	**Wha**1t **corractiva action** wlll **be** accompllahacl for those rnldenta **fo**nd to have been affected br the **d**eftclent practice? **N**o *midents* **wen!** ***a/fttted*** *by the /odlltla fa1/lure to not have staff* ,otfos *Included In* the *dally floor oalgnmen* t *posting.* **H**ow you wlll ldentlly other **reeld■n\8 having th**• potential **to be affected by the aama deflc**lent **practice and what corrective action will betaken?** ***The*** *Director of Nursing completed* ***om****audit of staffing* ***eln,*** *on* the ***5 u****nits at* the *ti that* the *deficient proctkt* ***was*** *brought to* the *Director of Nursing* ***otte****ntlon ond sto/Jfng au/1nment sheets* ***Inel****uded dally PPD and stoJ/ hours but* not ***staff****ms rotto. Dolly sto/flns o$Slgnment sherts* ***were*** *corrected and postld outsltk of* the ***nurs****lng stotlon.* **Whi**t **meaaurea** will be put Into place ar **wha**t eyatemlc **chlngu you** wlll **maketo en**sau**N tllatthe deflol8nl practlcll don not rec**ur? ***Dln*** *«toro f Nursing In-serviced core coodaa on* ***post****mg* of *stolftng assignment on* the *unit.* **H**ow **the conectlve actlon(a)** wm be **m**onttorad to **ensure the** daftclent practice **wi** not recur. **I.e.• what** quality **aaaurance pr**ogram will **be put Into place?** ***Th****,, Director of Nursing or deslgnee will* ***co****nduet a* Joo& *monthly audltJ of pasting of* ***st****Df/ing assignment on the units ensuring* ***co****mpllonat. Findings wlll* ***bereported*** *to/odl* ***Q****commltttt month* d.	**18.10.18**

Ce of Heallb C are Qualit\ STATEMENT OF DEFICIENCIE	(X2) MULTIPLE	(X3) DATE SURVEY
ANDPLANOFCORRl!CTION IDENTIFICATIONNUMBER:	**A.** IUILDIHG: - - - -	COMPLETED
211121		C 07/19/2018

NAME Of PROVIDEA OR SUPPUER	STREET ADDRESS. CITY, STATE, ZIPCODE
	9701 **VEIRS DRIVE**

(X4) ID TAG	SUMMARY STATEMENT OF DEFICIENCIES REGIULATORY ORLSC101!NT1FYINIJ INFORMATION)	11111 · o&U8 ib.. TAG	PROVIDER'S PLAN FCORRECTION CRQSS.REFEREHCB) TO THE APPROPRIATE DEFICIENCY)	DAT&
S1885	Conttnued From **page** 4 format of their staffing Information.		12 Resident Relccatlon **and Bed** Hold.	**8.10.18**
S5097	10.07.09.08 C (3) Right to **dignified existence** .08 Resldenra Rights and Services. C. A resident has the rfghtto: (3) A dignified existence, eelf-datem,lnatfon, and communication with and access *to* lncltvlduals and services Inside and outside the nurslng facfllty; Thia Regulation fs not met as evidenced by: **Refer** to CMS 2567 F581			**8.10.18**
S8022	10.07.09.08 C (18) Right to peraonat privacy .08 Resident's Rights and SBNIC8S, C. A resident has the right to: (18) Personal privacy, lndudlng: (a) Confidentlallty of personal reeorda; and (b) Privacy In: (I) Medical treatment. and (II) Personal care; Thia Regulatlon la not met u evidenced by: Refer to CMS 2587 F583			**8.10.18**
8821	10.07.09.12 C (2) **Res Reloclbed** hold;nallceat b'an&fer			8.10.18

S5097	Please refer to F661 of POC	Completion date: 8.10.18
S8022	Please refer to F583 of POC	Completion date: 8.10.18
S6217	Please refer to FB25 of POC	Completion date: 8.10.18

Office of HeaHh care QuaBtl

STATIMINT OF DEFICIENCa!S ANO PLAN01"CORRaCTIQN	(X1) PRO\IID&RIIIUPPIJSIICUA IDI!NTIFICATIONNUMBI!R:	oa') MUL1FLI! CON8TRUC'n0N A,IMJ&am:- • • • • • ••	lXI) DATE IURV&V COMPLET&D
	2111H	8.MilCI . - - - - - -	C 07/19/2018

HAMS OF PROYIDEA0R8UPI'IJ&R	8TAEET ADOREII CffV, STATE, ZIP CODE
THE VILLAGE AT ROCKVILLE	8701 **YIIM ORNE** ROCKVILLI!, MD 20IIO

CXA)ID PRI!I'DC TAG	IUMIIARY' STATEUliNT OF DIPICIENCIU CIACH DI!I'Ial!NCY MUST 8& PRECEDED *11Y* FULL RI!OUI.ATORY OR L8C IDamFYING INFORMATION)	ID Menc TAO	PROVIDER'S P&M0, CORRECTION (EACH C01UUCTIWACTIOH8HOULD BE CROS8-R!I'I'!R2NCIDTO Tiff!APPAOPIUAT& OIPICIENCVJ	DATE
S8217	Continued From page 5 C. Notice. (2) Notice of Bed-Hold Polley at Time of Tranafar. At the time of transfer of a resident to a hospital or for therapeutic **leave, a** nursing facllity shall provide a written notice to the resident, or when appllcable, the resident's rapreaantattve or Interested famlly member, which specifies the duration of **the bed-hold** pOIICy **daacrlbed** In §C of thfa regulation. This Regulation Js not met **as evidenced** br, **Refer to** CMS 2587 **F825**	Se217		**8.10.18**
883101	1 U.U7.UY.15 **A ADuse;t'OllCles/1-'rocedures** .15 Abuse or Realdents. A A nursing fadllty shall develop and Implement pollcle9 and procedures prahlbltlng abuse and neglect of residents. This Regulation 18 not met aa evidenced by: Refer to CMS 2687 F943	**61310**	**rlease refer to F943 of POC**	**18.10.18**
888491	10.15.03.08 a (2) Food Protec:tfon During Storage, Service and T .08 Food Protection During Storage,Setvlce and Transport B. When storing and Holdtng Food: (2) Except for metal beverage contatnera and	88849	Jeaae refer to FB12 of P0C	1,.10.1,

81'ATEMENT OFDIRCENCIE8 AND PLAN OF CORRECTION	1X1) PROWIIAISUPPU&AICUA IDli TION NLIMIWI: 21112&	CJC2) MULTIPLI CONSTRUCTION .''- IUIU)INrJ:. BWWG	(XI) DAI& SURVEY COMPLETI!D C 07/'lll20tl

NAM1OF PROIIIDEJI OR IIJPPUl!R	S1RUI' MJ0111111, CNV. IT.All. ZPCODa
THI VILLAGE AT ROCKVILLE	ffIt VEIRS DRIVE ROCKVILLE, MD 20110

IX4> ID PIIEFIX TAG	SIJAMIUn' ITATIM!Hf OF DEFICIEHCEI (EACH DEFICIENCY MUST II PRICED&D BY FULI REGULATORY Oft UC IDENTIFYUIIG INFORMATION)	ID PREFIX TAG	PROVIOER'8 PLAN OF CORIIIECTION (EACH CORRiCTI\11 ACTION SHOULD BE CR TO THI:!APPROPRIATE DiFICIENC't)	CO:.... DAfI!
88849	Continued From page 6 waterproof contalnet1 ttan1d aa provided In §8(3) of tht8 regulation, contalnera of food ara stOted: (a) Off the floor; (b) 18 lnehn above the floor or higher If food 11 exposed; (c) On clean racks, d01Ues, or other clean aurfaces;and (d) In a manner 1ha1 will protect from splash and other contamination; This Regulation la not mat aa evidenced by: Refer to CMS 2697 F812	I se&49		8.10.18

PRINTED: 07.12512018
FORM APPROVED
0MB NO ospa.o:v.1 •

DEPARTMENT OFHEALTHANO HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF OS:ICIEHCIES AND Pl.AN OF COMICTICIN	0(1) PROYIOEMUPPLUICUA IOENTIFICATION NUMBER:	CU, MUlTIPLE CONSTRUCT10N	CU)DATESURVEY COMPLETED
	211121	A.BUILDING ____________•__ awug; _______________	C 07/l!l/2018

NAME OF PROVIDER OR SUPPLER	STRiET ADDRUI, CITY, STATE, ZIPCODI
THE VB.LAGE AT ROCkVILLLi	9701 VEIR8 DRIVE ROCKVILLE. MD 208&0

ID PREFIX TAG	IUMIWIV8TATB1ENI' OF DEFICIINCU (!ACH DEFICENCY MUST E PRECEDED IV FUU. Rf:GULATORY OR LSC IDEHI"IFYINO INFORMATION)	I) PREFIX TAG	PROVIDER'8 PIM OF CORRECTION (I:ACHCORRECTM!ACTION SHOULD IE CE>TOTHI!APPROPRIfITE 0EFICIENCY)	DATE
F 000	INITIAL COMMENTS	F 000	Thi1 Planof Coneiitlon la prepated and executed because II la requbd by the provi ol Ille state Ind FederaJ regu1allona and nol becaun The VIiiage at 1g1Ha wftll Me d,g,tlona end citaJona lated on the atatemenl of defIt:lendN. The VllJage al Roclcvl1le maIntainl that the dtl(JtKI defi:lent:111 dO It«, indi 111Y and collacllvely, Jeopanllze the headh and ,ar.(>'offht INldenls. norBte they ol such r:haracttr., to Blnlt ourcefJ#Jdl1 to rvnder aquate cara as Pll#ffbed by regulat/on. Thi,Plan of Conectlon shaN The V/lage atRodMIM's written ___ a.0,non o1cornp11anoe. By thlaPl111 olComN:tion. 1"eVllage at RodMlle dou not admit tothe 8GCUI'8Cy of defici ... Thia Plan of ComH:tion la not meaant toatabllah any atandard of ca,e, cont obllgatJon, or position, end The Villa,.atRodMlle tuelWI.0dghta to,.,,. all poaaJble contMUona enddefenaea In any civil or Clfmfnll cltlm ecfton. or proceeding.	
	The following deflclencln are the result of the annual survey conducted by the offlca of Health Care Quality on July 18, 17, 18 and 18, 2018, ta determine the facllty"e compllanca with MedlcaralMedlcekt requirements. Survey activities consisted of • review of 48 reeidenta' records, observation of nt1ldanl care and etaff practices, Interviews of rnldenta, residents' family members, the ombud1man, Ind faclUty"a 9taff, AddltlonaHy, administrative records and resident care pollclea were reviewed. In addition to standard ewvey protocols, facllty repa,ted Incident MD00128823, MD00128828, MD00127873 and an addftlonal facllily reponed Incident which was provided to the au,vey team were reviewed. This survey did not Identify noncompllanca with Federal requirements that W819 reviewed In ralaUonshlp to these facfflty reported Incldenta. The facUlty Is licensed for 180 comprehensive beds. At time of this survey, the facility can1US was 155 beds.		ID) le IC le D ij frn mil AUG 1D llt'II IIW OFFICE Of HEALTH CARE OUAUTY	
F 5811 SSzsD	Self-Detennlnatlon CFR(s): 483.10(f)(1H3)(8) §483.10(1) Self-determination. Tlie realdent has the right to and the facUlty must promote and faclltate resident eeff-<fetenninatton 1hrough support af tetident choice, Including but not limited to the rights apecffled In pa,agrapha (t) (1) through (11) of this section.	F 581	What comictlve action wlll118 accompllehed for those ntaldentl found IO haYe been affect8d by the deficlent pracace? Resl/dent ll20 wru assessed byattending physi n on01.11.J.Bond conclutkd the cardlo/ow oppolntl'Mtlt wos not medlm/'1 necessary. Attending physician tlocumentrd the convenotlon wldl the Resident IJ.20family.	8.10.18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 8/6/18

Ally ddcllncy llitenul'II endilg 11111" an aterfSll'c, dellCllllaCllllclincf wflfdlUle InllIulon lllaybe 8llQll8CI tmn mriac:lna prowldlng I ISdetetmllled lllt other ufqualdap,avlde111llicllnt lJ-.e:tlonIO I'll pdanll. (See Inllruc:donl.) Emi,tfornUlllng hamal, lheffndlna•llatad 1bowe.,.dllclolallle to Claya 11:111Dwfna1heclateof1U1V9yw111theror not a plan ofconlCtlOn I S PornW'Slna IIOmel, 118 IDOvlflnd •and plans afcomsc:tiona,a CfilCIGIIIDlI 14 Cle,t fOI Ult dltll thal dolunantl.,.mlele avallalll to N I'tellly. If dlfldlucln... died, en IPPfDV9d plan Of COfflldlan II reqlllde to COnUl'lueCI proaram palllClplUOft.

STATEMENT OFDEFICIENCIES ANO PC.AN OF COARECTIOH	Ol1) PROVIDERISUJIPUERICUA mENTIFICATION NUMBER:	(X2) MUl.'nPLe CONSTRUCTION A.IUILDJNB_____	()Q) DATE SURVEY COMPLETED
	211121	**8.Wl(p** - . - - - - - - - - -	C 07M9/2018

NAMEOFPROVIDERORSUfilll.JER	6TREE1'ADDRSSS. CITY. STATE. ZIPC00e
THE VILLAGE ATROCKVILLE	1701 VEIRB DRIVE ROCKVILLE. **MD Z08IO**

(M)ID PREFIX TAG	SUMMARY STATEMENT Of DEFICIENCIES (EACH DEFICIENCY MUST I& PRECEOED IV FULL REGUI.ATOR'f'ORL8CIDENTIFYING INFORMATION)	D PREFIX TAB	**PR0VIOEll'8 PLAN OF** CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSB-REFliRENCEDTO THE **APPROPRIATE** Dl!FICIENCV)	DATE
F 581	I Conunuad From page 1 §483.1O(f)(1) The resident has a right to choose activities, schedules (Including sleaplng and waking tlmH), heaJth care and provlde18 of health care services consistent with his or her fnterests, aBS8Slmenta, and plan of **can, and other** applfcable provisions of thlspart. §483.1O(f)(2) The resident haa a right to make ch01c:ea **about aspecll** of hla or her life In **the** faclUty that are significant to the resident. §483.10(1)(3) The resident **haa a** right to Interact withmembera of the community **andparticipate** In community actlvttles both Inside and outside the faclllty. §483.10(1)(8) The reafdant **ha a** right to participate In other activities, Including soclal, reUglous, and community actlvffln that do not Interfere with the rights of other residents In the faclllty. This REQUIREMENT Is not **met 81 evidenced by:** Baud on review of the cllnlcal record, and resident and staff Interview,, It was determined that facility staff falled to lnfonn the resident of the option to follow up with a cardlologllt as recommended. Thia finding waa evident In 1 of 3 records reviewed for self determination. (#120) The findingIncludes: **On•••** resident #120 waa discharged from the acute care settJng and admitted to the faclllty after having been diagnosed with a myocardial nfarction.(heart attack) Th•hoapltal dlaeharge Instructions provided to the facility directed the resident to follow up with a cardlologlat within 1wo **weeks.**	**F 561**	**How you** wllt **Identify other raafdentl having the potential ta beaffectacl by the a■me defelent practice and what conectlve action will be talcan?** *On 07.2!1.lB, the Med/col Director conducted a 10m5 oudlt of alf* t#le ***disdlorge*** *summaries In the lost* ***30 doy,*** *focusing on follow-up appolntmenu listed In the* ***discharge*** *summor,. Attendln9 phys/don documented any appolntments 1ug9nted but not medlm/Jy necessary on the resident', chart.* **Whs** 1t **menurn** wfll be put Into place or **wh** ataptemlc **changea** rou wlD **mar.to en1ure** that the dllfk:lent **pnelfce dNI** not **rec** ur? *Mredlcol OlledOr wl/l l,t.,ervla every phy,kian and NP by 08.3.UB,foa,sln9* on doc:vmenfat/on *of medk:olly nemssory follow-uP appointments, and resident's right* of, *elf-d1etermlnotlon.* *A trending ph1J/dot11 willeonrJnue to re11lew af/ldtorge summaries, and If a follow-up orppalntment II dHmed unn O!UO,Y, ottend/i p1h,stt:lon wlll document hll/her re,commendations In the re1ldtnt's H/P.*	18.10.18

STATEMiNTO, DEACENCIES AND PLAN OFCORR!CTION	0C1) PROVIDERIBUPPUERICUA IDENTIFICATION NUMBER:	CQ) MULTIPLI CONSTRUCTICIH	(1(3)0!\TESURVEY COMPLETB>
	211121	A.BUILDING_ - - '!' • - - 8."'NI - - - - - - - -	C 07/19/J0lL

NAME 0FPftOW>ER OR SUPPLI&R	STREET ADDRESS.cm',STATE,ZIP CODE
THE VILLAGE AT ROCKVILLE	1701 **Vl!IRS DIUVI** **ROCKVILLI, 1111) 20850**

IX4)1D PREAX TAG	SUltMMY lfAlBIENTOF Dl!FICEHCES (IA.CH DEFICl!MCT' MUSl' IE PRECEl)ED **BY RILL** .REGutATORY 0A L8C IDENTIFYING INFORW.llON)	I) PREFIX TAG	**PROVIDER'S PLAN** OF CORRECTION (EACH CORRICTNE ACTl0N IIHOUI.D II **CROSS,Ri,IMHCeD**TO **ffll APPltOPRlflTI!** DEFICIEIIICY)	IICIJ **CQINJIOII M'II!**
F 581	J Continued Fram page 2 On 07-1 18, et 11:00 *AM,* ln181Vlew with resident #120 revealed that he/ahe was not aware of the recommendation for the cardl0logy follow up. On 07-18 18 at 11:30 AM, Interview with a famll member cf reatdant #120 also revealed no awareness of the recommendation far cardiology follow up. On 07-17-18 at 10:00 AM, Interview with resident t1120's attending phyak:lan 1'8Y881ed that the physician dilcusaed the cardiac statue of the resident with bath the resident and famlly, Informing both that the resident's heart condition could be managed within lha facility. The attending did not mention the recommendation for a carclology fallow-up to Ula resident *or* family member during the vlall As of Iha time of •urvey, the rwaldent had not had the recommended cardiology appointment.	F 581	**the carncllva acaon(e)** wlll be onltDrad to___,,.**the dlflcfent pracllce** not recur'? *ldlcal Dlttctor willconduct* 100J' *monthly udlt of all dlscha,gtt summatlll* ***ond HSh sing*** *on ntcondllotlon of fDllow-up i,ppolntments documenrotlan on HAP. Flndmgs wtJJ bft reported* ro dtft *fodlity OAP# commltm ''onthly x3.*	
F 5831 SS=B	Personal Privacy/Confidentiality of Records CFR(a): 483.10(h)(1H3)(f)(lij §483.1O(h) Privacy and Conftdentllllty. Tha raldent has a right to personal privacy and conffdantlallty of hla or her personal and medical records. §483.10(h)(1) Paraonat privacy lncludee accommodations, madlcal treatment, written and telephone communications, personal care, Yltltl, andmeetings of famlly and resident groups, but this does not require lha faclUly *ta* provide a prtvata roam for each rnldent. §483.1O(h)(2) The faclllty must respect the residents right to pe11onal privacy, lncfudlng the	**F583**	**5 corractlve action** wlll be **pflllhed for thole Nlldentl tDhaw been lffecbtd bf the lent practice?** ***ocfc,I Work•r Director OSHssed Raldttnt lll04*** *nd no ,wgatllle outtame* **MIS** ***not/ad dw*** to *O&fflW* ***poptl postlnf*** *ln* ***,e•n(s*** *tDOm.* ***tthob Director ollo MSased ond tr1mo'lf!d a#*** *hob lings of RUltlftnrs 6104 room* on 7.J7.l8.	**ID&.10.18**

STATEMENT OF DEFICIENCl!S AND PUN 0Jr «:OIIRiCTI0N	(lc:t)PRO\IIDIRIIUPPUEIIICUA IOEfifflFICATION NUMBER: 21&121	pQtMUI.11PUi CONmlUCTtON AIUILDING ____ I.WIN_G_ --------	(Q) Df4TI! SURVEY COMPl.eTED C 07/1912018

NAMEOFPROVIDERORSUPPLIER	8TRI!£1'ADDRS88 Cll'Y.STATE.ZIPC0DE
THE VILLAGI! AT ROCKVILLE	1701 VER& DRIVE ROCKVILLE, MD 208IIO

ID IIRII/X TAG	SUMJMRY STATEMDII' O,DEPICIENCIE8 (MCHDIIICl!NCY MUIT IE PRECl!DED 8Y FUU. REGULATOIW OliL8CIDINTIFYIHG INFOMiAnON)	ID PR&fDC TAG	PROVIDER'S I'IAN OFCORRECTION (EACNCOMICTMACTION SHOULD BE C TOTHI!APPROPRIATI DlflCtENCY)	Oli) CDIII'la1ION IMTll
F 583	Continued From page 3 right to privacy In hie or her oral (that Is, spoken), written. and eledronlc ccmmunlcatlons, Including the right to send and promptty receiva unopened man and other letters, packages and other materials delivered to the raclllty for the rasfdent, Including thole delivered through a means other than a postal service. §483.1O(h)(3J The resident has a right to secure and confldentJal personal and medlcal racordl. (I) The resident has the right to refuse theMleala of personal and madlcal records except as provided at §,483.70(1)(2) or other appllcabla federal or state raws. (II) The facfflty muat allow representatives of the Office of the State LOng-Tenn Care Ombudsman to examine a resident's medlcal, IOClal, and administrative racotds In acccrdance with State law. This REQUIREMENT Is nat met as evidenced by: Baaed on surveyor oblelvation, Itwaa noted that the faellity staff fallad to malnlaln the privacy of a resident. This finding wu evident In 1 of 48 raldents selected for the survey. (#104) The finding Includu: On 07-18-18 at 09:27 AM, during lnlllm round•, surveyor noted afgna poatad In rafdent #104'11 room Instrucllng staff on specific care related a■ua related to •PNCh the,apy awallawlng strategies and occupatlonal therapy transfer strateglas. nterview of rufdanl #104 revealed Bhelhe did not request that Information be poeted at the head of hlalher bed. On 07-18-15-18 at 3:00 PM, the lfgna we• stlll	F 583	H/N/ vou wlll ldtntlt,other nlSldentll having the pDlanlfal tD be affeclad a,, Ille llffle deficientpractice and what corrective action wlJH be mlcen? Rtrhob Dlm:tor conducted JOO. audit of olJ reldents In COS on the short ond long-te'Mt unitsond removed on1 rwroblllotlon signs. Wha,t fflHSUlff wllbe put Into place a, what ayetamlc: changn you wlll make CD ensunt that the deficient practice dou not recur? Rehob stoff W0S ln-tetvlced on 01.J1.JB and 07.18.JBabout resldenr's prlvoq focuslna on rehabsigns dlot ore given to the residents. Rehob Dlm:tor will provide o/older to ewt1 resIldent on tM cou-lood tomofntoln reslftnt spe reltobfflotlonlnfonnotlon. All rehab staffand nurses wlll ln-servla on tM new prmass.focusing on r,s/dent's ptiw,ey by 08.:JO.JS How the corrective action(•) wUI be monltond to enawe the daflclent pndlce willnot recur, •·•· what quality anuranc:e proa,am wll be put Into piece? Rehab Dlrfftor will conduct JOOJII Wfftly audlrs on all residents on tose-lood focusl tna onfolder utlllzotlon and rthob signM9t. Findings wlH H rttpormJ IDQAPI Com1m/ttnd months.	

STATEMENT OF OEFICIEHCIEI AND PLAN OF CORRECTIOM	(X1) PROWJEIIIIUPPI.I IDI:NTIFtCATIOH NUMIIR:	C,X2) MULTIPLE COltl81RUC110N A IULDING _ _ _ _ _	(JQ)DATIIUR\IEV COMPI.ETD
	211121		C 07119'2018

NAM!OP PIIIOVli:IER OJt IUPPLD	8TR&ET ADDRESS, Cm', STATI. ZIPCODI!
THE VILLAGE AT ROCKVILLE	9701 VEIR8 DRJVe ROCIMLLII!, MD ZOIIO

0(4) II) PRUDC TAO	SUMMARY STATI!UENT Of DEFICIENCIES (EIQf DEFICENCY MUST IE PRECEDB> IYfllLL REGULATORY OR LIC IOENTIFYIHG INFORMATION)	IO PREFIX TAO	PROVIDER'& PLAN OF CORRECTION (&M:H CORRECIlVli ACTION SHOULD BE CR08a.R&FEIUiNCEDIU THEAPPROPRIAIE DEFICIENC'tt	oIIII
F 583	JConUnuedFrompage4 posted and visible to anyone entering the room. On 07-17-18 at 7:60 AM, algna were SUH vllible over the hod Of the bed On 07-17-18 at 4:00PM, the signs werwstitJ present. The director of nursing **was made aware,** and had no additional Information.	F583		
F 823 SS=D	Nottce Requirements Before Transfer/Discharge **CFR(s):** 483.15(c)(3H8)(8) §483.1S(c)(3) Notice before transfer. **Before a** facfllty tnlnlfer& or dlscha,aes a resident, the facllity muat- (1) Notify the resident **and the 1811dent'a rep,esentattve(a)** of **the tran1'8r or discharge and** the reason, for the move In writing and In **a** language and manner tt"Y understand. Thi facility mUlt nnd a copy of the notice to a representative of the Office of theState Long-Term Care OmbUdaman. (II) Record the reasons for the transfer or dlsc:harge In the residents medlcsl record In accordance with paragraph (c)(2) *of* thlHectlon; and (lll) Include In the notice the **Items dNCrlbed** In paragraph (c)(5) of this section. §483.1!(c)(4) Timing of the notice. (I) Except **n apecifitd** In **paragraphs** (C)(4)(0) and {c)(8) *of* this section, the notfee of tranafer or discharge raqulrad under this section must be made by the facwty at least 30 days before Iha resident fa transferred ordlleharged. (II) Notice must be made ae soon ■1 practicable before transfer or dllcharge when- (A) The safety of Indlvlduall Jn the facllfty would be endangered under paragraph (c)(1)(1)(C) or this section: (B) The health of Indivlduall In the facltlty would	F 823	col'NCtlve action will **be ompllshed** for **those realdentl** und **ta have been affectld bi, the** eficlent **p,ac:tlce?** *S l WothrDJmtor edttsldents 115; 11155 ond non,gotlw* ouacome was *nottd o the lade of written dOt:Umentotlon rnvlded on o /odltt,lnltlomd transfer.* cw you wll Identify other 1'881denta having potanUal ta **beaffecltd br** the aame eftclent practice and what corrective action I **betaken?** *clotWatter (SW) Director c:ompltml* 1001' *It of all ruldenu/Quests transferred to* die *:pltol In the lastJO dayJ who returned to our dllty. SW Director met with each reJldent ontl f'Olllded tlwm with o wrl n tronsfer notlc.. w Dlret:tor unt th1tton,f,r notltt vlo rtJ/IH moll to hospltoliffd tald-,u and otJjled* tire *ombudlmon vloJuon 08.01.18.*	loe.10.18

STATEMEHT OF DEFICIENCIES AND PLAN OF CORRECTION	CX.1J PROVIDERISUPPUERICUA l0ENTIFICATION NUM11R:	MULTIPll COMSTRUCTION	(QJ DATE SURVEY COMfUTED
	111121	AIUUNNG _____ 1 .. \\1fll0! - - - - .. - - -	C 07/1,/1018

NAM& O,PROVIDER OR SUPJILIIR	STREET A00RE8I, CRY, STATE. ZIP' COIJE
THE VIUAGE AT ROCKVILLE	1701 VEIR8 ORNE ROCKVILLE. MD 20850

(Jf.t)ID PR!flX TAG	8\MMAR'I' SJATEIIEIR' OF DEFICIENCIES CIACH DEFICIENCY MUST BE PRECEDliD BY FULL REGUlATOlIY OR LSC IDOTIFYINO INFORMATION)	ID PREfDC TAO	PRCMOEll'I Pl.AN OF CORRfiCTION (EACH COMICTIVE ACTIOM SHOULD IE CR088-AEfERENCEDTOTIE APPROPRIATE DEFICIENCY)	DAtl!
F823	Continued From page S be endangered, under paragraph (c)(1)(i)(O) of thla aecuon; (C) The resldenra health Improves sufflclently to **allow a** more **Immediate** transfer or dl1eharge, under **paragraph** (c)(1)(1)(B) of thlaaectton; (0) An Immediate transfer or dlscha,ge fa required by theresident's wgent medlcal needs, under paragraph (c)(1)(0(A) of this section; or (E) A resident haa not resided in the fllcllty for 30 days. §483.15(c)(5) Contanta *of* the notice. **The written** notice epecifled In paragraph (cX3) of this lectlOn must Include the fallowing: (I) The reason far tranafer or dllCharga: (IQ The effective date af transfer ordllcharga: (ii) The location to which Ihe realdant fa tranaf'errad ordlscharged; (iv) A statement of the reBldent's appeal rtghta, Including the name, **addrea1** (malDng andemaflJ, and telephone number af the entity which receives such requests: and Infonnation on how to obtain an appeal form and asalstanca In completing the form and submitting the appeal hearing request: (v) The name, **addrau** (malling and email) and telephone number af the Offlca of the State Long-Term caraOmbudsman: (vi) For nursing facility residents with Intelleclual and develcpmental dfaablHIH or related dlsabllitlea, the mallfng and emalf address and t8'ephone number of lhe **agency** reaponslbJa *fol* the protection and advocacy of lnclvlduall with developmental dlsabDltfel establlahad under Part C rA the Developmental Dlaablltlh AAJstance and BlH **of Rights Act of** 2000 **(Pub.** L 108-402. codified at 42 U.S.C. 15001 et **NCI,);** and (vii) For nursing facfllty residents with a mental	F823	**Sat meuure1**wlll **be put** Into placeor atayatemlc changea youwlll maketo a&n lhatttaedeficient **practice daft** not ur? *Director In-•Nlced oll Ikenlff nursa on* new *dlschorr,,/rronlfer proadure on .26.JB.* The MW *DCTmnsjer Notke form ntlive on07.JO.JB. SW Director revised ottd 'P(loted the fodllty's pollt:y to «:tnew tons/fr notl/faltlon procedure. Ra/ants* or *eslden s* ***R-„rtMntotlve*** *will bl gltml* **a *DC*** *tonsfer Norlc.within* a *practkol time. Medlall KOrd$ Technician wlll /oil tM DCTrons{er otke* ra *the Ombudtmon.* **the carnctlva actlon(a)** will be **anltored** ID **ensure the** deficient prK1lce Il not rec11r, **I.e., what** quality U8LftIIC8 ram wlll **be put** Into place? *W Dlrlaor will amdua o* 1 0 1111 *month'1 audit altdlsdtorged diam to* ensaue *oU* residents *nd ombudlmon Md o* written DC*Tron,te,* tlce. *Findings will be reponed ot QAPJ mmlttH mntfno monthlyxJ.*	

STATIMENTOI' omct!NCIH *NfO* **Pl.AN 0fl** CORRECTION	CX.1) P AOVIDEMIUPPUDUCUA IOENTif1CATION **NUMBER:** 211121	()(2) MULTIPL& CONSTRUCTION A. BUAJ>IHG•••••••• &.Mla_ -- - - - - -	(X3J DATE 8URYEY COMPlffl D C *01n,no11*

NAME OFPROVIDER OR SUPPLIER	STRiE1' ADDREIS. cnY , ITATE. ZIP CODE
THI! VILLAGE AT ROCKVILLE	11711 VEIRI DRIVE ROCKVILLE, MD 208l0

TAG	SUMMARY STATEMENT OF D&FICIENCIEI (EACH DEFICIEHCY MUST IE PR&CEDEO BYFIILL R!OULATORY OR L8C IDENT1fYING IN10RMATION)	ID PREFIX TAO	PR0VID1:R'8 PIAN OF CORRECTION CORREC11VE AC110N lftQULD BE CROB&-RiFER&NeEDTO TIE APPROPRIATE DEI'ICIENCY)	OSI) I:MII
F823	I Continued From **page 8** disorder or related dlaablllties, the malling and emall address and telephone number of the agency responalble for the protection and advccac:y of lndMduall With a mental dfaatder establlshad under the Protection and AIJvocaey tor MentaJly IU lndlvlduala Act. §483.15(c)(8) Changes to the notice. If the Information In tile noUca changes prior to effecting the transfer or **discharge,** the facility must update the recipients of the notice **as 800I'I** aa pracUcabte once the updated Information becomes available. §483.15(c)(8) Nctica In advance of faclBty closure• In the cue of facluty closure, the Individual who fl the administrator of the faclllly must provide written notlflcatlon *prior* to the Impending claaure lo U,e State Su,vey Agency, 1he Ofllce of the State Long-Tenn Care Ombud Sman, realdenta of the faCINty, and the resfdent rapntsentatlvea, as well as the plan for the transfer and **adequate** relocatlon of the resldanta, aa raqufntd at § 483.70(1). Thia REQUIREMENT Is not met **as evidenced** by: Based an surveyor review of the cllnlcat record, and Intervlaw with faclllty staff, It was determined that the faclllty staff failed to notify a residents' representative In writing when the resident waa sent to the hospital Thia finding wa evident for 3 of 5 realdenta selected for review durtng tlle survey. (#76, #95 and1155). The finding• Include: 1. on 07•18-18 at 10:30 *NII,* surveyor review of the cllnlcal record revealed ttull.rlll5ll,n *t115* wu transferred to the hospital **an——** due to an emergency situation.	F823		

8TA1BENT 01' DEFICIBICIES ANO PI.AN OP C0RRECTtOM	(X1) MOVIDEMIUPPUERJCUA IDEHTIFICATION NUMBER:	(X2'MUL'TIPI!C:ONSTIWCTIOH A BUil.DiNG- • • • • • • •	PQJ DATE SURVEY c:oMPI.ETED
	211121	YIIIJ9 - - - ... - •. - -	C _ 07/18/2018

NAME OFPROVIDER OR 8UPPUER	StREET AOORUS. ClIY,STATE. ZIP CODE
TH& VILLAGI! AT ROCKVILLE	1701 VEIRI DRIVE ROCKVILLE, MD 2DIIO

CXA)ID PREFIX TAG	SUMWJIYITATEIIBITOFIJEFICIINCIES (EACH D&FICIINCY MUST IE PRECEDiO BY FUiL IIEGULATORY OR UC IDENTIFYIHG INFOAMATIOH)	ID PREFut TAG	PROVIDER'S PLAN OFCORRIICTl0N (EACH CORRECTM AC1l0N SHOUI.O 8' CROB8-AEFIAENCIDTO THE APPltOPRIAta DIfICIMCV)	0Cl> COIOU110N D,I,fI!
F823	I Continued From page 7	F823		

Review of the nurse's note, d-t 12:02 PM. rwe&led that resident #75'8 representative was called and made aware of the transfer.

However. theta was no evidence that a documented written notlflcaHon was provided to retldent #75'a representative nor documentation on notifying the ombudsman Inwriting about the transfer ta the hospltat

On 07-18,.18 at 11:10AM, Iha Olredorof nursing (DON) said notification to the residlnt representativewaa given by tlfaphOne; nowritten natfflcation was given to resident #75 or the representativewhen the lransfer accurrwd. The DON alatad that the facility waa woddng to correct this anomaly. No additional fnfonnalfon was provided.

2. On 07-17-18 at 2:30 PM, awveyar review of the clnlcal record revealed **llal.allllPt 185** waa transferred to Iha hospital __,,__due to an emergency situation.

Review of a nurse's note, datad--1:32 PM, revealed resident #95'a aon was called and made aware of the transfer.

However, there WN no evidence that a documented written notification was provided ta raldent #95'• representativenor documentation on notifying the ombudsman In witting about the tranafer to the hoapltel.

On 07-18-18 at 11:10AM, the DON said notlflcatlon to the 1'98ldenl representative wae given by telephone: nowr1tten notification waa

STATEMENT Of O!FICIENCIES ANDPI.AN OF CORRiCT10N	CXQ PAO\IIOERI8UPfILIERICUA IDENT1FICATIOHNuuaeR:	CXZ) MUL11PLI COWITRUCTION A. IUILDIHO / e.WINB...	(X3) DA11!IURVIY COMPl.ffIO
	211121		C 07/1'12011

tfAME OFPROVIDER ORSUPPLIER	STAEEr AIXNIE.81, CffY, ITATI!. ZIP COOi
THB Vft.LAGE AT ROCKVILLE	**1101 YelRB DRIVE** ROCKVILLE, MD 20IIO

CJW)ID PRUDC TAG	SUIIIMMY S1ATIMI!NI' OF DEFICEHCIU (EACH DEFICENCY MUST Iii PAECEDED 8Y FULL REOUlATORY OR LSC IDelffIF'tlNG INFORMATION)	ID PR&flX TAG	PROVIDERS PIANOF CORRECTION (EACHCORREC1M #ICnON SHOULD II! CROS8-Rf!PERENCED10 TifE APPROPRIATE DOICIIHCY)	DAD
F 823	Cantlm1ed From **page 8** given to resident #95 or the representative, when the transfer occurred. The Director of nunslng stated that the facBlty WU working to correct this anomal1. No addltlonal lnfonnatfon was provided. 3. On 07-17-18 at 9:50 AM, Interview with resident #155 revealed the resident **recaDad a** transfer out of the faclllty to the hospltal The resident ltated faclllty staff did not provide written notlftcatJon of tha transfer. On 07-19-18, review of the clnlcal teCOrd tor resident #155 revealed that the resident was ttan_lfMl_d out of the faclllty to the hosp1lal on [redacted] There was no evidence In the dlnlcal record that elth«.resident #155 or hlalher re1ponalble party hArt rAr.Ah/ftd wrlfhln Mtfflr.atJnn af thA tMMnfnr ttansfer out of the nursing faclBty. On 07-19-18 at 2:50 PM. Intervlhl with the director of nUl'llng revealed that faclUty staff Identified non compllance with this requirement. with upcoming ln11rvlce education ICheduled to achieve compliance.	F823		
F8261 SS=E	Notice of Bed Hold Polk:y Bafore/Upon Tmlfr CFR(s): 483.15(d)(1)(2) §483.15(d) Nattc:e **of bed-hold** poOcy and retu,n. §483.15(d)(1) Notice before transfer. Before a nursing facility tranafera • raaldent to a hospital or the resident gon on tl1erapauUc leave, the nursing faclJity must provide written lnfonnatfon to the rnld1nt or resident representative that epedftes- (1) The duration of the atata bed-hold pollcy, ff	F 625	Whi at corrective action **wll N** accomp1 pllahed for lhoN NSIdents foug nclIO **have been afflotld** by Iha defic olent practfce? *S'odOI Watter (SW} Director assessed residents #: , 115, ns, 111291 and 1155 ond no negativt* loutmme *was noted due* ro *the lad of Written raid not(Jlmtlon •fore* the/*otllty rnftfohld troru/er.*	8.10.18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	211121	A. BUILDING _____ B. WING _____	C 07/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ROCKVILLE	1301 YORK ROAD **ROCKVILLE, MD** 20850

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 825	Continued From page 8 any, during which the resident is planning to return and returns to the nursing facility; (II) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (III) The nursing facility's policy regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting **1** resident to return; and (IV) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met **as evidenced** by: Based on surveyor review of the clinical record, and interview with facility staff, it was determined that the facility staff failed to provide written information about the bed-hold policy to residents or the representative **when a** resident was transferred to the hospital. This finding was evident in 5 of 5 resident selected for review during the survey. (#32, #75, #95, # 128, and #155). The findings include: 1. On 07-18--18 at 2 PM, surveyor review of resident #32's clinical record revealed the resident was transferred to the emergency room. There was no evidence in the clinical record that a written bed hold notification was given to the resident or representative with the resident to the hospital.	F 825	**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** *Social Worker (SW) Director completed 100% audit of all residents, to identify residents who were transferred to the hospital in the last 30 days who returned to the facility. SW Director notified them with a written bed-hold notification letter. SW Director will notify the bed-hold notification letter to all residents and the ombudsman via fax on as.01.11.* **What measures will be put in place or what changes you will make to ensure that the deficient practice does not occur?** *SW Director in-serviced all licensed nurses on the bed-hold written notification procedure on 07.26.18. The new Bed-Hold Notification Form went live on 07.30.18. SW Director updated the written policy regarding Resident's Representative will be given a written Bed-Hold Agreement within a specific time.*	

8TAT8Mltff 01' 011'1CIENCIE8 *NG* PLAN OF CORRECTION	CJC11 PRO'AOERIIUPPU&NCUA IDEN11FICATION NUMB&A: 211121	CXIJ MULlIPLl!CONSTRUCTION A. IUILCCNG _ _ _ _ _ &.WING., - - - - -. • • -· -	C)C3JDATIBSURV!V COMPLETED C __ 0711$12011

NAMI!01' PROVIDD OR IUPPUIR	9TA&£T ADCRl88 *art,* ITA11!.ZIP CODI!
THI! VILLAGli AT ROCKVILLE	1101 VERS DANE ROCKVILLE, MD 20IIO

CJ") ID PR&l'lX TAG	8UMMMV **STATIMIHT** Of DEI'ICIl!NCIEI (tACli DEI'ICIENeV MUST BE PRECSII0 8V, uu. REGULATORY OR I.IC IDENTIFYING INI'OAMATION)	ID PREFIX TAO	PRDWlllfa PLNf OP COftRICTION (EACH CORRECTIV& ACTION IHOULDBII **CRDU4dll'IRENCIDTOTHl!APPAOPRIATI** DEFICIENCY)	MTI
F 825	I Continued Ftam page 10 On 07-18-18 at 12:55 PM, Interview with staff#1 revealed that residents on the long term care unit do not require • bed held policy nollffcallan to be sent during transfer to the hospital because they are permanent residents and wlll **elwaye be** accepted back from the hospital when they are ready to ratum. On 07-18--18 at 1 PM, Interview with steff #2 revealed that residents on the long tenn care unit do not require bed hold pollcy notlftcati0ns to be aent during transfer to lhe hospital because they are always accepted bade when they are ready to retum. On 07-18-18 at 2:50 PM, Interview with the Director of Nursing (DON) revealed no new Information. 2. On 07-18-18 at 10:30 AM, surveyor review of the cllnlcal record revealed that resident #75 wae traneferred to the hospital **oniiiiiiliidue** to an emergency situation. Review of a nurse'& note, dated. _.. 12:02 PM, revealed that r e s representative W• celled **and made aware of the** transfer. However, **there was** no evidence In the clinlcal record to Indicate that resident #75 or hlalher representative we• given a copy of the bed-hold pollcy, as required. On 07-18-18 at 3:30 PM, swveyor Interview with the Director of Nuralng revealed that **"we give** the bed-hald policy on adml8810n but not during t,ansfer to a holplla l. We a&waya take our resldenll back from the hDSpita\•. In addition we	F 825	ow the conectlw action(•) wlll be monllored to enlure Iha deffclent practice t-111 not l"ICUr, **I.e.,** wnltquant, assurance prag,am wlll **beput** Into **place?** *Sodol* S.,vb *Dl rtor will conduct* a l *monthlyoudltonresidentstronsfellff to hospitals to* ***ensure*** *dw written bed-hold* I09rHment *wosslgnftl. Findings wlll be ported* at *OAPI Commltttt meeting* **tlllpr.**	

STATEMENT 0, DIPICEHCIE8 AHO PLAN 0, COIUU!CTION	0C 0 PROVIIERISUPPUERICU.\ IDEffIFICATIONNUMIII!R: 21&12&	OCI'J MUL TUIUI COHITWCTION A.IUILOICG,. __ .,. .. _ - - - - WING.,,...	(JQ)DATEIURVEY COMPl.ETEa C 07/1tl2018

NAM.IOFMOVIDOI OR SUPPLIER	STREET ADDRESS. CffV, STATE, ZIP CODE
THI! VILLAGE AT ROCKVILLE	8701 VI!IRS DRIVE ROCKVILLE, MD 208IO

0(4)1D PREAX TAO	8UIINARY 8TA11:M1!'.Hr OF DIFICIENCIEI (I!ACIt DII'ICIENCVMUSTIEPRECeoeDIIY FUU. REGtJIATORY OR L8C IDENI'IFYINO INPORMATION)	10 PREFIX TM	PRCMDER'8 PLAN OF CORRECTION (EACH CORRECTIVI ACTION SHOULD Bl CROSSJIUERENC&DTO'THE APPROPRIATE DEFICIENCY]	0DIIPIETIOH IM11
F 825	Continued From page 11 have also Identified tht& deficient practice andwa are work{ng to correct thl& Nofurther lnfOrmatlon was provided. 3. on 07-17•18 at 2:30 PM, surveyor review of the cllnlcal record **revealed** that resldant **#85waa** transferred to the hoapltal **01rt111••** due to to an emergency altuatlon. Review of a nurse'8 note, date, at 1:32 PM, revealed that resident #95'1 rep,nematlYe was called end made aware of the transfer. However, there was no evidence In the clinlcal record to Indicate lhat resfdent #85 or his/her representative was given a copy of the bed-hold pallcy aa required. On 07-17•18 at 3:30 PM, surveyor Interview with the Director *of* Nursing revealed that **'we give** bed-hold policy on admlllllon but not dwtng transfer to hoapbf. We always take our 1Hldents back from the hospital". Inadditional we have alao identified this deficient practlGe and we are working to correct tflle anomaly. No further Information was provided. 4. On 07-1&-18, review of the cJlnlcat record for rasldant #129 revealed the resident was **ut of the** facility **to the hoapltal on** There waa no evidence In the cllnfcal record that either resident #129 and/or hlllher responsible party had **received** written noUflcatfon of the facllity's **bed hold** policy **at Iha time of, or** wllhln **twenty** four hcurt *of* the holpltal **transfer.** 5. On 07-17 18 at **9:50 *NII,*** Intatvlewwlth	F825		

ITATEMiMT' *OF* DEFICIENCIES AND PIAN OF COM!CTION	(X1) PROVIDEIWUPfILIERICUA IOENTIFICATION tUa!II:	(QJMULTPLE CON8TRUCT10N A . BU1LDING _____	CQJ DATE IUA\/EY COMPl.ITID
	2111H	•WlttO------ .. --	C 07119/U_11

NAME01 PROVIDIR ORIUPPLIEA	STRe&f ADDRIH. crrt,STATE, ZIP CODE
THE VILLAGE AT ROCKVILLI!	1101 VBAIDRIVE! ROCKVJLLI!, **MD 20850**

(X4)1D **PAUIJC** TAG	SUMMARY STATEMENT OF lIEFICli!NCIEI (EACH DEFICIENCY l4U8T IE **PRECEDI!rI BY** FIJU. REOUtATOAY OR UC IDENTIFYIHG INFORMATION)	ID **PRIRIC** TAG	**PAOVIDEA'I PIAN** OF CORRECTION **(EACH CCRIIIC1NI ACTION** IH0Ul0 IE NCEDTOTHE APPROPRIATE Dl!FICIEHCY)	DAll
F 825	I Continued Fram page 12 resident #155 revealed that the resident recalled **e** transfer out of faculty to the hoapltal rheresident stated facllity 1am 1:11a not provide written natfflcatfon of lhe bed hold pollcy at the time of tranafet. On 07-19-18. review of the cllnlcal record for resident #155 revealed that the reaidenl W88 tranefarred to the hospital on - There was no evidence in the cllnleal record thal either resident #155 or hlllher reaponalble party had received written notlficatlan of the facllity'e bed hokf paffcy at the time of, or within twenty four hours of the hospital transfer. On 07-19-18 et2:50 PM, Interview with the director of nursing revealed that the facility Identified non compliance with this requirement. wtth In-service education echaduled to achieve compllance, echeduled to begin an 07-20-18.	F825		
F 8411 SS•B	Accuracy of ASleBlfflanta CFR(a): 483.20(9) §483.20(9) Accuracy of Assasemen&s. The asaeasment must accurately raftect the resldenfa status. ThJ8 REQUIREMENT 1s·not met **as evidenced by:** Based on sutveyor review of cllnlcal record& and lntervlNa of facility **staff and** reaklenta, It **waa** determined that the facmty failed to complete 898888fflents that accurately reflect the reeldenta' atatua. This findings was evident In 2 of 49 residents (#98 & #101) **seJected** far this survey. The findings inclLlde: The Minimum Data Set (MOS) Is a mandated	F 841	tM-t co1"Cdw action WIii be • !lccompllehed for those realdlnla found to **have been affactlld** by the deficient practice? S *OlrKtor conducted onouasment on tu ldtnts 1196 and* llOJ *and der.rmlMd* no *otlv.outmme or furth,r concern,nottd to* the *lno«utate MOS documHtotlon.* *MOS Director correcttd HOlODC (OstomyJ of* e *Slgnljkant Cho• MDS 06/1.5/201.8. MOS* S *rector corr«tffl HOJD08 (Elttemol terJ* lthe *Annual MOS 06/IS/2018.*	08.10.18

8TATEMENTOF DEfICIENCIES AND PLAN OF CORRECTION	(X1) PIICMDIRISUPPLIERICUA ID2NTIFICA110N NUMBER:	(X2)MUI.11Pl.E CON8TRUC'110N A IUII.DING _ _ _ _ _ _ _	.CU)IMIE snwEY COMPLETE0
	211121	.8 Wlfill - - • - - - - -	C 0711912018

NAMI *0,* PRCMDiR OR IUPPLIIR	STREET ADDR!l8. CITY, STATE. JIP CODE
THI! VILLAGE AT ROCIMLLE	9701 VIIRS DRIVE ROCKVILLE, MD ZOIIO

TAG	&EACH DEFICIENCY MUSTBE PRECEDED BY AUU. SUMMARY 8fATEMEHT OF D!IICIENCIES REGUIATORVOR L8CIDl!NTFYING IHFORMATION)	ID PREFIX TAG	PRCMD&R'8 PLMOF CORRIC110N (&ACtf CORR£CIM ACTION IHOULOIE CROSS-REFERENCl!DTOTHSN'PROPRIA'TI! DIPICIINCY)	COM=- aAT&
F841	I Continued From page 13 procua for cllnlcal 81888Bment of all residenta In Medicare or Medicaid certified nuralng hOmea. This Pft1C889 provides a comprehensive and accurate aaaeument of each raslдent'a functlanal capacity and health status to assist nursing home staff InIdentifying health problems. MOS aasesamanta are required for realdentl en admI11fon to the nursing facility and then perlodlcally, within specific guldellnes and Ume frarnu. 1. On 07-16-18 at 3 PM, aurveyor revlaw of resident #98'1cllnlcal recon::I revealed that Sectlan H of the quarterly MOS, ■**ubmltted on** 08-15-18. **waa coded** stating that **raslдent '98 had** an However, surveyor review of the clinical **record** revealed no evidence that resident **188 had an** on that data, or ever had an on07-17-18 at12:30AM, aurveyor lntetvlew with the MDS supervisor revealed lhlt the staff member who ceded the MOS for residents #98 on 08-15-18 was anew employee, and Incorrectly completed Section H. 2. On 07-17-18 at 10 **AM, BUNayorrevlew** of resident #101's cRnlcal **record revealed** Section H of the quarterly MOS, aubmitted on 08-15-18, was coded stating resident #101 had an ostomy (an ostomy la a surglcal procedure In which an artHlclet opening is made ao as to permit the drainage of wasteproductl either Into an	F 641	H *OIi* rou wtrl Identify **otherrHldell18 having** th • potantlat **to be affect8d llr ttle HffIt** detic lent prac:tfce and what corrective action will **betaloln?** *Mlros Dltector mndua, don audit for Section H of/ollComprehlns/11t1MOS$ In tli. lost30 days to ffISCllf! aca,,oqof tM MOS cmeuments inc duding urlno,y and boMI appllanas.* **What fflIHUNI** wll **be put** Into place or what 1tayatamlc chang.. youwlDmake to ena **18Unt lhat the** deficient practice doee not reci ur7 *MDS Director In-sttvktd ta atl MDS Coo ordlnotan on01.l9.l8 ono a:urote MDS data ,nr,y and o.sussm,nt.* 8)' OB.JO.JS *GNAs will be ln-s,tvla on* accu,om *doeum,ntotlon.* MF *rom MOS Coordlnotars will partner with Oinleo/* ted *to nrvlewRnlT1m1 dolly* to *monltorllrtd* odt drl a the *tnor:curare documenrotlons* focu *'sing on urlnor,and bowel appliances by* GNA *NA$.* **What**,t **meaaurN** wlll **be put** Into placeor **what**.t ayatamlc **changn** youwfll make to **ensi unt that the** deflclent **practice don** not **rec** cur? *MDS Director will conducta J mantllt, out tilt of Section Hof all Comprehtnslw* MOSs *lor nd report findings to* tllt Q4PI *month/yd.* 1-	

STATBl!Nf OF DIfICl!NCll8 ANO PLAN OF CORIIECTION	OC1J PRCMOEMIUPPUERICUA IDEHT111CATl0N NUMBER:	(1(2) MUI.TIPLE CONSTRUCTION	QCa) CMTE SURVEY
	211126	A.BUILDING,_____ I.WINO_ -	COMPIETED C 0711 112018

NAME 01 PRCIVIDIER OR SUPPLIER	8TR&T ADDRE88, CnV, STATE, ZIP CODE
THE VILLAGE AT ROCKVIU&	8701 VIIR8 DRIVE ROCKVILLE, MD 20IIO

CX4) ID PA!FDC TM	SUMMARY STATEMENT 0, DEPICIENCIEI (!!ACHD!PICIENCY MUST BE PRECEOED BY FULL R&OUiATORY OR t.SC IDENTl!'YIHG INFORMATION)	ID PREFIX TAG	PRCMOI!R'8 PIAN OF CORRECTION (EACH CORRECTIVE AC1I0N BHOULO 8E CROSl,IIEFEIIINCED TO THE APPROPRIATE OEFICIEHC'tl	CICI) TI
F 841	t Continued From **page** 14 appropriate organ or outside the body), However, review of the cUnlcat record revealed no evidence that resident #101 had en oatomy or had ever had anostomy. On 07•17-18, aurveyorlnteJvlewwlth the MOS supeNlsor revealed the staff member who coded the MOS far resident #101 an 08-15-18 was a new employee and Incorrectly completed Section H . Following surveyor Intervention, on 07-17-18, the MOS lnaccuracfas **were corrected** for residents #98 and #101.	F641		
F 7571 **SS•D**	Drug Regimen Is Free from Unnecessary Oruga **CFR(s): 483.48(d)(1)-(6)** **§483.45(d) Unnecesaa,y Dn,ge-Genetal.** Each resldenra drug ,aglmen must **be ftN** from unnecessary drugs. An unnecl888ry **drug Is any** drug when used- §483.45(d)(1) In **excessive dOle** (Including duplicate drug **therapy):** or §483.45(d)(2) For excessive duradan; or §483.45(d)(3) Without adequate monitoring: or §483.4S{d)(4) \Nithout adequate Indication, for itl use; or §483.48(d)(5) In the presenca of **adverse** consequences which fndlcate the dose should be reduced or discontinued; or §483.45(d)(6) Any comblnauons of the reasons	: 757	**W**hat corrective action wlll be **accom**pllahecl for **those mldentll** **found** to **have been affected** by the **defici**ltnt **practice?** **Me**d/tol Director assnnd Ra/dent I 16, **de**etennlttd nontgadw! ouccome wos noted **du**ue the ptDlattgtd use of PfOl'h'lloxls **M**ouodantln. Medleol DllfftOr reviewed **Re**es/dent's mrdatlans and dHmed ssory **thi**hat ttr.raldenteonrlnffs toltlng the **met**dlcat1on. **How** you wll ldantlfy other **realdenta having** **tha**le **potential** ID **be affected by th-• ■me** **defic**:**c1ent pr,ctlce and what col'NCtlve action** **will** ill **be taken?** **On**n,, 07.30.18, Mfflcol Otrector eonducted o **10**OOl¥ audit of residents with ontlblatlc orders **for**,, greater rhon 2 weeks. The Medlcol Dlrec:tor **ide**entlfted twsldents who hod an ontlblotlc **or**rdeml /orgffoter than two weeks ond **review**wed order/Dr approprlateneuof the **cont**i/nued ontlbtotk, ond compllonce to our **Anti**tlblottc Stewardship Pro,rom.	Ol.10,18

8TATEMI£NT Of' DUICIEHal8 *MID* Pl.AN 01' CORRIICTION	OUJPRO'IIIDENIUPPUERICUA IDaNTIFICATION NUMl&R:	OC2) MULTIPLE CCINITRUCTtON A.BUILDING _____	OCSJ DATE 8UIlYE't COMPLETED
	211121	LWING_ .. - - ... - - - -	C 0711tl20l8

NAM£ OP PROVIDER OR IUPPl.ll!R	STREET ADDAUI, CITY, 8TAff, ZIPCODE
THEVILLAGEATROCKVILLE	1701 YEIR8 DRIVE ROCIMLL&. MD 208IO

CX4J ID PRIl'IX TAG	SUMMARY 8TA'11!MENTOPDEFICIIHC11!9 (I!ACH DIPIC,ENCV **MUsr N PREC!O&D** IIY,IIULL IIEOUI.ATOA'tOR I.SC ID!NTl'YINGIN,ORMA110N)	ID **PRIIIX** tAG	**PAOVIDl!R'I Pl.AN** Of CORRECTIOH (IACH CORAIC1M! AGTl0N 8HOULOIE ClIOSI-IIBPMIMCIDTO THI APPRDPRIATe Dll'ICIENCY)	1,111) CDIPl.&TION l».TI

F 767 I Continued From page 15

stated In paragraphs (d)(1) through (5) ofthla section.
This REQUIREMENT la not met **aa evidenced** by:
Based on 1urveyor review of cllnlcal record• and interviews with facility staff, It wu determined that the facility failed to ensure residents' dn.19 regimen• were free from unnaceasary drugs. This waa evident In 1 of 8 realdent1 selected for this survey (#98). The findings Include:

On 07-18-18 at 1:45 PM, review of resident #98'1 cllnlcal record revealed that ha/ahe **hat been** taking an antibiotic since 09-15-18 for urfna,y tract lnfactlon (UTI) prophyta,da or p19V811tlan. Further review of the clinical record revealedthat resident ne last **saw a** urologist on 09-27-13 for aUTI.

On Q9..01-18 1 realdenfs #88'1attendingphysician documented that the resident had a history of recurrent UTII. There was no further evidence of cllnlcal documentation Jultifylng the continued uaa of the antlblOtic far UTI prophylaxlaalnce 0.01•18.

Review of the facilty'a antibiotic stewardship program revealed that anUblDllc orders mu1t Include the duration of treatment aa Indicated by a start and stop date, or number of days of therapy.

Thant was no evidence that a durauon of treatment waa specified for resident #98'& antibiotic usesince 09-15-18.

On 07-19-18 et 3 PM, lntsrvlew **with the** Director of Nursing (DON) revealed no new fnforrnetlon.

F 757 **Wha mea■uraa will be put** Into **place** or **what** cyatemlc **changes** i,ou wlllmake to **ensure that the deficient practice don** not **recur**?

Medi' DIreaor /n-Sfflllmd ph,sklons and an 'our Antibiotic Stewardship Polle,.
Pro 1;,l,1/octfc *antibiotic* orders *wJIl have a stop dat 'ote of one year, and documentation wlH nud to re/Ifft on annual nMew of ntasslty of the me dlmtl_on. AJJ phylldom 1ducoted on da 0..:umentotlon In POS and srop dotes.*
Medi 1co/ *Dltcctor wUl partner with Consultant phan* rmorut *ta ldentlfy unnett1111ry medl* 1edlt:0tlons.

How the coffllClfwe IC:llon(•> will be mon anltoNd to enaure tht deficient practice will n notrecur, **I.e., what quality ... urance prog** ram wlll **be put** Into **place?**

Me 'edlcol DlrKtor will conduct *o* **ZOO•** *monthly ou udlt of 111/dents with ontfbfotla* ***ordered*** *to en* nsute *there Is opp,optlote documentation of the i lndlt:atlon* ***and stop dote.*** *Flndl9 wlll be repo on.d to the fadlltv QAPI* mmmlttee *mont thf1"3,*

c==1

STATEMENT OF OEFICIINCES ANDPIANOF CORRICTIOH	OU)PRCMDEIWUPPI.IERICUA IDINTIRCATION NUMBER:	OCI) MULTIPLE COHSTRUCTION	(Q) DATE SURVEY C0MPI.ETID
	211125	A.IIUILOING • • • .. - .. • • IWlftO_____ -	C _0'7119/1018

NAM1! OF PROVIDER OR 8UPPLIU	ITR!ET ADDRESI, crrt,STATE. ZIP CODE
TH£ YA.LAGE AT ROCKVILLE	1701 VERIDIIIVI! ROCKVIL.Lm1 11D 2DIIO

0C4)1D PREN TM	SUMMARY STATEMENT OFDEFCCIENCES (IACH DEFICIEMCY MUST 81 PRECEOeD BY PUU. REGULATORY OR L8C IDeNTFYING INFORIMTIDN)	ID PREFIX TAG	PRCMDER'B PLAN OF CORRECTION • (($\CH CORRECTIVE ACTION SHOULD II! CftOIS.REffRENCE TD'THE APPROPR TE DEFICIENCY)	MTE
	F 758 Continued From page 16 F 758 Free *trom* Unnec Paychot,oplc Meds/PRN u,e SSaO CFR(a): 483.45(c)(3)(e)(1H5) §483.45(a) Psychotropic Drugs. §483.45(c)(3) Apsydtotroplc drug la*8l'lf* dtug that affacta brain activities as1oclatac:I with mental procanes and behavior. These druga Include, but are not llmtted to, drugs In the follDWlng c:ategortea: (I) Antl sychotlc; (II) Antkfapressant, (lli) Anti-anxiety; and (Iv) Hypnotic Baaed on a comprehensive asseaament of a resident, the facility must ensure thllt-- §483.45(e)(1) Rnidents who have not uaad psychotropic drugs Int not given these dNQI unless the medlcalton ii necneary to treat a specific condition as diagnosed and documented In the dlnlcaf record; §483.45(e)(2) Residents who use psychot,oplc drugs teeelve gnadual ctose reductions, and behavioral Interventions, unlua cllnlcally contraJndfcated, In an effort to discontinue these drug■; §483.45(e)(3)Residents do not receive psychotropic drugs pwauant to a PAN older unle88 lhat medication Is neceBIBry to trot a diagnosed specific condition tha118 documented In the cllnlcal record; and §483.45(8)(4) PRN orders for psychotropic drugs are limited to 14 days. Except aa provided In §483.45(e)(5), If the attending phyalefan or	F 7585 F 758	hit carrectlve action wlll be **ccompf11hlld for._fclen19 ound to have been affec'lltd** br the clant **practice?** *ldlarl Dlrec:tor assessed sldent 1141ond no egotilo'lt ouacome wos noted due to the ,esldtnt hollInQ o PRN psychotropic Jr,rQrtattr thon* 14 *da,s. Mftl1col Director discontinued thf. IPRN medlt:atlan.* 5 you wlll **lclentlfr other INldents having** potential to **be atrectacl** by **the ama** effclent practice and what conctiva action **l'letakan?** e *In:1:11 Director conduc:r* Jcro,& *audit of tnts who had o PRN psydtotropk tcotlon ordered. Relldents wlrh an ardtr for o PRN pqchotmplt/or greater tllon 14 days lw,11be assessed and orders modified ccordingly by 08.10.18.*	08.10.18

STATEMENT 01'DEFICIENCIES AND PLAN OF CORRECTION	OC1)PROW)(MUPPLIERICUA IDENTIFICA'I'IOH NUMBEIt	A.BUILmNG. MUI1IPI.ICONITRUCTION	(.X3)DATE8UfNEY COMPLITEO
	211121	I.WI - -	C 07/1"2018

NAME OF PROVIDliR OR &UPPLIER	mm AOOAUS. CITY, STATE. ZF cooe
THE VILLAO! AT ROCKVILLE	1701 VIIRS DAIVI'. ROCKVIU.E. MD 208ICI

(X4) ID PREfIJ(TAG	$Ul't9MRYSTATEMENTOl'DUICISICIEI (EACH DEFICIENCY MUST Bl,REC&OIID BY FULL AEGUIATORV 011LSCIOENTIFYINO INFORMATION)	ID PREFIX TAG	PROVID!R'I Pl.AN OF CORfIECTIOH (EACH COM!CTM!ACTIONSHOULD BE CROSS-RE1ERSICEO TO THE APPROM!f.TE D!FICIENCY)	MTE
F 7581	Continued From page 17 p181Cribing practltfonar believas that It **la** appropriate far the PRN order to **be extended** beyond 14 days, ha or she 1hould document their rationale In the mldenr1rnedlcal record and lndJcate the duration for the PRN order. §483.45(a)(5) PRN order& for anti-psychotic drugs are limited to 14 days and cannot be renewed unlea tha attending physician *or* prescribing practitioner BYBluatea the resident for the approprlataneu of that medication. Thia REQUIREMENT la not mat • **evidenced** by: **Based** on surveyor review of th• cllnlcat record and interviews with facllity staff, It was determined. that the fac0lty ataff falled to docUmant a detannfned duration for tne use of a PRN (as needed basis) psychotropic medication beyond the orlglnal 14 days. This finding was evident rn 1 of 8 residents selected for tna Unnecessary Medication Review (#47). The findings Include: On 07-18-18, surveyor review of the cllnlcal reeotd of resident 1147 revealed that the reefdent was admfttad to [redacted] facility from **en acute** care hosplta! on [redacted] _tilth a prescription *for* AUVan 0.5 mg **every 8** hours, **as need** for **agitation** or **anxiety.** Further record **review revealed** that the pharmacy"s Medication **Regimen Review (MRR)** ror May os.10-201e through 05-31-2018, **revealed a pharmacy recommendation advising** that -r0r PRN **ordera used paat** 14 daya. the prescriber must doeument their rational In the medical record far continued uae and Indicate the duration for thla PRN order". There was no evidence that the orlglnat	F 758	**Wh**It **ffIN8UI"N** wlU **be put** Inta **place Of what** Q8temlc changes rou wlllmake to **e neur**e thatthe deficient practice doN not **recur**? ***Medk**ol Director will Implement o new **process**: all psydtottoplC* medfcatlo,u *will hove on ou*tomotk ***stop do** of 14 d11y1. All **asych** otropk medlcotloM will hove oltondlng **with** an Ind/mt/on. End dotes eon W renewed **ondd**documentation put In resld1nt'1 chart. All **ohysl** nr andNPs will be educated on)tlocvmentotlon lit POS ond sCOp dotesby **08**.10.18. Med/col Dlret:tor wlll portttttr with **asycho**,gerlottlc **1roup** and pharmacist **consul**,tont ro1110luote all resld•nts on **asycho** tn,plc both Jtondlng and PRNs.* **How the corrective actlon(e)** will be **monltored to ensura the deficient p,actlce w**UI **not recur, I.e., wllatquallly usurance** IDroarlm wlll **be put Into plaae?** ***MIdloJI** Director w/11conduct **o100M** monthly **ou**dlt of RUldena'pqd,ottoplc medlcof/ons, **ensure** psychotropic medk:otlons hOtle the **appn**optlate lndlmtlon and stop dottsof J4 **days**. Findings wlR I» reported to the focJltry **QAPI** month, V.d.*	

STA'TliMl!Hf Otr DllfCIEHCIE8 AND PI.MO,COMECTION	()C1)PIIOV105'11UPPUEM:UA mE#I'IPICATIONNUMBER: 211121	OU MULTIPLE CONSTRUCTION A. BUii.DiNG._____ 8. WINO...,_____	ClC.Il DATE 8URVEV COMPLE1'iD C 07/1912018

NAM!o, PROVIDER 0A SUPl'UER	STREET ADORE88. crrY, ITATa. ZIP CODE
THB YIU.AG& AT ROCKVILLE	1711 VEIRI DRIVE ROCKVILLE, MD 20110

QC) ID PREFIX TAO	SUMMARY aTATIMINT *OF* DEFICl!NCIEI (EACH DEFICIENCY **MUST Ba!** PRECEOEO BY FULL REOUlATORY 0Jl LSC IDIHTFYING IHFOIUMTION)	ID **PR!FIX** TAG	PROVIDER'S PLAN OFCOMECTION (fM;H CORRECTIVEACTIONSHOULO BE **CROQ.REI'ERENCI!DTO** THE **APPROPRIATE** DEFICIENCY)	IMTe
F 758	IContinued From page ,a prescription order was written with a atop date 1 days a1ter admission to the facllity, as required tori a PRN psychcttoplc medk:atlon. Review of the May, June and July 2018 MAR• (Medication Administration Record) revealed that staff admlnlatered one PRN dose In May, five PRN doses In June, and no doses through the current survey date In the month of July. On 08-19·18, the CRNP (Certified **Regratered** Nurse Practitioner) documented on the pharmacy's MRR that the •reatdent had to take Ativan 5 times In the monlh of June, last given 08-18-18 for severity or target l)'mptoma and agitation•. The CRNP signed the document as "noted and reviewed •on 08-19-18. However, there was no evidence that the nurse practitioner lnduded a stop date for the medication in th11 review. On 07-18-18 at 10:30 AM, Interview with staff #3 revealed that resident #47 did have occasional behavlcra that were conalstent with the need for use of a sedative mec:llcatlon. which was evallabte for this resident In the automated dispensing system. On 07-19-18 at2:30 PM, Interview with the Director of Nursing provided no additional Information.	**F758**	**5 aofflIGtfva action will be compllahed fDr 1hoH resident& ncl to have been affectad by the lent practice?** *lttQ Manager comp r«I o* lotM *audit* of *the khen and r:ornpl«ff tt. follow/no: discarded* open,, *unlohl«I container of* lce tftl *ond 'll of mu/Jlr,s. Dlscotd«l the open, unlabeled ttle of honey., vinegar# ond Oreo noodln, fnu•n boxofvesetoble* cookies, *and bqels t* w.re *on* the */IOOt.*	**8.10.18**
F 812 SS-C	Food ProcurementStore/Prepare/Serve-Sanltaty **CFR(s):** 483.80(1)(1)(2) §483.80(1) Food safety requirements. The facility must •	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF C0RRECTION	(X1J PROVtDeAllUPPLIERICUA IOSmFICAllON NUMBER:	(X2' YUlTPLI COHITRUCTION A.BUii.DiNO_____ - -	(QI IMTE SURVEY COMPLETED
	211121	I.WING_ - - - - - - - -	C 07/18/2018

NAME 0, PRCMDIR OR SUPPLIER	ITRHT ADDR£88, CITY, 8TATe, ZIP COO!
THI! VILLAGI! AT ROCKVILLE	17Dt VERB DRIVE ROCKVILLE, **MD 20880**

(X4) ID PRS:IX TAO	SUMMARY BrATEMENT OFDEFICIENCIES (EACH DaFICIENCY MUIT IE PRECEDED BY FUU. REGUlATORY 0R LSC IDENTIFYING IIFORMATIOHJ	ID PRI!FIX TAG	PROVIDER'S PLAN *OF* CORRECTION (eACH COARECTMi AC110N IHOULD BE CRoss.RiFERENCEOTO THE APPROPRIATE DEIICIENCV)	DAR
F812	Continued From **page 19** §483.80(1)(1) - PRH:Ure food from sources approved or considered satisfactory by federal, &tate or local authoriUea. (I) This may lncfude *food* lten,s oblalned directly from local produce,s, subject to appUcableState andlocal l8W8 or regulatlons. (II) Thia provision does not prohibit or pravant fBcilltles from ualng produce grown In facJllty gardens, subject tocompllanca with applicable safe growing endfood-handling practices. (Ill) This provlalon does not preclude residents rrom consuming foods not procured by theflcllty. §483.80(1)(2)- Store, pn,pare, distribute and aerve food In accordance with pn:nsalanal standards far food service safety. Thll REQUIREMENT Is not met **M evidenced** by: Based on surveyor obaeNatlon and staff Interviews, ftwa1detennlned ttlat the facWty staff failed to store, pnipartt, and serva food under sanbry conc:lHlona. This finding was evident In the facllity's kitehan during the auN9Vot1lntllal tour. The findings Include: On 07-18-18 at 8:30 AM, surveyor oblervatlon of the kitchen with the fOOd N1Ylce manager revealed an opened container of Iced tea In a reach-In refrigerator with no opened datemartcad, an opened box of mufflne In a reach-in **refrigerator** with no opened **date marked, an** opened bottle of clover honey In the pant,y with no **opened date** marked, **an opened** bottle of vinegar In lha pant,y with no **opened dale** marked, and **an opened** baX *of* Orzo noodles In the pantry with no opened date marked. Surveyor observaoon of the walk-In freezer revealed a box of vegetables. a box of cooldea,	F 812	H'''' JOU wlll lclenllfJ other relldenl& having th• patantfat to **be affed8l** by the aama deflclent pnactlce and what comtallve action will **be laken?** *Dlitllng Monog,rcondudld JOO.audit o/all theteodt-ln ,e/rlg,n,tots.dr, goods sroro,e room, and /f'ffle;toensun: au pmducts .,,.,. opprOPrlatd/ ltOred and lowllff.* **What meaSUNS** wiU **be put Into place or what systemic changea you** willmalceta **eneuN that thedeficient practice doea not re**lcur? *Dlining **Mana,,rkHavlctd to**oll **ldtdre11sttll/** be*fftltlffn *01.21.JB and 01.30.18 on proper food storage, food la•llno, ond new doily check* /1st **How the corrective ac:llan(a)** wHl be monltarad **to ensure the** deflcl•nt **practice** will not recur, **l.e., what** quallty **INWllnce** praaram wm be put Into place? *Dlnlng Monoger will conduct* JOO,C *WHk/y* audlts*focusing on food ,to,og lobe/lng, and d'ally checkllst* compldlon *toensure* appproprlottl *food storage and doting proctlca. Flndlngs will* **N** ***Nported*** *to the QAPI* commlttu monrlutJ.	

STATEMENT o, OEFIC U ANOPLANOFCOMECTICIN	(X1J PROVIOERISUPPUEM:UA IDiN11FICATIOH NUMBlft	CX2) MULTIPLE CONSTRUCTION A.fUILDIHO _____ B. WINQ_, -:-- _ .. _ - - -	1(1) DATI SURVIY COMPLETE0
	211121		C 07/19/2018

NAM!OFPROVIDER OR SUPPIER	SIREET ADDRESS, CIfY, IfATI. ZP CODI!
THE VILLAGE AT ROCKVILLE	1101 vau DRIVE ROCKVILLE. MD 208IO

C,W)ID PREFIX TAG	IUMMMY STATEMENT OF DI!.FICIENCIEI (EACH DOICl&NCY MUST IE PRECEDED IY FULL REGUIATORY OR USC aiNTIFYING INFORW.TIOH)	ID PIU!FIX TAO	PROWJ&R'S PLAN Of' C0RREC1l0N (&ACHC0RAEC1NIAC110NIH0ULDIE CR088-flEFEJIENCITO1Hli APPAOPRIATE DEFICIENCY)	COM DATE
F 812	I Continued From page 20 and • box of bagela s1Drad dlrectly on the floor of the freezer and not on an appropriate atorage unit Surveyor lnfeNiew with the food service manager revealed the facllity has an ongoing Issue wllh unlabeled opened packages of foOd and the atalff are working an the lasu.. On 07-16·18 at 2 PM, BU1Veyor Interview with the administrator revealed no new lnformallon.	F 812		
F 880 SSi=D	lnfactlan PrevanUon & Contra! CFR(s): 483.80{a)(1)(2)(4)(e)(f) §483.80 lnfec:tlon Control The facllity must estabUsh and maintain an Infection prevention and control program designed to provide **a aete,** sanitary and comfortable environment and tohelp **prevent the** development encl tranamJsslon of communfcable dlMaaas and Infections. **§483.80(a)** tnfactlon preventton and control pragram. Thefacfllty must 89tabllsh an infection prevention and control program (IPCP) that must **Include, at** a minimum, the followlng elements: §483.BO(a)(1) Asystem fer pravantlng, Identifying, **reporting, Investigating, and** controtllng lnf ons and comnwnlceble df18818s for all **residents,** staff, volunteers, Visltora, and other lndivlduals providing **services** under • contractual arrangement **baled upon** the facllity **assenment** conducted **according** to **§483.?0(e) and** following **accepted** natlonal **standards;** **§483.80{a)(2)** Written **llandarda, poBcles. and**	F880	cam,ctlve action will be camplleh**ed** for**thON mldanta** round to have been affNbtd by the deflclent practfce? *eJldent1115* wo.r GJSfffff *by DON ond cho,oe* 11,se. *No nqotlve outcome or further narn.r* we,e *noted a.r o result of tM 01(Ygen bin,not 1»11111 stDrtd In "" whHe not In UII* r,w youwtn Identify othar **raldenta having** • potential to **be affecfad br the eame** flclent **praGtlce and** what conectlve action I **betaken?** *m Monoprr completed* Joo,t; *audit of oil m.rfocuslng on properitoror,eo/or,gen t,lng while not In* use. *Residents who relldtd* ...e *ordm for pm 11.rt of IM)'len hod* the *tentfol to be affected. No funh,r Improperly* HulWd *tubing* wo.r *ldentf/led.*	k)8.10.18

laTATEMENT OF DffICIENCIU IAND PLANOFCORRECTION	(X1) PRCMDERI8UPPUERICUA IDBffIFICATION _.UMIIER:	(X2) M.ILTIPLE COHITRUCT10M	•rDAT& COMPLETED
	211111	WltUI - - - - - - - - - - - -	0'1:;9/JG 1 1

NNM OF PROWIER OR SUPPLIER	ITIU!ET ADDRe8S, CrTY, STATE. ZIP CODI
THI VILLAGI AT ROCKVILLE	'101 **VEIRI DRIVE** **ROCKVLLE.UDZ08IO**

(M) ID PREFIX TAO	SUMMARYITAT!MIHTOF DIPICIENCIEI (EACH DEFICIENCY MUST II **PRICIDIID 1ft'** FULL AE®LATORY ORIIC IDSmFVINO INFORMA'T10N)	ID **PRIfDC TAO**	**PROVID&R'I PLAN OF** CORRECTION **(EACHC0RRe:CTIWACTION SHOUID BE CR0II-REF£RI!NCIOTitEAPM0PAIATE** DEJIIICIENCY)	**IMTI**
F 880	Continued From page 21 procedures for the program, which must Include, but are not limited 10: (Q A system of su,velllance dallgnad to Identify possible communicable diseases or Infections before they can spread to other parsons In the facility; (ff) When and to whom possible Incident& of communicable dleease or Infections ehould be reported; OH) Standard and transmission-baaed precautfcns to be ro!Jowed to prevent spread of Infactlana: (Iv) Whan and how Isolation should be used for a resident; Including but not limited to: (A) The type and duration of the lsolltlon, depending upon the Infectious agent or organism fnvolVed, and CB) A requirement that the Isolation should be the east reslrictlve poaslble for the resident under the dR:umstsnces. M The clrcumatancea under which the facllity must prohibit employees with a communicable disease or Infected skin lellons from direct contact with residents or their food, If direct contact will transmit the dl88818; and YI) Th• hand hygiene procedures to be followed by staff Involved In clract raaldent contact. §483.80(&)(4) A system for recording Incidents dantfflad under the fac:Hfty'a IPCP and the correctrve actfona taken by the fac:lfty. §483.80(e) Linens. Personnel must handle, store, procesa, and transport linens so as to prevent the spread of nfec:Uon. §483.S0(f) Annual review. The facility wlH conduct an annual review of lta	F 880	,nuit me■1ura wUI be put Into place or ■t aye tem lc ctaangee yau **will make** to **n& UI9 lhat the deftclant practJce does** otrecur? *of Nursing ond Nurse Manager MJe,v/ced oll stoff on pt0per storoge of* qg4tn *tubing •n not In use.* ow the corrective actlan(s) wlllbe toen1ure the deficient practlc. not recur, I.e., what quality ■N urance ram wlU be put Into place? *Dltffror of Nursing will* t:oncfuct 1 *rpontll,,oud/U to ensure pro,-r* lffol'Ofe *of qiygen tubing when not In* use. *Flndllt(IS will* u *'ff.o e'd to Jadlltr QAPI* eommlrrH *monthly*	

STATEMENT Of DUICIENCIIS **AND Pl.AN** OF CORRECI'ION	(11) **11ENTFICA110tj NUMl!lt** 21&121	(121MULTPI.E C0NSTRUCTl0H **A** BUILDIN-.,.. **a, WINQ**_ ., ., - - - - -	(X3J DATESURV&V COWi.EYED C **07/19/2018**

NAME Of PROVIDER OR SUPPLIER	STRUT ADDRUS. CffY, 8TATE. ZIP COIJE
THE VILLAGE AT ROCKVILLE	8701 VEIRS DRNI! ROCKVILLE. MD ZOIIO

(X4)1D **PMIOl** lAG	SUMl'AARY STATEMENT OF DEFICIENCIEI (EACH **DIEl'ICIINCY MUST IE PRECIDID** IV RILL Rt!GULATDIW OR L8C **I>ENTIFYll!i IMl'OAMATION)**	ID **PR&Fll** TAD	**PROVIDER'S Pl.AN** Of COMI!CTION **(EACHC0RRECTIWACTION**SHOULD ae CROSI-RIFERENCIDTOTHE **APJIROPRIAT!** OlflCl!NC\')	**(XI> COIIIUpoN** 0».18
F 880	I Continued From page 22 IPCP and update their program, as neceaury. Thia REQUIREMENT le not met as evidenced by: Baaed on surveyor review or the cllnlcal records, observation and facllty ataff Interview, It waa detennined that the facllity staff faflad to provldaa safe. aanttaty and comfortable environment to help prevent tha development and ttansmlulon of dleease and Infection. This was evident rn 1 randomly Identified residents out of 11 retldants selected for nwtaw during the survey. (#75). The findings Include: On 07-1fS.18 et 08:30 AM, surveyor tour to resident #7f/s room revealed oxygen tubing connected to an oxygen tank. The tank was In■ leather pouct, hooked behind the resident's wheefchalr. The wheelc:halr waa stored In the r81idanra bathroom. The tubing was observed on the floor with the nostril aectlon (the tip that goee Into the noee) lyrng beside the toilet bowl. On 07-16-18 at 1:10 PM. additional tour to resident #7S1,aom 1'8Vealad oxygen tubing connected to a oxygen concentrator (a devtce whlctl concentrates the o,cygen from the surrounding air). The tubing wae ob88Mld on the *floor* with the nostril sectJon under the realdenra **bed.** surveyor review of the cllnlcal records for resident #75 reveafed a physician order that stated,"Store nasal cannula/mask In plaltlc bag H not fn use". However, facillty staff failed to store the oxygen tubing In **a plastlc bag 88 Indicated** In the ohplcian order or safe lnfacUon control practiCfl.	F880		

STATEUEHT OF DU'ICIENCIES AND PI.AN *OF* CORRECTION	(JC1)PRO\IID!RISUPPLI!RI'CUA lctamFICAT10N NUMll!lt	(XIJMULTPI.£ C0NSTRUCTI0N	CX1J DATE SURVEY COMPI.ETED
	211121	A.IUI.OltO_ - - - - - - - - B.W:NQ.,._ - - - - ... - - --	C 07/1912018

NAM& *OF* PROVIDER OR SUPPLIER	8TWT AOOREIS. ,;rrv, STAT&. .,. CODE
THI! VILLAGE AT ROCKVILLE	9701 VEIRI DRIVE ROCKVILLE, 111D ZDIIO

(M)ID PR&FIX TAG	SUMMARY 8TATEM!HT *OF* DEFICIEHCIES (EACH DIACIENCY MUST BE AAECEDED BY FULL REGULATORY OR L8C IDBffIFVIHG INFOIUMTION)	ID PAIfDI TAG	l'ROVID!R'I PLAN 01' CORRECTION HCOJtRECTIVIACTION **SHOULD 8li CROl&REFERENCED** TOTHE APPROPRIATE **DEFICIENCV)**	CXII CGMIU'I10N DAT&
F 880	I Continued From page 23 On 07-18-18 at 2:12 PM, surveyor intetvlew wlh the Director of Nursing revealed that the oxygen tubing was to be slol'8d In a plastlc bag when not Inuaa. No addltlonal lnformaflon waa provided.	**F880**		
F 943 SS-0	Abuse, Neglect. and Exploltallon Training CFR(s): 483.85(c)(1)-(3) §483.85(c) Abuse, nagtect. and e,cplottatJon. In addition to the freedom from abuse, neglect, and exploftatfon requirements In § 483.12, **facilities** must also provide training to their staff that et a minimum **educates staff on-** §483.95(c)(1) Actfvittes that conatltutaabuse, neglect. exploltallon, and mtsapp,optlatJon of resident property as set forth at§ -483.12. §483.95(c)(2) Procedures for reporting Incident& of abuse, neglect, exploltalon, or the mlaapproprfaflon of l'Bllident property §483.9S(c)(3) Dementia management and ,..ldent abuse prevenUon. This REQUIREMENT la not mat • **evidenced** by: Baaed on surveyor obaervatlon and lntaNlew of supplemental llaff, it was determined that the facility eteff faHed *to* **ensura** that prtvate duty companlonslcareglvera are prapcrly screened for abuse, ancror trained on abuse prohibition. Thia flnd'mg was evident in 1 of 48 residents selected for review during the survey. (#71). The findings Include: On 07-18-18 during lnltla rounds, surveyor obaervad resident #71 lylng aupine In bad with 11 female sitting at the bedside. The female Introduced herself **a resident** #71'•-aide". The	F843	**5comctlve action** WIii lie **ampUabed** for **thON raaldenll** tG h8V8 been affectlld by the cl1nt practice? *t#11 was OSStlSSff by* DONon 7•17-JB *110 negotlw ourrotM* was *noted due to* m*dutycompolliOn* not *properly scf'et!nftl forobus• wining.* rou wit Identify other raldentll having potential to be affec:tecl II)' Ille **same** eflclent practice and what corNctfve action **betaken?** *u,se Mona1en compltttd o* JOOIII *audit of* enu *who have prlwm ,:ompolllollS. All and/or resldrntJ wflo hove t»llloM haw th potential to be o/fectld.* GOS *of ollprlwlte duty ,:omponlons wlUbeln* 11111!11!'ff *on resident rights ond obwe rohlbltlons bv* 08.10.18.	**bl.10.18**

STATIM&HTOF DERCEICIE8 AND Pl.AN OF CORRECTION	0(1) PACMOERl'Sl#IPLEVCUA I>ENTIFICAYJQN NUMBER:	(XII MUITIPLI CONSTRUCTION A ,IU ILDING_ _ _ _ _ _ _ _	(X3) DATE SURVEY COMPLE'T&D
	211121	8 WI. • - - - -- .. - - -	C 0711"2018_

NAME OF PROVIDER OR SUPPLIER	llR&TADOMSII, CnV.STATE, ZIPC001
THEVLLAGEATROCKVILLE	9701 VERB DRIVE ROCKVILLE. MD 20lto

(X4) ID P'ftEflX TAG	SUMMARY STAlDWff OF DEFICIEHCES (EACH DEFICIENCYM.18T IE PAECEGED BY Rill. RiGUI.ATORY OR I.SC IDENTlfVING TIOlol)	ID P'ftl!PlX TAO	PRCMDIA'8 Pl.AN OF CORRECTION (fAafCOMECIMIACTIONIHOUU> BE CROSS,«EFERENCED10 THIAPPROPRIATE D&FICl&NCY)	IMTI
F 943	I Continued From page 24 "aide" fnform1d the aurveyor that 1he waa private duty, and net an employee of the faelllty. The "aide• Informed tha surveyor that she assisted resident #71 with hern,la activltf81 of daily Uvlng e,,ary other day. On 07-18-18 et 2:15 PM, &UMtyor observed reafd•nt #71 ambulating In the hallway with **a** walker, with the •afde" walking baaide him/her. On 07-18-18 at 1:50 PM, Interview with the director of nursing revealed that the family of realdent #71 had hired the "aldd' ta provide companionship for the resident, but not to provide any handa on care. However, the private duty aide had previously acknowledged assisting the reeldent with actMtles of dally living. Tha faclfty was unable to provide any evidence o1 abuse screening or training provided on abuse and neglect to thla prtvatefy hired nursing assistant who spends a algnfflcant amount of time with resident #71. The lack af **screening** far and/or training an abuse has the potential to endanger the **health and** safety of the realdent.	F 943	meaurn WM be put Into place or eyatiemlc **cflangn rou wll make** IO ure thatthedeficient **practice does** not r? *PltfC'tar of Nursing wlll ln-servlet oll* prlllate *ury companions on11sld1nt rights **and abuse** ,n,hlbltlon by OB.*lO.JB. *Nursing staff we111n-* *onenwrlng thot **pdvote r:omponlonl** re not providing actlvltl,s of dolly IMno **by*** 1.JO.JB. *Raponslble potties wlRk tducotrd n process and respanslb/U,, of p,tvor. mponlon as port of* Uteodmlalon pmceu. the corm:tlve actlon(aJ wlfl be onllar9d to.,....lll•deficient practice IMI1 not recur,Le.,whatqualla,aauranoe rogram wlll be put Inta **place?** *tutor of Nursing wHl conduct* JOOJI' *ntlll,audits of guest and reshhnts who* wr *private companions to* ensure *that al. vt rec:elved* opproprlore *abus. rrolnlng ond owoi'! of role o*spnvote *companion. findings will be reporttd to /aclRt, QAPI committee montht, Jt3.*	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENIERS FOR MEDICARE & M_I: DICAID SERVICES

STATEMENT OF DEFICIENCIES ANO PIAN OF CORRECTION	(X1} PROVIDERISUPPLIERICLIA IDENTIACATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215126	A. BUILDING _____ B.WING	C 02/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ROCKVIUE	9701 VEIRS DRIVE ROCKVILLE, MD 20850

(1<4) ID PREFIX TAO	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PR£CEDED BY FUU. REGULATORY OR LSC IOENTIFYUIG INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD SE CROSS-REFERENCEDIOTHEAPPROPRIATE DEFICIENCY)	(I(.5> COMPL1:TION DATE
F 000	INITIAL COMMENTS On 2 12-18, a survey was conducted at this facility by the Office of Health Care Quality to Investigate complaint #MD00119982. Survey activities Induded review of clinical and administrative records. policfes and procedures, interview of staff end resident family members, and obsetvation of resident and staff practices. The following Federal deficiencies are the result of this survey and are not related to complafnt # **MD00119982.**	F000	This **Plan** *o(* Correction **is prepared and** executed because ll is required by lhe provisions of the S1a1c and Federal Regulations and 1101 because The Village at RodcviUe agrees wilh l.be allegations and cilaliom lined on the slatcmcnt ofddldcncics. 111e Village al Rocb!Uc: maintains that the: allcgc:J dclidmdcs do not, individually and coU«Uvc:ly, jeopardize the health and safety of the: residents, nor arc lhcy of such charaaer as to limit our capa.dty lo render adc:qualc: arc u prcsaibcd by regulation. This Plan of Correction shall operate: as The Village at Rockville's written credible allep.llon of compliance. By $Uhmittlng this Plan or Correction, The: Village at Rockville docs not admit to the accuracy of ddicicndes.. This Plan *o(* Corrc:ction is nOl meant to establish any standard of arc, contnacl, obligation, or po$!tion, and The VUlagc at Rockville n:i;c:rvc:s all rights lo rai all poS5iblc contentions and dc:fmsc:s in any civil or criminal claim action or proceeding.	
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR{s): **483.1**0(i)(1)-(7) §483.1O(i) Safe Environment The resident has a right to a safe, clean, comfortable and homelike environment. Including but not limited to receiving treatment and supports for dally living safely. The facility must provlde- §483.10(1)(1) A safe, clean, comfortable, and homelike envlronmen allo\Ying the resident to use his or her personal belongings to the extent possible. {i) This Includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident Independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or the §483.10(1)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	F 584	(I) Whal correcllvc: action willbe accomplished for tho"resldenls found to hnc: been afrected by lhedeficienl pnctice? Guc:sl that was in room 3207-1 was not on oxygen. No nc:galivc: outcome or further concrrns were noted u a result *of* 1he oxygen concentrator being improperly stored outside: of guest's room. (2) How you will ldcnlify other r idcnts having the: potential to beaffcc:ti:d by the same dc:Ocienl practice and what c.orrc:ctivc: adlon will be taken? RN Care Coordinalor completed an environmental audit of all units focusing on proper storage of portable: oxygen tanks. Guests who resided on 3 Vlrglnii :ind 3 Maryland units had the potential to be alT1..-clcd since the lank was idenliOed as a lnnsport company's lank lhat they mistakenly lefl on the unit. No further improperly stored tanks on unil w1..-rc Identified during lime *o(* audit. (3) Whal measures will be put Into place or what 5)'$temic:: c::h11ngc, you wm make to ensure that lhe defldcal pradkc: doc:, not n:cur?	03/19/1018

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 3/15/18

Any denciincy slate!-enifIngWhtt..!Jf astf,fsll(") denolei"l'deflciency which the IMtltullon may be excused from correcting providing It rs determined Chat other aafeguards pro suffldenl Ion to the pallonts. (See Ins tructions.} Except for rnnlng homoa, lha findings statoc:l **above** are dlsdoseble 90 day. followlng the dale of uivoy whether or not a plan of corcectlon la pWiided. For nursing homes, the above findings and plans of l:Qrredloo are dlsdosable 14 days folowing the date these documents are made avanable to 1he facility. If deficiencies are died, an approved plan of correction Is requisite to conllnued program participation.

STATEMENT OF DeflCIENCES AND Pt.AN OF CORRECTION	t)(1) PROVIDER/SUPPLIER/CUA IOENTIRCATION NUMBER:	f)(2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215125	A. BUR.DINO _____ B, WING	C 02'12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE. ZIP CODE
THE VILLAGE AT ROCKVILLE	t701 VEIRS DRIVE ROCKVILLE, **MD 20850**

}ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DE!FICIENCY MUST Bl! PAECEOED BY FULl REGUIATORY OR ISC IOENTFYINO INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECIlVEACTION SHOULD SE CROSS-REFERENCED TO THE APPROPRIATE **DEFICIENCY)**	(M) COMPLETION **DATE**
F 584	I Continued From page 1 §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10{i){4) Private closet space In each resident room, as specified In §483.90 (e)(2)(iv}; §483.10(1)(5) Adequate and comfortable llghting levels In all areas; §483.10(i)(6) comfortable and safe temperature levels. Facilities inlllally certified after Oclober 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on sun,eyor observation, review of the cllnlcal record, and facffity staff interviews, *it* was determined Ulat the facility staff failed to provide a safe environment. This fmding was evident in 1 of 5 residents (#4) reviewed during complalnt survey #MO00119982 . The findings Include: Observation during Initial faclUty tour, on 2-12-18 at 9:50AM, revealed a portable oxygen tank standing upright In the hallway unsecured next to door of room 3207-1. Observation on 2-12-18 at 1:15PM by a second surveyor revealed that the portable oxygen tank was stillstanding upright unsecured in the same location next to room 3207-1. Surveyor noted the portable oxygen tank was not empty. Observation on 2-12-18 at 3;1OPM revealed the portable oxygen tank still standing uptight	F 584	DirectororNW"Singandnursecoachesin-serviced an staff on proper storage of oxygen tanks. Manda1ory compulu tninlng for alls11ff on proper storage of oxygen will be completed In March, (4) How lhe corrective actlon(s) **will be** monilored lo ensure lhe de6dcnt pnctice will not r«UT, i.e., whal quality aswnncc will be put lnlo plxe? 11\e Director of Nursing or deslgnee will conduct random environmental audits to C\$Urc the proper storage of portable oxygen tanlcs. Fine.lings will be reported to facility quality US\lrance committee monthlyx3.	

STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION	IX1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215125	A. BUILDING _____ B. WING	C 02/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT **ROCKVILLE**	11701 VEIRS DRIVE ROCKVILLE, MD 20850

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	**PROVIDER'S PLAN** OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO **THE APPROPRIATE** DEFICIENCY)	COMPLETION DATE
F 5841 SS=O	Continued From page 2 unsecured In the same location next to room 3207-1, On 2-12-18 at 3:15PM, surveyor record review of resident #4's order summary report revealed no active orders for oxygen use. On 2-12-18 at 3:15PM, surveyor record review of resident #4's treatment administration record revealed no active orders for oxygen use. On 2-12-18 at 3:30PM, the surveyor accompanied the unit manger to the doorway of room 3207-1 and was shown an unsecured oxygen tank. Surveyor verified with the unit manager that the oxygen tank was not empty. The unit manager removed the portable oxygen tank from the hallway after surveyor intervention. On 2-12-18 at 3:30PM, surveyor interview with the unit manager revealed it is the facility's practice to secure all portable oxygen tanks when In use and during storage.	F584	.	
F 880 SS=O	Infection Prevention & Control CFR(s): **483.80(a)(1)(2)(4)(e)(t)** §483.80 Infection Control 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. **§483.B0(a)** Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must Include, at a minimum, the following elements: §483.80(a)(1) Asystem for preventing, identifying,	F 880	(I) What corrective action will be accomplished **For those residents found to have been affected by the deficient practice** Guat who **resided in** room 3139 was **assessed** by Physician and RN Care Coordinator and no **negative** outcome or further concerns were noted **as a** result of the isolation **sign** not being posted outside of the door and no concerns noted with staff and/or Visitor, reporting issue of signs/symptoms of communicable illness/diseases. (2) How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: RN Care Coordinator will complete an audit of clients on isolation to identify if stop signs and/or visitor's log see nurse before entering room were placed when the complaint surveyor brought concern to facility's attention. All guests who were on isolation had the potential to be affected. [illegible] guests had isolation	**03/19/2018**

STATEMENT OF DEFICIENCES ANO PLAN Of CORRECTION	(X1) MOV1DER/SUPPI.IERICUA IDENTIFICATION NUMBER	()(2) MULTIPLE CONSTRUCTION	()(3) DATE SURVEY COMPLETED
	215125	A. 8UILOING _____ B.WING _____	C 02/12/2018

NAME OF PROVDER OR SUPPLIER	STREET ADORESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ROCKVILLE	9701 VEIRS DRJVE ROCKVILLE, MD 20850

(X4) ID PREFIX TAO	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGUIATORY OR LSC IDENTIFYING INFORMATION)	If) PREFIX TAG	PROVIOEA'8 PIAH OF CORRECTION (EACH CORRECTIVE ACTION SHOUlO BE CROSs-REFERENCEOTOTHEAPPROPRIATE **OEFICI£NCY)**	PIS) **CONPUalION** DATE
F 880	I Continued From page 3 reporting, Investigating, and controlling infections and commlJfllcable diseases for all residents, staff, volunteers, visitors, and oth8f' Individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80{a)(2) Written standards, policies. and procedures for the program, which must Include, but are not limited to: (Q A system of surveHlance designed to identify possible communicable d"eseases or infections before they can spread to other persons In the faclQty; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (ill) Standard and transmission-based precautions to be followed to prevent spread of infections; (lv)When and how Isolation should be used for a resident; inciudlng but not limited to: (A) The type and duration of the Isolation, depending upon the fnfectious agent or organism Involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or Infected skin lesions from direct contact with residents or their food, if direct contact wiQ transmit the disease; and (vi)The hand hygiene procedures to be followed by staff Involved in direct resident contact. §483.80(a)(4) A system for recording incidents Identified under the faciUty's IPCP and the	F880	(3) What measure1will be put into placeor what systemic **changes** you wW make to mAJre lhat the dc:Rdcnt practice don flOl *rcan1* Dirc:cior orNwsing ■nil nur= coachL-s in,scrviccd all nunlng ,rafTon the CKillty's guidelines on isolation and mal.ing sure that isolation slop sigm alerting visitor$ lo check with nurse before entering room are placed outside or doors. (-4) How the corrective aclion(s) will be monitored to **ensure** the dcnc:lenl prac:tlcc wtU not recur,le., what qualily usurancc will be put into pla"? The Director of Nursing ordcslgnee will conduct random audits of guests on isolation to ensure that isolation stop signs lo alen visitors to check with nursebefore entering room arc placed outside of doors. Findings will be reported to facilily quality usunncc commlltee monthly x3.	03{19/2018

STATEMENT OF DI!FICIENCIES AND PIAN Of' CORRECTION	(X1) PROVIOERISUPPIIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	()(3) DATE SURVEY COMPU!T!D
	215125	A. BUILDING _____ B.WING	C 02/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ROCKVILLE	9701 VEIRS DRIVE ROCKVILLE, MD 20850

(X4}1D PREFIX TAG	SUMMARY STATBreNT OF DEACIEHCIES (EACH DEFICIENCY MUST BE PRECEDED BY f'ULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (£A.CH CORRECTIVEACTION.SHO\I.DBE CROSS-REFERENCEDTOTHEAPPROPRIATE DEFICIENCY)	OCS) CONPI.ETIOH DATI!
F 880I	Continued From page 4 corrective actions taken by the facility. §483.BO(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.B0(f) Annual review. The facility wm conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on surveyor observation, review of the clinical and administrative records and staff interview, It was determined that faciUty staff failed to maintain proper infection control measures in 1 of 5 residents selected for review during Investigation of complaint #MD00119982. (#5) . The findings Include: On 02-12-18 at 9:00 AM during initial rounds, an Isolation cart was noted outside a room on the 3rd Floor Virginia unit Upon closer observation, there was no signage on or near the entrance to the room directing visitors to check at the nurse's station prior to entering the room. A review of the clinical record revealed the resident to be on Isolation for Clostridrum Difficile (C-Dlft). C-dlfficile Is an infection of the colon which results in diarrhea. Review of the facility policy for C-Diff instructs "gloves should be worn when entering the room": and "gowns should be worn if physical contact with the resident or the resident's environment is anticipated." There was nothing to Instruct visitors of the requirements prior to entering the room.	F880		

STATEMENT OF DEACIENCIES ANO PI.AN OF CORRECTION	(XI) **PROVIDER/SUPPLIER/CUA** IDENTIfiCATION NUMBER:	(X2) MULTIPIE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215126	A. BUILDING _____ B.WING	C 02/12l2018

NAME OF PROVIDER OR SVPPUER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ROCKVILLE	9701 VEIRS DRIVE ROCKVILLE, **MD 20850**

(X4) ID PREFIX TAG	**SUMMARY STATEMENT** OF **DEFICIENCES** (EACH **DEFICIENCY MUST BE PRECEDED BY** FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLANOF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSs-REFERENCED TO THE **APPROPRIATE** DEFIC1£NCY)	(XSJ COMPLETIDH DATE
F 880	I Continued From page 5 On 02-12-18 at 3:20 PM, interview of the 3 Virg1nia unit manager confirmed the facility requirement for a sign outside the resident room directing all visitors to check at the nurses station prior to entering the room. The unit manager also confirmed the absence of the sign, but the presence of the isolation cart containing the gloves and gowns which visitors may be required to use upon entering the room. On 02-12-18 at 4:00 PM, interview with the director of nursing revealed no additional info rmation_	F880		

O ffice of HeaUh Care Qualil'

STATEMENT Of DEFICIENCIES AND PtAN OF CORRECTION	(X1) PROI/IOER/SUPPUERICUA IOENTIFICATIONNUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215125	A. BUILDING:_____ B.WINO	C 02112/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ROCKVILLE	9701 VEtRS DRIVE ROCKVILLE, MD 20850

[X4) ID PREFIX TAG	SUMMARY STATI:MENT OF OEFICIENCIES (EACH OEACIENCY MUST BE PRECEDEO BY FULL REGULATORY OR LSC IDEI'.{TIFYINO INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION {EACH CORRECTIVE ACTION SHOULD BE CROS8-REFI!RENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPL..EIE DATE
S 000!	Initial comments On 2-12·18, a survey was conducted at this facility by the Office of Health Care Quality to investigate complaint #MD00119982. Survey activities Included review of residents' medical records, Interview of staff and resident family members, and observation of resident and staff practices. The following Code of **Maryland (COMAR)** deficiencies are the result of this suwey and are not related to complaint# MD00119982.	**S000**		
s 506	110.07.02.12 o Nsg Svcs;Care 24 Hrs per Day .12 Nursing **Seivices.** O. Nursing Care-24 Hours a Day. There shall be sufflctent licensed and supportive nursing **service** personnel on duty 24 hours **a day** to provide appropriate bedside care to assure that each pauent (1) Receives treatments, medications, and diet as prescribed; (2) Receives rehabilitative nursing care as needed; (3) Receives proper care to prevent decubitus ulcers and deformities; (4) Is kept comfortable, clean, and well-groomed; (5) Is protected from accident, Injury, and Infection; (6} Is encouraged, assisted, and trained in self-care and group activities, This Regulation Is not met as evidenced by: Refer to CMS 2567. **F--584.**	**S506**	PLEASE REFERENCE **POC FOR F514**	03/19/18

OHCO
IADORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 3/15/18

0 mc:e. Of Health Care Qualihj

STATEMENT OF DEFICIENCIES AND PIAN OF CORRECTION	Q(1) PROvtDERISUPPLIERICUA IDENTIFICATION NUMBER:	1)(2) MUlTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215125	A.BU IL DING _____ 8WING _____	C 02/1212018

NAME OF PROVIDER OR SUPPI.U:R	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ROCKVILLE	9701 VEIRS DRIVE ROCKVILLE, **MD 20850**

()(A) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST eePRECEDED BY FUU REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOH (EACH CORRECTIVE ACTION SHOULD 8E CROSS-REFERENC£D TO THE APPROPRIATE DEfICCENCY)	CXSI COMPLIITE DATE
S1118	Continued From page 1	S1119	PLEASE REFERENCE POCPOR F880	03/19/2018

S1119, 10.07.02.21 G Inf Control Program; Prevent Spread of Infec

.21 Infection Control Program.

G. Prevenring Spread of Infection.

(1) The facility shall assess any residents with signs and symptoms of an Infectious illness for the possibility of transmission to another resident or employee.
(2) The facility shall take appropriate infection control steps to prevent the transmission of a communicable disease to residents, employees, and visitors as outlined In the following guldelfnes:
(a) Guideline for Isolation Precautions In Hospitals; and
(b) Guideline for Infection Control In Health Care Personnel.
(3) The facifity shall prohibit employees with a communicable disease or with Infected skin lesions from direct contact with residents or their food if direct contact could transmit the disease.
(4) The facility shall require employees to perform hand hygiene after each direct resident contact for which hand hygiene is Indicated by accepted professional practice.
(5) The facility shall handle, store, process, and transport linens so as to prevent the spread of Infection.

This Regulation is not met as evidenced by:
Refer lo CMS 2567
F-880

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

P31NTEO: 01/03/2018
FORM APPROVED
Ome NO. 0938-0391

STATEMENT OF OEFICENCIES AND PIAN OF CORRECTION	(X1) PROVIDERISUPPUER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215125	A. BUILDING B.WING	C 12127/2017

RECEIVED
JAN 22 RECD
OFFICE OF HEALTH CARE QUALITY

NAME OF PROVIDIIR OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ROCKVILLE	9701 VEIRS DRIVE ROCKVILLE, MD 20850

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST ee PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD ae CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	CXS) COMPIETIOH DATE
F 000	INITIAL COMMENTS On 12-27-17, a complaint survey was conducted at this facility by the Office of Health Care Quality to Investigate facility reported incidents MD00120011, **MD0012014,** MD0012016, MD00120017, MD00120018, MD00120065, and MO00120833. In addition, two additional facility reported incidents were investigated during the **survey.** This survey did not identify noncompliance with Federal requirements that were reviewed In relationship to these facility reported incidents. AdditionaUy, facllity reported Incident. M000120375 was investigated and resulted in a Federal deficiency. The survey activities consisted of observation of resident behavior and facility staff practices, interviews with residents and facility staff, and review of clinical and administrative records. The following deficiency is the result of the survey:	F 000	This Plan of Corree1ion Is prepared and executed because it is required *by* the provisions of the State regulations and not because The Village at Rockville agrees "'ilh lhe allegations and cilalions listed on the statemenl of deficiencies. The Village al Rockville maintains th.it the alleged deficiencies do not, individually and collectively, jeopardi1.e the heahh and safely of the residents, nor arc they of such character as lo limil our capacity to render adequate care as prescribed by regulation. This Plan of Correction shall operate as The Village at Rockville's written credible allegation of compliance. By submitting this Plan of Correction, The Village at Rock-ville does not admil lo the accuracy of deficiencies. This Plan of Correction is not meant to establish any slandard of care, contract, obligation or position, and The Village at Rockville reserves all righ1s to raise all possible contenlions and defenses in any civil or criminal claim, action or proceeding.	
f 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21**(b}(2)(i)-(iii)** §483.21(b) Comprehensive Care Plans §483.21{b)(2) Acomprehensive care plan must be- (1) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to- (A) The attending physician. (8) A registered nurse with responsibility for the resident (C) A nurse aide with responsibility for the resident (D) A member of food and nutrition services staff.	F 657	I. **What corr«Uve action will be accomplished for those residenls found** to have been affected by the deficient practice? (l S I (s l. How you will Identify other residents having the potential lo be affected by lhe same defidcnt practice and what corrective action will be taken? RN care care coordinators completed an audit of falls from last 30 davs to ensure care plans	01/16/2018

ABORATORY DIRECTORIS OR PROVIDER/SUPPLIER REI PRESI:NTATIVE'S SIGNATURE TITLE (X6) DATE

E:)(.t?CM'h\t'£. D feL'tz/C 1/15/18

Any deficiency statement enc9ing wfttl an asterisk (") denotes a deficiency which the Inslltutlon may be excused from correcting providing it is detennlned that other safeguards provide suff'tcient protection tolhe patients. (See Instrudlons.) Except for nursing homes, lhe findings stated abOve are dlsdosable 90 days following Ihadale otrsurvey whether ornot a plan of coneclion Is provided. For nursing homes. the above finding& and plans of correction are dlaclosable 14 days following U1e date lhase clOcuments are made available to the facility. If deficiencies are cited, an approved plan of conectlon Is requ1$1te to conUned pn,gram partic:ipallon.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3> DATE SURVEY COMPLETeO
	215125	A BUILDING _____ 8 WING _____	C 12/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATEZIP CODE
THE VILLAGE AT ROCKVILLE	9701 VEIRS DRIVE ROCKVILLE, **MD 20850**

(X41JO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES !EACH DEFICIENCY MUST 8£ PRECEDED BY FULL REGULATORY OR LSCIOENTIFVING INFORMATION)	10 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (CACH CORRECTIVEACTION SHOULD BE CROSS.REFERENCED TO THE APPROPRIATE DEFICIENCY)	lll51 COMPLETION OATE
F657	Continued From page 1 (E) To the extent practlcallle. the participation of the resident **and the** resident's representalive{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. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on surveyor review of the clinical record and staff interview(s), it was determined that ttie facility staff failed to revise a care plan in a timely manner. This finding was evidentfor 1 of 10 residents reviewed during the investigation of facility reported incident MD0012037.5(#7) The finding includes: on••• resident #7 attempted to reach for something out of hisJtler walker when he/she slid to the floor. The resident sustained no injury as a result of this fall. On ____, resident #7 again attempted to reach for something on hislher bedside table, and sustained a fall which resulted in a right pubis fracture (break in the right side of the pelvlc bone). Further review of the clinical record for resident first fall on ■ - • nor after the second fall on #7 revealed no revision of the care plan after the	F657	were rc:viscJ limdy to include new intervenlions to prevent re-occurrence. Guest :ind Residents who sustain a fall have the potential to be afTectc:d . 3. What measures will be put into **place or what** systemic **changes you** will make to ensure that the deficient **practice does** not **recur?** Director of Nursing and/or dcsignee ,in serviced all licensed nurses on revising comprehensive care plans and adding new inlervention with all falls lo prevent re-occurrence. To 1msure that the highest practical care is being rendered to our guests/ rtsidents, care coordinators completed an audit on falls that occurred in lasl 30 days, ensuring thal care plans are upda1ed to include: new inlerventions as per regulatory guidelines. 4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, I.e., what quality assurance program will be put into place?** **Care** coordinators will conducl random audits of falls to ensure revision *of* comprehensive care plans and new intervention has been completed . Findings **will be** reported to facilily qualily assurance commillee monthly x3.	01/16/2018

STATEMENT OF DEFICIENCIcS AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPUERICLIA IDENTIFICATION NUMBER.	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215125	A. BUILDING _____ B WING	C 12/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS. CITY. STATE. ZIP CODE
THE VILLAGE AT ROCKVILLE	9701 VEIRS DRIVE ROCKVILLE, MD 20850

(X4) IO PREFIX TAG	SUMMARY ST,.TEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 1DENTli::v'NG INFORMATION)	JO PREFIX TAG	PROVIDER'S Pc.AN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE **APPROPRIATE** DEFICIENCY)	(XS) COMPLETION DATE
F 657	Continued From page 2 AdditionaHy, f the occupational therapy notes, dated– (3 days after the initial fal revealed no mention of the fall. There was also no recommendation for any adaptive equipment (i.e. reacher) that might assist resident #7 to obtain items and prevent further falls.	F657		

Offi ol He alth Care Quali

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XU PROVIDER/SUPPUER/CLIA IDENTIFICATION NUMBER	(X2} MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215125	A.BU|L D|NG _____ B. WING _____	C 12/27/2017

NAME OFPROVIDER OR SUPPLIER	STREET ADDRESS. CITY. STATE, ZIP CODE
THE VIL AGE AT ROCKVILLE	9701 VEIRS DRIVE ROCKVILLE, MD 2D850

(X4)1D PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGUU.TORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	[X51 COMPLETE DATE
S 000	Initial comments On 12-27-17, a complaint survey was conducted at this facility by the Office of Health Care Quality to investigate facility reported incidents MD00120011, MD0012014, MD00120016, MD00120017, MD00120018, MD00120065, and MD00120833. In addition, two additiOnal facility reported incidents were investigated during the survey. This survey did not identify noncompliance with State/COMAR requirements that were reviewed in relationship to these facility reported incidents. Additionally, facility reported incident, MD00120375 was Investigated and1esulted in a Slate/COMAR deficiency. The survey activities consisted of observation of resident behavior and facility staff practices, interviews with residents and facility staff, and review of clinical and administrative records. The following deficiency is the result of the survey:	**S000**	Please *reference* PoC for F657.	01/16/2018
S173 0	10.07.02.37 E Care Planning; Organization of plan .37 Care Planning. E. Organization of Care Plan. (1) Problems and needs shall be Identified, based upon the interdisciplinary assessment. The care plan shall address all of the resident's special care requirements necessary to improve or maintain the resident's status. The interdisciplinary team shall incorporate resident input into the care plan. (2) The team shall establish goals for each problem or **need** Identified. The goal shall be realistic, practical, and tailored to the resident's	S1730	Please reference PoC for F657.	01/16/2018

OHCO
LABORATORY DIR 6CTOR'S OR PROVIDER/SUPPLIER/REPRESENTATIVE'S SIGNATURE — TITLE Executive Director — (X6) DATE 1/15/18

STATE FORM 3CDP11 — If continuation sheet 1 of 2

Office of Health Care Qualih1

STATEMENT OF DEFICIENCIES AND PIAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2J MI/LTIPI.E CONSTRUCTION	(X3) CATE SURVEY COMPLETED
	215125	A.BU I LDNG _____ WING	C 12/27/2017

NAME OF PRO\IIOER OR SUPPLIER	STREET ADORESS, CITY , STATE, ZIP CODE
THE VILLAGE AT ROCKVILLE	9701 **VEIRS** DRIVE ROCKVILLE, MO 20850

(X4) ID PREFIX TAG	SUMMARY STATEMENT 01' DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BV 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)	C , COMPLETE OAT£
S1730	I Continued From page 1 needs. Goal outcome shall be measurable in lime or degree, or both. (3) Approaches to accomplishing each goal shall be established. Approaches shall communicate the work to be done, by whom it is to be done, and how ffequenUy it is lo be performed. This Regulation is not met as evidenced by: Refer to CMS 2567 F-657	S1730		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
cetm:RS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 071l512017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OFD&FICIENC& #11D PLAN a, CORRECTION	(X1J PROVIDEAISUPPUERICUA IDINTFltATION NUMIEII: 215121	IX2JMULTP\.E CONSTRUCTION A.BUILDING ____ I.WINO	OU, QlliTE SURVEY COMPLETED C 07#20/2017

NMi1E OF PROVIDER OR SUPPLIER	STR&ET ADDRESS. CITY, STATE. ZIP CODIE
THE VILLAGE AT ROCKVILLE	1101 VEIRB DRIVE ROCKVILLE, MD 20850

CMJID PREFIX TAO	SUMMARY STATEMaNT OF DEFICIENCIES ce,,cH DEFICIENCY MUST IE PRECEDED BY FULL REGULATORY OR LSC IDENTIFVINO INFORIMTION)	ID PRIFUC TAO	PROVUJEA'S Pl.AN OF CORRECTION CORRECTIVEIICTION SHOULD Bl Clt085,REFEREHCEDTOTHEN'PROPRW.TE DEFICIENCY)	DAT&
F 000	! INITIAL COMMENTS The following daflclencies are the result rJ the annual Qualily Indicator Survey (QIS) for MedlcarelMedleald N!Ceftiflcation survey ; conducted on July 17, 18, 19 and 20. 2017. Survey activities consisted of a review of 70 medical records during stage 1 and 30 medical records during stage 2, observation of residents. staff practices. and Interviews of 1811dentI. the ombudsman, family members and facility's staff. In addition, administrative records and resident care polldes were also reviewed. In addition to standal'd survey protocols, 'comp1alnts # MO 0011S>78, MO 00113198 and faciity reported Incident #MD 00113913 were investigated. This survey did nDC identify noncompliance wllh Federal requirement& that were nwiawed in relationship to these complaints and facilily reported incident. The facllty Is licensed for 160 comprehensive beds. At time of this survey, the facilily census was 153 beds.	F000	This Plan of Comtction II praparad and exeoAed bacause ltIs required 1ry Illa provisions of the ht8 and Fednl l'IQUIIIIOns and natbacaule The Vlage at Rodlvlle agrees wlth lhe allegallons and dlallDna listed on Illa lltaterMnt of deflclerldes. Tba Vlage 81 Rockvlla maintains that Iha lllagad daflclanda cfO nat.lndlvlduall'/ and colecll\lafr,jeapaldlzethe 1181111 and safety of lhe residenta.nor area.,,of IUd'I c:harader as to llmll our capacity lD render adequate ..,..aspreealbad 111,egulatlan. TbllPlanof Conedlon lhall operale .. 1be Village al Rockvllle's written credlbla allagatiOn of campllance. BY IUtlmlllilg lhlaPlln of Comicdan, The Vlllga at ROCkvla dolllnot admit to the accunacyot dellciencln. Thia Plan of Conaction IInotmeant to eatabllSh any llandlld of care,conlrad,ablrptlan. ar posltian, and Tbe Village ti Rockvlle rIII8MISal llghtl to raised Polllbte c:ontenlions and clefenlea Inany cM oralrnlnal clalm, action or proceec11n9-	
F 281 SS..e.	483.21(b)(3Xi) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (bX3) Comprehensive Cete Plans The services provided o, ananged by the facility, as ouained by the comprehenshle cara plan, must- (i) Meet professional standards of quality. Thi& REQUIREMENT Is not met as evidenced by: Based on surveyor review of the clinlcal record, ..'[WYOI observ(lllon, and Interview with facility	F 281	fl)'MIIICOINdllaa:llanwllmma-1olllll•1Dr tmelllllllllllbundlDha911eeridadild1Jtb dalcllntpiac:lae'I Rnilllnt •204 wu IISalacl lryMedli:al Dnctor and DhctDrofNurllng,no negattva OUCCOMES or fur1hlrconcema W11n1 noted II eresull of LPN edmlnlllarfngmadleallansID. ..,_nt •204 20 mlnuta arty and not!'obiing prvcaa i,, signing off anmldicallonl. Resident 84 was tswsed 111 Nurse PnictitiDw and Dimmr of Nursing, no negaUwe auecomes ar rurtterconcems were noted asa resuloftreatment l'8COIIIIMndltlbrWO\.llcl COIIIUlant NII btfng fDIIOwlldlirnllly.	08110117

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRES 'ATNE'S SIGMTURE — TITLE: Executive Director — (X6) DATE: 8/3/17

Affl/ dliiltsi&C(•lalemifllemtinII'wiUtbI'--- II IDilllttt a cerld811Cly which lie lnltlludon Illay 11e tlCUMO Ilalll collecung pniw1111ng it is determined that Gliier ufeguMls provide1 Ufflcien1 protedlan to lie pedents. CSN inllrudlanl.) EllCllPt for nutslng l'iomel. lhe findings ltafN IIIMMtn dildollble mdaJII folblint. date DflllINllr whether ornol a p11n Of conecllon II prowlded. FornWl&lt W. ltl8abcMIndinp and p1a111 ar mncttan1 re disclolabla •• days r1IIIOMng Ille dale UleSe dDCUmenb ... madl avalllble to Ute facility. If dlllclandn are cllld, an approved plan of Wion Is reqlllllle to conllnuecl program paltldpatlon.

&TATEMINT OF D111CIENCIES AND PLAN OF CORAECTI0N	0'11 PROVIDERISUPPIJAICUA IDINTtFICATION fjlJMBER:	OC2t MUI.TI"LE CONSTRUCTION A.IUILDIHG _____	OC,}DATE SWNEV C0MPLETEO
	215125	I.WING	C 07'201Z017

NAME OF PROVIDER OR SUPPUER	STREET ADDRDS. CITY. STAIE. ZIPC0DE
THE VILLAGE AT ROCKVILLE	9101'IEIRS DRIVE ROCKVILLE, MD •SO

(Xol)ID PREFIX TAG	SUMMARY SfATEMENT OF Dl!l'ICIENCIES (PCH DERCfENCY MUST Bl PRECIEUS)IYl'UU. REGUtAT0RY OR LSCIOENTU='nNG INFORMATION)	ID PREFIIC TAG	PROIIDEt'S PLAN 0. COIIREeTION EACH COAAECTIVEM:TION SH0UU) IE CROS&REFEAENCED TO THEAPPROPRIATi DEFICIENCY)	L +
F 281	Continued From page 1 &taff, it was determined lha1 the facility staff failed , to ensure standards of nursing practice. TIiis I finding was evident in 2 of 30 residents setected • in the stage 2 review. (#94, #204) The findings include: 1. During medication observation, on 07-20-17 at • 08:10 AM, 1lwas observed that LPN1 administered medieatlons to resident 0204. However, surveyor review of resident #204's , madlcatlon adminiattaticm rec:ord revealed that LPN 1 faffed ID document the medleation as 1 admlnlstaracl. I 1 On 07-20-17 at 08:20 AM, surveyor intenriew with [1]LPN 1 revealed that shelhe did not document the · administration because the medication was given 20 minutes early and thecomputer would not allow hlnvber todocument Per the Nurse Practice kt 10.27.09.02 E (2) (a) (iv), **as a** standard of nursing practice nursing staff **are expected** to document the administration of medication immediately after the medication Is given. 1 On 07-20-17 at 10:30 AM, surveyor intenriew with Director of nursing (DON) reveafed no new • information. 2. On 07-20--17. surveyor review of the clfnlc.al recont far ,asldent #94 revealed a wound care consultant note, written on 07•14-17. which that stated a wound on the rower **back had** been opened, drained and lhen packed, before a dressing was appried. The recommendations were to clean the wound and change the packing and dressing everyday.	F281	(2) tbw)llrwlll ldenut, otller ruld8ntl llaVInl Ill.I potential to **be llfflIded t»rthe ume d8'lcleftt** prectlce and wtiat CDIRldlYe action wlD be taken? • Dnccor of Nul"llng or designaa wiD mmplete., audl of facllltymedlcetlan admfnimallan dmesan'Zr/A. idemlfylng lf **medications 1111 being admlnllllertd** Prtr **and being** Signed off after adminislrllfan. Resldanll an'Zr/A whO **r1C1M1medicllianS have** llle patentlal ID be affected• DfreclCW of Nullingor deslgnee will compl8t8 anaudh of waund mnsuUanl recammendallons, ldanlifylng lf recommendelian was fallcl'Mld timely. Resldenls willh wound mnsultanlara lhe po1anial 10 **beaffected.** (3) Whll meauns wll beputInto place or what a,atamll: dlanga,cuwlll make u, ensure lhat 1118 deflclam **practlm dae** not recur? • Dil'IICIOr'af Nuiu,gand or designee wllllln-seNfce nurses on not admlnis!Rring lhllll:allons IOO atf and following pracasOrsigning. Taensure d'81n hlghallpnicllcalcare is beingrendered coour ralidtnts, DntlOr of Nursing and or designee will complltt anaudit of medlcaliDn adrniniSlraliOll, ensuring that rnedicatianl are not being glwn IO early and procass falaWlld focusing onsigning off on mecllcationl. Dnclarof Nul5ing **andoreleslgnee** wil ilH9MC8 wound teamontlmely followupohwund consullanl recommendations and obtaining wriaen Ol'dars. To ensur9 lhltlha hid1811prKIICllca ii beingrendeml ID **ourruldents,** Dlrec=,ofNursing and or cl8llgNe wlD complale anaudit of wound COl'ISUllllnl mc:ommandldonl, ensuring lhll dmaly followupand Onfeq **arawritlen.** (') Howtlle cornn:tJv8 Cldlan will llamanllDred IO ensu,e the daflclent pnic:llca wBl11111 rea,r, **l.e.,** what quality IISUtlnat pragram wlD be put lnlO place? • Pharmacy Consultant wil conduct randam audi1s of fec:llity medk:allon adnmisll'llliDnID•nsure S rlghll of admililInnlDn andIWl'ling pracauere being followed. FlndlnpwlllIie nipai1ed ID facility qual"ity BSS\l'lnce conwnllINmonlldyx3. Nurse Prectiliol11r Ittd or deslgnee will conducttandoln audiis or facility	aanom

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215121	A. BUILDING _____ B. WING	C 07/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ROCKVILLE	1701 VUIS DRIVE ROCKVILLE, MD 20890

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	MTI
F 281	Continued From page 2 Further review of the clinical record revealed no evidence that an order was written on 07-14-17 to pack the wound on the rawer back. Surveyor review of the Duty Treatment Administration Record (TAR) revealed that, from 07-01-17 through 07-18-17, staff were signing that they were applying a dry dressing to the area on the lower back. On 07-20-17 at 2:30 PM, surveyor interview with the nurse practitioner revealed that, from 07-14-17 through 07-18-17, staff had been packing the wound and applying the dressing as recommended by the wound consultant on 07-14-17, although they had been signing that they were applying a dry dressing to the area on the lower back. Per the Nurse Practice Act 10.27.09.02 E (2) (a) (iv), as a standard of nursing practice nursing staff are expected to document implemented interventions.	F 281	would consultant recommendations and follow up on Findings will be reported to the Quality Assurance committee for further review.	

Office of Health Care Quality

STATEMENT OF DEFICIENCIES AND PLAN 01' COM&CTION	(X1)MCMDERISUPPUERI ID&N'f1FICATIONMUM8EII:	IJC2) MULTIPLE CONSTRUC110N A IUIL0ING:	IQJDATESUIW&Y C0MPLEffD
	215121 B.	WING	C 07120l20LL

IWilE 0, PRCMDER OR SUPPUl!R	STRUT ADDR!IS. CITY, STATE. ZIP CODE
THE VILLAGE AT ROCKVU.LE	9701 VEIRS DRIVE ROCKVILLE. **MD ZOUO**

(M) IO : PAERJt' TAG '	SUMIIARV STATDl&NT CF DEFICIENCtES lv.ctl 0En;IENCY IIIUSTII PAICIO!D IY RA.I. REGUI.ATORY OR L8C IDENTIFYING INFORMATION)	ID PAEAI(TAG	PRCMDI!R'SPIANOFCORAECTION CEACH CCRRECTNEAC1'10N SHCULD Br CAOSS-REtlIRINCEO101HEAPPROPRIA1£ DEF1CIIHCYI	CJII) COIIIUT& DA11
SOOO.	10.07.02 lnillal comments The fallcMfng defteiencies **are lha** result of the annual Quality lnd'ator Survey (QIS) lo : determine the faclrity's compliance with state COMAR requirements c:onducfed on July 17, 18, 19 and 20. 2017. Survey activities consisted of a review of 70 medical records during stage 1 and 30 medlcaf record& during stage 2, observation of residents. staff practices. and intervfaws af residents, the ombudsman. family members and : fadltya staff. In addlUon, administrative records : and resident care policies ware atso teVlewed. In add"dlan to IClndanl sun,ey protocols, · camplafnll I MD 00115078, MD 00113198 and : facllity reported lnddent IMO 00113913 were · Investigated. This sun,ey did not identify : noncompliance with State requirements that were Lreviewed in relationship lo these complaints and • facility reported Incidents. j The facility is ricensed tor 180 c:ampretiensive 1 beds. All lime of this survey the facility census I was 153 beds.	S000		
S5121	10.07.02.12 R Nsg SVCS: Charge Nurse Daily : Rounds .12 Nursing Services. R. Charge Nurses• Dally Rounds. The charge 1 nurse or nurses shall make dally rounds tD all nursing units far which responlible, performing 1 such functions as: i (1) Visiting each patient: , (2) Reviewing dlnical rec:ards, medication orders. patient care plans, and &laff assignments: • (3) Ta Dia degree possible, accompanying pt\ysfdans when visiting patfenlB. I	S512	See CMS 2517 F281	08'10"7

OHCQ
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRE! ASSIGNA — TITLE Executive Director — (X6) DATE 8/3/17
STATE FORM 3W6N11 f continuation sheet 1 of 2

PRINTED: 0712512()17
FORM APPROVED

of Health...Care...Ovallbil

ITATUENTOf' DE1ICll!NCES ANO PIAN o, C0ARECT1DN	IX11 PRCMDEAISUPPLIERICLIA IDENTl'l'ICATl0N NUMll!lt	CX2) MULTIPLE C0NSTRUCTI0N A. BUILDING: _____	CJQ> DA.TE SURVEY COMPlR1ED
	2111125	aWIIG	C t'l/20'-2l17

NN.90,PRCMDEJIOA UER	STRl!ET ADORESI, QTY, STATE, ZIP CODe
THE VILLAGE AT ROCKVILLE	1701 VEIRS DRIVE ROCKVILLE, MD 2Cl85G

CM)ID MEFIX TAG	SUMMARY STAT!MeNT OF aeFICIENCG!S (EACH DEFICl8IC t MUSTIE PRECEOED IV fUU. REGUlATCRV OR LSC IDSffll'TING l•DRMATl0N)	ID PREFUC TAG	PRCMDIR'S PINI 0, COM!C110N EACH CORREC'IIV!ACTION SHOULD BE CROS&-R&fER&NCITOTHI APPROPfUAlll! DlfltCIENeY)	pcS) COIOUff DAn
S 51Z.	Continued From page 1 This Regufatlon Is not met as evidenced by: I Refer to CMS 2567 F281	S512	See CMS 2517 f281	Olll0#l7

STATEMENT OF DEFICIENCII!S AND PLAN OF CORRECTION	(X1) PROVIDeRISUPPLIEAICUA IOENTIFtCATION NUMBER:	(X2) MULTIPLE CONSTRUCTION ABUILDCNO	(X3) DATE SURVEY COMPU:TEO
	216125	B WING	C 3116/2017

NAME OF PROVIQER OR SUPPLIER	STREET ADDRSS. CITY, STATE. ZIP cooe
THE VILLAGI! AT ROCKVILLE	9701 VEIRS DltlVI! ROCKVILLE, MD 20850

(M)IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRI!,CEOEO BY FLU REGULATORY OR LSC IDENTIFYING INFORMATION)	I) PREFIX TAG	PROVIDER'S PLAN OF CORRiCllON (EACH CORReCTIVE ACTION 6HOU1.0 BE CROSS-REFERENCED TO THE APPROPRIATE DI!FICIENCY)	CX!) COMPLE'TIOH DATE

F 000 INITIAL COMMENTS

On March 13,and 15, 2017, an onslte Investigation was conducted at this facility by the office of Heallhcare QuaUty to Investigate complaint M000110152 and facility reported Incidents **MD00109982,** MD00110153, MD00110791 and MD00110803. Survey activities Included a review of the residenrs medlcal records, Interviews of facility staff, observation of staff **practices and** review of administrative records.

This survey did not identify non-compliance with Federal requirements that **were reviewed** In relatlonship to complaint M000110152 and facUity reported Incidents MD001099B2, MD00110153, MD00110791 and M000110803.

However, the following deficiency was Identified during the Investigation of MD00110803 and Is unrelated to the facility reported Incident

F 281 **sS=-D** 483.21(b)(3)(1) SERVICES PROVIDED MEET **PROFESSIONAL STANDARDS**

(b)(3) Comprehensive Care Plans

The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-

(i) Meet professional standards of quafity.

This REQUIREMENT is not met as evidenced **by:**

Based on surveyor obselvation, review of the clinical record and staff Interview, It was determined that the facillty staff failed to folJow nursing standards of practice 10.27.09.02 e Implementation, The nurse shall Implement the

F 000 This Plan of Comclion Is **prepared and** executed **beca,ue** It Is requlrtd by tbe pravbions **of tbe** Stale **and Federal** rqubtions ud not beca11s. The VWase at RodMile 1,l?CU with the aJlea:atlons and citations listed on the 1lltemeJK of dellcimc:ics. Tbe Village II Rockville 11W11taln s that tbe alleged dclld.cndes do not, indlvldually and collccliYdy, jeopardize the hralth and safety of the residents, Mr IR they or such character as to llmlr our capacity 10 render adequate care as pmaibcdby regubUon. This Plan of Conedlon lhall operate as The Village at Roc:kvllle's written cttdlble allegation of compllance. By subml1t1ng this Plan of Coneclion.1be Village 11 Rodcvllle does not admit lo tht accuracy of defldenclH. Tbls Plan of Conec:liolI Is not ineant 10 esrabllsb any 11aiidatd or cue, contract, obllgallo11, or position, and The Village at Rodtvllie reserves all rights to nlse all pomble contentions and dlf1nses hi *uy* civilor criminal claim action, or proceeding.

F 281 !. Whal con«1lve action will be accomplllhed for those resldenu fouad to have been effcc1cd by I.he deficient pncllcel S1 4 7

ClltnUI cUent was ISfCSSCcl by pbyslcbn on 2-4-17 and Physician Indicated that client tteeived fo11t Uten of Nonna! Saline and condition slowly lmpro\llng. No negative outcome noted due IO nurses{allure to document toul amount admmlstcml, when IV **wu Inserted.**111d when IV **was**, initiated.

.\! P'l{ \ 5 ?il:.CU

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESE A TIVE ENTATIVE'S SIGNATURE | TITLE Executive Director | (X6) DATE 5/5/17

Any detlc:le nt ending with 1nfasterisk ll denotes a deficiency which lhe lnatitutlon may bo excused from comtetlng providing It It delennlnlld tliat other safeguards sufficient protection to the patients. (See fnsbuc:tions.) Except for nunlng homes, the findings stated above are dlscloeable 90 days follow1ng the date of survey whether or **not a** phln of correction Is provided. For nursing **homes, the above fwfings and pll111** of correction **are dlsclD■able** 14 **days follow1ng the date these documents are made available** to the facility. Jf **defiellllncles ■re** dtecl, an approved plan of correCIIOn Is requlalle to contfnll9d program **participation.**

STA'reMENT OF DEflCIEtilCIES ANO PLAN OF CORRECTION	(Xt} PROVIDERISUPPUSRICUA IDENTIFICATIONNUMBER;	()(2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPUm:D
	216126	A.BUILDING _____ B.WING	C 0311512017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE. ZIP CODE
THE VILLAGE AT ROCKVILLE	9701 VEIRS **DRIVE** ROCKVILLE, MD 20850

(X4) ID PREFIX • TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH RECTIVE ACTIONSHOULD BE CR0SS-REFERENCEDTOTHEAPPROPRIATE DEFICIENCY)	CXII COMPLITIOH DATE
F281	Continued From page 1	F281	2. How yuu will Identify other residents having the poten!W to be affected by the same detlclent praake and what corrective lcilon will be taken?	S/24/17

Interventions identified In the plan of **care,** measurement criteria, and interventions which shall be implemented in a competen safe,and appropriate manner consistent with **knowledge** of scientific principles and documented. This finding was evident In 1 of 9 residents selected for review during the Investigation of facmty reported incident MD0D110803 and Is unrelated to the facility reported Incident The findings include:

On 03-15-17, review of the clinical record revealed resident #1 had an order dated 02--01-17 at 4:25 PM to administer Sodium Chloride solution 0.9%, also known as normal saline (NS). Intravenously at 75 cc.Jhr for a total of 4 liters of solution due to a low sodium level. The NS comes In 1 liter (1000 cc.) **bags.** To deliver 1000 cc of fluid at 75 cc/hr It would take 13.3 hours to Infuse.

Further review of the clinical record revealed no evidence of the time the IV was Inserted and the NS was initiated for resident #1.

Review of the MAR (medication administration record) for February 2017 revealed:
- On 02-01-17 on the 7 PM-7 AM shift resident #1 received 1000 cc of NaCl 0.9%. This Is questionable If the rate was as ordered at 75 cc/hr. This is a 12 hour time period.
- On 02-02-17, on the 7 AM -7 PM shift It was documented that 300 cc. of NaCl 0.9% was administered in 12 hours.
- 'On 2-02-17, on the 7 PM-7 AM shift revealed 900 cc. of NaCl 0.9% was administered.
- 02-03-17, from 7 AM-7 PM 800 cc. of NaCl 0.9% was administered
- 02-03-17, from 7 PM-7 AM 900 cc. of NaCl 0.9% was administered

Clinial Care Coordinator willcompkte an audit of residmts who have orded for IV flu1ds to ensure that IV ofders have amount administered documented, when *IV* wu Inserted documented. and when IV was Initiated doculll!'ntcd.Clients with IV orders for fluids have the polentlal 10 be: affected.

3. What measures will be put Into place or wha1 systemic changes)'Du will mm toensure that the deffdenl pnctice does not recurf

Clinical. Care Coonlinator and/or Care Co;ichcs wlll ln-rvlce all licensed stalTon the process o([V orden and standards *of* practice as lt relates to IV Ouids and ant0WII admlnlsltred, lnsmion oCIV, and IV IAltiatcd. To ensutt lhe best mcdkal care possible for the dienu. Clinkal Care Coordinator willcomplete an audit or clients wbo haveofden !or a IV fluids, ensuring lha1IV fiulds have the proper documentation pctr nurslAg slAlldards of practice.

4. How the cotreetivc ac:tlon(s) will be monitored to ensure the defJCient practice will not recur, **I.e.,** what mullllce program wW be pu1lnto placd

Clln!Ql Catt Coordinator or deslgnff will conduct random audjts of cllents with IV ofders to ensure nursing ,tandards of practice are being met

Findings will be reported to facl1ity quality a5$U c committee monthly x3.

STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CU'\ IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) 0.-.TE SURVEY COMPLETED
	2111120	A. BUILDING _____ EVING	C 03115/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, crrv. STATS. ZIP CODE
THE VILLAGE AT ROCKVILLE	9701 VEIRS DRIVE ROCKVILLE, MD 20850

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCISS (EACH DEF1CIl:NCY MUST BE PRECEDED BY FULL REGULATORY OR LSC ID£NTIFYING INFORMATION)	IC PREFIX TAG	PROVIOER'S PLAN Of' CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCEO TO THE APPROPRIATE D!fICIENCY)	(XS) COMPI.ETION D"TE
F 281	Continued From page 2	F 281		

There was no further evidence of fluids administered on 02-04-17 to resident #1. This totals 3900 cc., not the total of 4000 cc. as **ordered.**

Review of resident #1's progress notes revealed the followlng:
On 02-02-17 at 8:02 PM [11]OnNS@75 cclhr x 4 liters via right arm peripheral flnErbag 2/4 in progress at this time with no IV-related compllcatlons noted at this time.•
2/312017 at 07:00 **AM•... Type** for eMAR (electronic medication administration record)
Note Text Sodium Chloride Solution 0.9 % Use 75 cc intravenously every hour for Low sodium Administer 4 liters bag 314 started at 3:25 am." 2/312017 at 10:37 **AM"...** Note Text Guest w/ low sodium (2/1120; 212118). Started on NaCl tabs and IV NS @ 75 ml/hr x 4L. 3rd L (liter) Infusing at present ..... Will continue to monitor and *flu* as needed."

There was no further evidence of when the 4th and last bag of NaCl was administered either In the progress notes or In the MAR.

• In addition, it is unknown what occurred after the last 1000 cc. was administered, If the peripheral llne of resident #1 was removed or remained In place with a maintenance plan to prevent blood clots from forming In the *N* line and maintain the patency of the line. A peripheral JV line Is a small cannula/catheter inserted Into a small peripheral vein for therapeutic **purposes such** as fluid or medication administration.

Resident #1 was seen on 02-04-17 at 3:52 PM by the attending physician as documented....
"A (assessment): Hyponatremla (low sodium),

STATEMENT OF DEFICIENCIES **ANO Pl.AN** OF **CORRECTION**	(Xf) **PRO\IIDER/SUPPLIER/CIIA** IOENTIFJCATION **NUMBER:**	()(2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	216125	AB LOING _____ B. WING _____	C 0311512017

NAME OF PROVIDER OR SIJPPUeft	STREET ADDRESS, CITY, STATE, ZIP COOE
THE VILLAGE AT ROCKVILLE	9701 VEIRS DRIVE ROCKVIUE. MD 20850

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATIONJ	ID PRI!flX TAG	PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSs-REFERENCEDTO THEAPPROPRIATE DEFICIENCY}	CXII COWteTION OIIT1'

F 281 Continued From page 3 F 281

: slowly improving
P(Plan): Finished 4 liters of NS, will need at leat (sic) 2 more bags, wil start IVF (Intravenous fluids) at 5 PM per patient request
Check BMP (laboratory blood work) on Monday."

Reliswl111Jtad a fall at approximately 7:30 PM on **lllllllllmd was** sent to the hospital. Review of the progress notes revealed no IV fluid was being administered at the time of the fall.

On 03-15-17 at 1O AM, Interview of the Director of Nursing revealed tllat the electronic medical records used by the facility are not conducive to documenting the Infusion of intravenous fluids.

There was no evidence or documentation of the total amount of NS being administered or the care of the peripheral line when no fluids were being administered.

O.ffice of Health Care Quallhi

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	{X1) PROVIOER/SUPPLIERICUA IDENTIFICATIONNUMBER:	(X2) MULTIPLE CONSTRUCfION	(X3) DATE SURVEY COMPLETED
	215125	A BUILDING: _____ 8.WING _____	C 03/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE. ZIP CODE
THE VILLAGE AT ROCKVILLE	9701 VEIRS DRIVE ROCKVILLE, MD 20860

(X<I}tD PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY **MUST SE PRECEDED BY** FULL REGULATORY OR LSC IDENTIFYING INFORMATION}	ID PREFIX TAO	**PROVIDER'S PLAN** OF CORRECTION (EACH CORRECTIVE ACTION SHOULD SE CROS$-REFERENCED TO ffIEAPPROPRIATE DEFICIENCY)	()(5J COMPIETE DATE
s ood.	10.07.02 lnltfal comments On March 13, and 15, 2017, an onslte Investigation was conducted at this facllity by the office of Healthcare Quality to Investigate complaint MD00110152 and facility reported Incidents MD00109982, MD00110153, MD00110791 and MD00110803. Survey activities included a review of the resident's medical records, Interviews of facility staff, observation of staff practices and review of administrative records. This survey did not identify non-compliance with State requirements that were reviewed In relationship to complaint MD00110152 and facility reported Incidents MD00109982, MD00110153, M000110791 and MD00110803. The following deficiency Is the result of this visit and is unrelated to the complaint or incidents.	S000	Rd'er 10 PoC Cor CMS 2567 FZ81	5/24/17
s 506l	10.07.02.12 ONsg SVcs;Care 24 Hrs per Day .12 Nursing Services. 0. Nursing Care-24 Hours a Day. There shall be sufficient licensed and supportive nursing service personnel on duty 24 hours a day to provide appropriate bedside care to assure that each patient: (1) Receives treatments, medications, and diet as prescribed; (2) Receives rehabilitative nursing care as needed; (3) Receives proper care to prevent decubitus ulcers and deformities: (4) Is kept comfortable, clean, and well-groomed; (5) Is protected from accident, Injury, and infection; (6) Is encouraged, assisted, and trained In self-care and group activities,	**S506**	Refer 10 PoC for CMS 2567 F281	5/2,t/17

OHCQ
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 5/5/17

STATE FORM 6JIZ11 If continuation sheet 1 of 2

Offi of Health Care Quallty

STATEMENT OF DEFICIENCIES AND PLAN OFCORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATIONNUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETEO
	215125	A. BUll.DING- _____ B. WING _____	C 03(1612017

NAME OF PROVIDER OR suPPUER	STREET ADDRESS, CITY. STATE, ZIP COOE
THE VILLAGE AT ROCKVILLE	9701 **VEIRS** DRIVE ROCKVILLE, **MD 20850**

(X4)1D PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGUIATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CRO EFERENCEDTOTHEAPPROPRfATE DEACIENCY)	()(5) COMPLETE OAT£
s 506	Continued From page 1	S506		

Thia Regulation is not met as evidenced by:
Refer to CMS 2567
F281

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/14/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PINf OF CCRRECTION	(X1) PRO\IIDERl8UPPUERICUA IDl!NTIFICA110NNUNIIR: 2111 .	(X2) MULTIPLE CONSTRUCTION ABUILDING ______ B,WING.	(D)DATESIJR'4Y CQMPI.Em) 07/08/2016

NNtE 0, PROVIDER OR SUPPU	ITREETADOIISS.cnv.8TATE,ZIPCODE
NATIONAL LUTHERAN HOME	1701 VEIR8 DRIVE ROCKVILl.i, MD 208IO

()(4J ID PREFIX TAO	SUMMARY STATEMENT OF OSFICICHCtU (EACH Dll!l'ICl!NCV MUST Be PRECED&D BY FUIL REGULATORY OR LSC IOENTil'YINO INFORMATION)	ID Pll!I'D(TAO	PRCMDER'S PLAN OF CORRliCTION (EACH CORRECTNeM:'TION SMOUID 8! CR088-REFER!HC!DI0THE.APPROPRIATE DEFICIENCY)	Mn!
F 000	INITIAL COMMENTS The folowing deficiencies are the result of the annual Medicare/Medicaid QIS recartlflcatian ewvay conducted on July 5, 6, 7 and 8, 2016. Survey activities consisted a review of 70 medlcal records during stage 1 and 25 medical records during stage 2. obsefvation of residents and slafl' practices, and intetviews of residents, famBy member&, and the ombudsman and facifity staff.	F 000	Tliis Plan of Corredlan II prepanid n, execded beoause 11,, reqi.ved byIlle Pl'IMSIOIII oflhe 6b11a end Federal regulalionl Ind not because 1hlt Wege at Racblile ..,.__wllh lhe allegalon■ and dlellons llIled anllle11tement d delldenc:lea. The Wage al Roc:kvllle malntanl that the alleged ddclendal do not, lndlvkualty and . 'feopaldZe lhe hullh and safely of the relllerlll, nor are lhey of such c:hsader n to lmlt our capacity to render adequate Clf8 as preecrlbed by rapllon. 1hls Plan of Cornsdlan ■hall opeme.. The Vlllaa• at Rock\tle'I wstnen credible aJJegallon ofc:ompllance. By aubmlttlng 1h11 Plan of Ccmldlan, Tlle Vllaga alRodNllle does nat ldmll	
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent sun ey of the facifily conducted by Federal or Slate SUlYe)'Ol'8 and any plan of conection In effect with respect to the faclllty. The facility must make the results avaBable for examination and mulf post in a plece readily accessible to resktents iId mu sf post a notice \ their availability. !;:Is REQUIREMENT Is not ... ced Based on surveyor observation and staff and resident Interview, it was determine d lhat lhe facifity staff failed to make the most recent survey, resulls avallabla for examination by posting In a place readily aocassibla to residents, as wall as posting a notice of their availability. Th• findings, Include: on 7-8-18 at 10:00 AM, surveyor Interview with the resident council president revulad that she/he was not aware that the most recent survey results were avaDabre to residents for	F 1671	ta._ acanc:y o1deflc:lencl.._ Thia Plan or ConacUon fl not meant ta ..cablllh-,atandanl of care. CCll1lr8cl, abllgatlon, or pcmlllon, and The Vllage al RGclcvllle resenn aD llgJD tor'lile all ponlbta oontenlionl and defenses In any clvll or alnllnal dalm adlon, or proaeedfng• 1, What correctfve action wfll be accompll:shecl for thase IN!doni. found to haWl bNn affec:tecl ll» the deficient pracdat ConectJve action wu C111-1ipleled-"" on 7rat18by Ole llelocatlon of sun.eylPoCa copies..N graund floor enlranal a dil,1liJ C8lVhis bNn die repo,1$ 11 surwyllPoCl for p!Jlllc aaaeu 1n1 lnfonna1lon. 0n .... floomnaln addedtolhefrontdNPkwo11.leadymarred labels cleatt;' l'll8l1fad flbell ldenllfJfng 1h11repo,118S su,wyllPaCa forpubic accna ancUnfOfflllan. 2. Haw you will ldendty other raldentll having l11•potellllal to lboaflDc:tDcl bf the same ddclont practlCe andwltll cOffOGtlftactlon wlll lla taken? All lllldanit have Ole polentlal IO be affedal by1he ume ddcllnt ... provlding it is determined that labellng ldentltyfng the lnfonnalon • Uwtyll PaCa ... willbemade It regulady lCheclulid realdent counal meetings to lncreaae awareneu cl llm!III to the lnfotmatlon.	1/ZZl18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 7/30/16

Anr • · an..... r,denoteaacldclencywlllchUlelmllullon1HybetllQIIOClfrom corrac&,g

other • piovtde suffldanl p,ollClJon ro the patlenls. (Set lnStlucllons,) Except fDr ninlng llolnls, lhli llndlnp llated oove 119 dlldoeallle 90 clap

followlng the date of ■UNB)I whether or nate plan Ofcairedlon II p,ovlded. Far nulling ttomes, Iha abowe findings ■ndplans of m.ec:tloll .,. dlldos■ble 14 days folowlng Ila, date Utdse doc:umanll are made avalhtbla to lie fldlly. If deflclanc:ies ■re clad. an•PPftMld plarad co la ,aqulsllt to continued program partlclpallon.

8TAT Nr'OF DEFICIENC!al ANOPLAN Of CORRECTION	CX11 PROW)ERISUPPUERICUA IOEHTFICATION NUll8ER: 21112'	pea) MULTIPLE CONSTRUCTION .A:- BUILDING ___ I WING_	(Xa) DATE SURVEY COMPUTED 07/Gll2018

tW!'E OF PRO'ADER OR SUPPLIER	STRI:ETADDRI!S8,CITY, 8TATI!, ilP CODI!
NATIONAL LUTHERAN HOME	97G1 YEIRS DRIV& ROCKVILJ.E, MD 20850

p(4) 1.D PRl!fOC TAG	8UMMARV STAT!MI!NT OP Dl!FICIENCll!s (!ACH mFICIENCY MUST 8& PRECEDED BY FULL REOUlATORY OR LSC IDEHTFYING INFORMATION)	ID , IX	PRCMOER'8 PLAN°0f CORRECTION " (EACH COM!CTM!ACTION SHOULD BE EFERENCEDTOTHEAPPROPRIATE DIFICENCV)	1+
F 167	Continued From page 1 examination. Raaditf accessible to residents would mean fn a place sueh as a lobby or olher area frequented by most resldenlS and whera individuals wishing to eumine survey results do not have to ask to see them. On 7..S.16 at 11;00 AM, surveyor observation of the lobby revealed the fsctllty staff didn't post a notice stating the avalabllity of survey rasulls. Further observation and Interview of the front desk receptionist reveaed the swvey results notebook was kept behind the front desk where a resident or a YIBltor would haVe to ask a staff member to hava access to the BUfVeY resulls. On 7..S-16, interview with the Directer or Nursing ravealad no ftJrther Information.	F 1871	3.. Whit ffNIUIW wfl be put lnta place or What syatamlc changes you will malut ro enau,. that tho daflclent practice does not NCUr? Alllll8nl to the Elltc:utlvll Director wa con&mlhat lhe uveylnfonnatlan nmalns In anaazalbll eru tobalh lll8lclenla and vialtolL SUMyllPoC binder -11nolongerbelritp1111eadl enlranca ona ahelf 111 Ille recepllanllt dak. Nellher lesidenll nar lllsllOtl ....need to•• far aa:esa lo lhe lUlVey lnrormatlun. 4. How lho correctlvo ilctlon(a) wll be monitored to ensura 11\e deficient p,ectfce Wliinat 1'9CUr, Lo,, what qllllfty aaurance program wlll be put Into place? Aallllanl to the Exeallva DhctorwlO rautlnely dledc each display ... to make1&n: (1) capfa May upID date to rellecllha fflOll cwre,t completed survey Wllh Poe n (2) '1at any 0/Jfl'I temolled IP/a resident m vllllor has Ileen replaced lolrmunt acceaalDall. Alllllanltoll8 Dhctorcr tonldnk llaffIng.prllVlda I 0011'1 lo an,one requellJng IUdl. CGmplancewllbe rapoR8d tolhe OAPI cammHtee for 3 man1hL The plan may be amended by the QAPI conwnlttee to... continued campllance.	1
F 248 SS•B	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facnlty must provide for an ongoing program of activities designed to meat, in accordance with the comprehensive a1S881ment. the lntare&ts and the ph)'aical, mental, and psychosocial well-being of each resident This REQUIREMENT is not met as evidenced by. Based on surveyor obseMttlon, review of the dlnlcal record, and staff, resident and family interviews, It was detannlnad that the facl&ty failed to ensure that an ongoing program of activities designed to meet, in accordance with the comprehensive aSNS&ment. the Interests and the physical, mental, and well-being	F 248	11. Whatcomn:tlva action wfll be a"ompDlllad for lhOIO IWldants found to hava been atrecllld by lha dlfldent Dntdlee? Resident. 31! 2. How you wm klantlly othar l'lllfdenll havblg Cllo pat9ntlalto be.,.._. bythe•me dafldant pndlco and what camN:tlvo ectfan wlll bo IBlatn? Al resldenll have Iha polientlll ta be ■ll'eclad lhe aame delldent pnidlm. Al ac:thlly care plane and adlvlly ...,.simnts \IMJ beNN!ewed to ensure ac:ancy, Resldenla with documerded Interests Ill aclMly par11dpllllan wlD be encawqed to atllnd and !heir allendanc:e orrefuNI wlD be dOaunanted monthly In calreainll. 3. What m■u u ras wlll beputInto place or what systemic dlangnyouwlllm■llotoon■un1 lhat 1118 delclent pracace does not nacul? &tiff edur a on ancl- ■ro-lffilcn Yltl be	113111

NAME! Of itRCMDER OR SUPPUIR
NATIONAL LUTHERAN HOME

8TAEET ADDIU!SS. crTY, STATE. ZIP CCOE
1701 VEIRS DRIVE
ROf;:KVILLE. MD 20850

TAG	' Sufl.Wtv STATEM!NT Of DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX	PROWJER'SPlAN OFC0RRECTION (&ACM COMECmlEAClION SHOULOIE BE EAPPROPIMTI:
F248	Continued From page 2	F 248	

of each resident This finding was evident In 1 of 25 residents salacted in the stage 2 reviews (1385). The lindngs include:

On 7-6-16 at 1:415 PM, aurwyor Interview with a family member revealed that resident #385 wu not participating In the llfe enrlchm,nt (resident activity) program at lhe faciflty. Furthermore, the family member stated she believed that facility Staff had not Invited the resident to the Bfe enrichment activities.

Surveyor observation of resident #385 on 7-6-16, 7-7-16 and 7-8•18 revealed herlhim sitting In the wheelchair In herlhla room most of "'8 day. She/he did leave tile room for therapy and her/his family visited each day. However, resident #385 stated that shelhe would like to participate In the fife enrichment program.

Review of lhe cllnlcal record revealed that the care plan, dated S.7-16, included the following goals: resident will pa,ticlpate in 1-2 self.fnltlated activities dally that support therapy effol1a until discharge occurs, encourage self-direded activities as guest energy permits. provfde guest with materials and supplles based on (hialher) Identified mterests, guest needs aaslstance lelcort to actfvfty functions, and invite guast to attend musical events.

Further review of the dlnlcal record revealed an activity assessment on 6-7-18 was done end the resident reported that It was aomewhat important to do things with groups of people and tD do favorite activlllea, and very impor1ant to be around pets. However, thare la no evidence that resident #385 was Invited or assisted to any activities

4. How the cornctlvo K1 1on(•t wll bo manJtcnd to ensure thll d■lld ent practice wll not.....,, l.o., what q aaunnce p,ogram wlll Ila put lnlo place?
Audlta of adhlly QR planstassasment wlll be mlewad QA Commllteemont Ny x3. Auclll of ICli1otly pal1idpallonlrdlsal WIO be reviewed QA Cclrnmlt■morthly x3..

ITATBENT OF DIFICIENCIE8 AND PI.ANOF CORRECTION	(Xtl PR<MDIIVlllPPUEM:LIA IDEHTIPJCATION NUMlllt	(Jl2J MULTIU CONSTRUCTION	CQI DATE SURVEY C0UPLI1B)
	215125	A. BUI.DINO I.WING	07I0812018

NAME OF PROVIOEf! pR SUPPUl!II	8TRE&T ADDRESS, CITY, STATE. ZIP CODE
NATIONAL WTHERAN HOME	1701 VIIR8 DRIVE ROCKVILLE, MD 20IIO

PREFIX TACJ	9UMMM'f STATEMENT OF ueFICENCIES (EACH OEFICIIHCY MUST BE.PREa!DI!O BY FUI.L REGUI.ATORY OR L8C I0ENT1FY1NO DFORMATIOH)	ID PREFIX TAO	PROVIDM'I PLAN 0F C0RR&C1I0H (EACH C0RREC11VEACTION SHOULD Ii CR088-REFEREHCED TO THE APPROPRIATE O&FICIENC't)	DA1E
F 248	Continued From page 3 On 7-7-16 at 1:45 PM, Interview with the gerlalrtc nursing asaistant (staff #2) revealed that aha/he hasn't dlsc:uased ar encouraged dally actlvllles with resident #385 because hlalher daughter villtl every day. On 7-7-16, Interview with the life enrichment aaalalant (staff #3) revealed that she/he couldn't confirm that resident #385 attended life enrichment activities because resident pa,tlclpatlon Isn't documented. On 7..S-16 at 11:00 am, interview with 198fdent #385 revealed the villting dog came to herlhls room •one or two times• and it made her/him very hippy. The resident COUid not recdpartldpatlng In any further activities. On 7-8-18 at 10:30 AM, intelview with the director of life enrichment revealed the life enrichment staff don't documant Individual resident participation in the program. On 7-8-16 at 11:00 AM, Inletvlawwfth lhe Director of Nursing revealed no further information.	F248		
F279 SS-8	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must usa the mull&·of the a88888ffl8nt to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that Includes measurable objecllvas and tlm81ables to meet• resident'& medleal, nursing, and mental and payc:hOSOcial needs 1hat are Identified In the c:amprehenslve assessment	F279	t. What coJNCtlve action wlll lie accom,ll1bed ror IN16 thou raldenta found to have IINn llffw:tad bJ the dellclent pnictlce? alanl153 &•101werw , ... _, bJ Phyllclan and I RN Nurse M■n■ger and _, negative outcome• lurtl-,concemswe,e NlIlNI • • 19Mdt0flhe an p■n not being InllflCed I0 ■d dl■u the ■Ide effada auodalfld with anllOOaaulanta. Z. How JOU wll ldentlfJ other raldentll having the poeentlll to ba atracwd br the ame deflcllnt practice and what cOffllClmt action wlll batllMn? Dlrec:torof Q..uty AIMll'°9 complel8cl 11'1 ■udlt of mitlll'lllgunt who wIl8on ullml, IdenllJilng If a C818 plan wU In plla lD addraa llla Ilda affecll UICldllled with IM.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CI:NTERS FOR MEOICARE & MEDIC SERVICES

STATEMENT 0FDEFICIENCIES ANDPLANOFCORRECTION	(X1) PROVIDER/SUPPLERICUA IDElmFICATION NUMBER:	(X2) MIA.TIPLI CON811WCTION A.BUIt.DiNG	ptS) Di\TE SURVEY COMPI.ETED
	211121	B.WINO	071G812Dt8

NAME OF PROVIDER OR SUJtPLJER	STREET ADDRESS, cnv,STATE. UI 000&
NATIONAL LUTHERAN **HOME**	9701 VEIRS DRIVE ROCKVILLE, 11D I08IO

(X4J ID PREFIX TAG	&UfellARY STATEMENT OFDEFICIENCIES (iACH DEFICIENCY MUST BE PRECEDED BY FULL REGUIATOAY OR L8C IDENTIFYINO INFORMATION)	ID PREFIX TAG	PROVIDER'& PIAN OF CORRECTION (eACH CORRECTIVEACTION SM0UU) BE cmoss.REfERENCEDTOTHEAPPROPRIATE DEFICENCY)	IW£
F 279	Continued From page 4 The care plan must de&cnbe the services that are to be fumlshed to attarn or maintain the residents highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise ba required under §483.25 but are nat provided due to the resident's exercise of rights under §483.10, Induding tha right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not mat **as evidenced** by: Based on surveyor review of the Clinical record and Interview with staff, It was determined that staff Faired to devetop a care plan to addNSS possible side effects associated with antfc:oagulants. Thia finding was Identified In 2 of 25 residents setacted In stage 2 reviews. (#53, #107) The findings Include: 1. On 07-07-16, clinical record review revealed resident #53 has diagnoses to Include atrial ftbrHlatlon. Atrial fibrillation Is an abnormal heart rhythm characterized by rapid and Irregular beating. A risk fador with atrlal fibrillation is the formation of blood clots. Based on review of the physician order sheet for resident #53, o,_ following a ra-edmisalon to the facility, Iha physician ordel'8d Xarelto 20 mg. xaratto 11 used ta prevent blood clotl from forming due to a certain Irregular heart beat, auch as atrtal fibrillation. It Is also used to treat blood clots and to pn,vant the blood dots from forming again. Xarefto18 an anticoagulant that works by blockIng certain clotting proteins In the blood. On 07-07-16, review of the care plan for resident 3 revealed that there was no care plan	F 279	Other IIIIdenIIIguelIt on anIcoagulant use hid 118polantlal to be affected. All realden!II guat who did nal have a care plan In placa were c:anadad at the time of Int audil. a. Wllat measures wtll lbe put Into place or what ayatllmlc chanpa youwlll mab toensuiv lhllt b dafldent p,actlce does nat I'IICUr? DnclOr of Nuf'lfng ln-eervlced nurse managers and aupemsora on Inlllallng care pfanS to address 1'81ldentslguesl onenttcoagulanl use and 1h11 8IIOClated slda effac:ta, 1he Director of Nulling and/ ordaslgnae wlll ln-Hnllce Vie llcensacl nuraes on lnlliallng care plans•• a result of comprehenSly8 aaaumen1I that .. completed. IrMarvieas wll be ledB-3-1a. 14. How1119 cofflldlva actlon(st wfll 119 monitored to IMUIW th• dllllclent practlat wlll not recur, Lt,, whit quallly uaurance program wlll be put Into place? TlieDirector of Nlrllng or de:llgnee v.111 canduct randOm audits of cara plans, foculIng on those allOdatad wUh anllcoagulant ..... to enauRI and lhat care plans are **mmprehenSlve 111d** address plltflntlal llllo affect8. Findings wlll be ,-portad to facility qUlllly auurance cammlttee fflOIIUlly113,	

STATEMENT CFDEFICIENCIE8 AHO PIMI 0, C0IIRECI10N	(X11 PROVIDERISUPPUE IDENTIFICATIONNIMI!R:	(JC2) MULTW'I..E CONSTRUCTDI A. BUILOING-::-----,..,._--- 8.WINO	(XJJ DI'TESUIMIV COWLETED
''	2115125		07/08'201 1

: NAME OFPROVIDER OR.SUPPUI:R.	811I!ET ADDRESS. CITY, STATE, ZIP CODE
NATIONAL LUTHERAN HOME	t701 YEIRS DRIVE ROCKY,ILLE, 11D 2GBH

(X4)1> PREFIX TAG	SUMMARY STATBIENT OF 0!PICIENCES 11:ACH DEFICIENCY MUST BEPR£CE01:D BY FULL REGULATORY OR L8C IDENTININO IHFOftlMTION)	•0 PREFIX TAG	PRO'tlll)191'1PI.AN 0F CORAIIC110N (I!iACH CCRRECIIV& ACTION SHOULD BE CROS8-AIFIR&NCED TOTHE APPRCPRM.TE DEFICIENCY)	IWl
F 2791	COntlnued From page 5 addressing lhe risks associated with anticoagulants such as: easy bNlalng or bleeding, pain, swelling. There was no careptan that would Include prevention of Injury and monitoring of the side effects of antlcoagufants. On 07.0S-18 at 8:45 AM, lnterv1ewwtlh the director of nursing revealed no additional lnfonnation. 2. On 07..07-18, ravlewofthec:irmllrecord f ravealecl that resident #107 wu p,escribed an anticoagulant for abia1fibrilallon upon admlsslOf'!: Further review of the Medication Adminfstration Recani (MAR) revealed the nursing staff signed off the anticoagulant was adminlstan!d dallV as ordered between In resident #107 was sant *to* a hospital due to a change of condition. The resident ratumed to the facility after a 10- day hospitalization. Upon re-admlaion, resident 1'107 was prescribed the same antlc:oagulant for atrial fibrlllatfon. InMarch 2018, a new anUcoagulant. XareltD, was ordered for raldent #107 to treat atrial fibrillation. On 07-08-16. review of the MAR between revealed the nuraing ataff signed off that the anQcoagulant was given dally as ordered. However, 1here was no care plan written related to anticoagulant therapy since On 07 18 at 11:35 AM, lntervfewwlth the director of nursing and qua6ty assurance coordinator revealed no addltlanal Information.	F279r-		
F 309 SS=D	3.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must ceive and the facility must	F 30911. What cormc:Uve ac:llan wlll be1ccampll1had for fllSNI lhoae resldema found to havttbeonaff.ctedbJ the doflcltmt pncdce? Resfdenl 1118 wu •sesled by Phylldln and RN Nurse Manapr and na negaUve outcome ar lllther c:ancems wfll noted u a result of Ull bnled fadllw		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215125	B. WING	07/01/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NATIONAL LUTHERAN HOME.	17411 VEIRS DRIVE ROCKVILLE, MD

TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	(Continued From page 1) provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on survey and review of the clinical record, interview of facility staff, attending physician and assistant, it was determined that the facility staff failed to follow a physician's order for resident #188. This finding was identified in 1 of 26 residents selected in the stage 2 reviews. The findings include: On 07-08-16, review of the clinical record revealed that, on 08-09-16, the attending physician ordered staff to administer an Immediate release anti-Parkinson medication every evening at 8 PM. An additional extended release anti-Parkinson medication was instructed **to be** administered between 10 PM and 11 PM. However, review of the medication administration record (MAR) revealed a change was made on 08-22-18 to move the scheduled time of the extended release anti-Parkinson medication from 10 PM to 9 PM. There was no additional physician orders to change the time. On 07-06-18 at 5 PM, Interview of the attending physician revealed he ordered the Immediate release anti-Parkinson medication at 8 PM to maintain resident #188's functional status before **bedtime at** 10 PM. Therefore, **he expected the** nursing staff to administer the Immediate release	F 309	07/20/2011

STATiiMENT OF DEFICIENC1&.8. AND PLAN 0F CORRICTION	PROVIDEMUPPUERICUA IDVffIFICATION NUMBER: 2111125	(JQ) IIU\.TIPUi CON8T1IUCT10N Bw.DING, ____ a.WING	(QJ T& IUIMY.. COMPI.ETID 07/08l2011

NAME OF PROWH!RORSUPPt.lER	BTRliET ADORII&, CITY, STATE, ZIP CODE
NATIONAL LUTHERAN HOME	8711 VEIRS DRIVE ROCKVILLE, MD 20850

QC4)1D PREFIX TAG	SUMIIAIW 8TATalENT OF DERCIENCIES (IACH D!FICIENCYMUIT BE PRI!Cl!DI!O BYRA.L REGULATORY OR UiC IDINTIFYING INFORMATION)	-i-	PRCMDI!R'SP\ANOF 00RRECTION (liACtiCOMECTIVEACT10N SH0U1.DBE CROII-R9EAENCED TO THEAPPRCPRIATE IJEI'ICGNCY)	DATa
F 309	Continued From page 7 and extended release anti-Parkinson medications at different time intarvats as ha OJ'darad. On 07 7-18 at 10AM, InlelVlewOfthe 2VAunit manager revealed a change was made on 08-22-16, based on the request of resident #188'9 spouse In Oecamber 2015, to assist the resident to steep at 7:30 PM, If ponlble rather than have to wake for the later dose. The unit manager stated the change was '"80 based on quality of lffe because resident #188 went to bed around 8 PM. However, the physician was not consulted nor did the unit manager Indicate the resident hlmlhersetf was Involved in the dedsion. However, review of social services notes, dated 08-22-16, revealed resident#188 tcfd lhe inteldlsclpllnary team that "it was OK to go lo bed at 10 PM or 11 PM". On 07-08-18 at 10 /w., Interview of resident #188 reveated hlslher **bedtime was around** 11 PM. Therefore, resident #188 should be receiving the extended release an ParkInson medication as ordered based on the resldent'l lndMdual bedtime schedule, not the family's request	F 309		
F 3331	· **483.25(m)(2)** RESIDENTS FREE OF SS-O SIGNIFICANT MEO ERRORS The facilly must ensure that **residents an, free** of any sfgrilficant medication errors. This REQUIREMENT Is not met IS **evidenced** by: Based on surveyor observation, review of the dinical record and interview of faclllty staff,	F 33J	**t. What cal'I"Nllvo** IC1fanwlll **be aCCOMpflsbad tori INtl** thou NSIdenlll found tohlV9 been effacted by the detldent practlco? Relldent **'181 was mealed** by Phpldan and RN NUM M111111g1t and no **negallVB aw:ome ar** fwlher c:oncema weta nated **81 a1911.dt** of the licensed nursing Slaff fllIin to follow a phya(darn Olds with the admMillrallan *af* an lnmedlaie **rwfnM and** extended **releale anl-Parllinlon** llllldlc:atlon.	

8TAT£MENT Of DEFICIENCE9 AND PlAN 01" CORRECTION	CXI) PROVIDEMiUPPUEM:UA IDEHTIFICATIOH NUMl!R: 215125	CX2) MULTIPLE c:oNSTR\JCTION BUILDINC; ________ EWING	(O)O,.TE 8\IRVI!.Y I.ETED 07108121'1 8

.: NAME OP PROVIDER"ORauPPLIER · NATIOHAL LUTHERAN HOME	STREET ADDRUS. arv, STATE. ZIP CODI! 1701 VEIIIS DRIVE ROCKVILL&. MD 20IID

(X,4) .: PREFIX TAG	8UMIWt't STATIIM&NT OF DEFICI!HCIES (!ACHOEFICIENCV MUST Be PRECEDED BY F\IU. ASGUIATORY OR USC IDENTIFYINO DlI'OJtMATION)	ID PfW'I)(TAG	PIICMOER'I PI.AN OF C0RRECTI0N (!ACHCORRECTIWACTI0HSHOULD R CROS9-IIEFERENCEDTOTIEAPPROPIMTE DEFICIENC'I)	CXI) caoumoN Dlff'I!

F 3331 Continued From page 8

attending physician and resident, It was **detenrkled** that the facility staff failed to be free from a significant medication error for resident #188. This finding was evident In 1 of 25 residents seledad In stage 2 review. The findings included:

On 07-05-16 at 8:44 PM, obselvetfon of medication administration revealed stafr #1 administered two different kinds of anti-Parkinson medications to resident **#188 at** the **same time.** One was an immediate release and the other was an extended releale anti-Parktnson medication.

On 07-06-16, review of the cRnlcal record revealed that, on OfM>9-1B, the attencrmg physician ordered an Immediate ,alease anU-ParkInson medication every evening at 8 PM. An additional extended release antl-Paf1cinson medlcatlon was ln&tructad to be admlnlstated between 10 PM and 11 PM. However, the ph 's order **was Inconsistent** with surveyor observation In **the evening** on 07-05--16.

Further review of the Medic:atlon Administration Record (MAR) revealed the extended **release** an arkinson medication wa, scheduled every evening at 9 PM, which was inconsistent with_the phpician's order, dated 06-09-18, of 10-11 PM. SeeF309

OnO7-Q8..18at4:50 PM, IntefyJewofthe attending physician revealed his pfan on 08-09-16 was to maintain resident #188's functional status aftar 8 PM and prior to bedtime. Therefore, he expected the nursing staff *to* administer the Immediate release and extended release antl-Parkln10n medications at different dme interval as ordered.

F 333

rHow va11·w11Udlnllfy **other NS1d1nla having** tbe pDIllntlal ta be affected bV Iha aama deftclent **practice and** what **cofflICflYo action** wlll be **11ken?**
NuneManagen1CClfflllllllld an auclt ull'lllldentsl 11uest Physician *orden,* fOCUllng **an lldmnlsIra1lnn** or- **Immediate releaH rklnson medication and mended -----** **meclcallan. 0lher** raldenls onlmml!dlate **and utended niln• anU-** PIlldnson medlcaUona had the patenlal to **be** atfecled. All**reslclenWJluest YIIO 11111 an lrrmldlale and 8ldended f81UN PIltdnlon mecfcallon9 Wint rnfelwd and** Ill **dllerepancfea wIIIII ClOIl'lIded 8I Ume** of audit.

S.What measuras wOI be put Into place rw what IptomIC cl!angn JOU wlD make to llftSIH'II that tho cleffclant prac:tlca doas not ..air?
DndorofNlnlnglrt-NMCldwfflll'mge.&
and aupervllarl an fa8awlng phyaldan ordeis and admlliltratlan of lrnmadlatl and extended -- anll-Parknon medlcaUons. TIit Dlreclor of Mining **endlordutgnee •IMeNlce U. lcenud ruses** on foltawlng physician ordars 1nd adntialrBllon of lmrnedllrla and extended,.... antJ.Patdnsan meclcallana. IIHeMcel wtD be a ar 8-3-16.

4. How Ure comtCtlYa ectlan(aJ wlll lNt manltond to annn•Uta detlclllftt pnscllce wUI not recur, I.e.. what quality asauranc. program wlll be put *Into* place?
The Dlledatof Nlnlng ordellgneelllllconduct random audlla ofPhysician antera, fOQllng on admlnlslratlCln oflmmadlal9............ ml-Paltdnaon medlc:atlan **and extended releue** anti-Pa.1clnson fflldlcallon ensurtng that phpk:lal• Oldn n being folawad and thal Ihe 15 lfghll of madlcallan admlnlsttaUon are bllng rolawad. Findings wll be repor1lld to fec:llty Quallty AllurancB Comrrffee monlllyx3.

STATEMSff OF DEFICIENCIES AND PLAN OF CORRECTION	ou, PAOYIDER/8UPPUERICI.I,\ IJENTIFICATION NUMlll!R:	CX2} MULTIPLE CONST'RUCTION BUIU)INO	(XS) DATE SURVEY COIIPI.ETED
	215125	1. & \MNG_ ...	07/08l2016 .

NAME 01' PRO'IIIOER 011"8UPPUER	STREET ADDRESS, CRY,.STATE. ZIP.CODE
NATIONAL LUTHERAN HOME	178'1 VEIR8 DRIVE ROCKVILLE, MD 208S0

(JC4)10 PtlEF1X TAG	. SUNMMV STATEMENT OF DEFICll!NC1i8 (EACH DEFICIENCY MUSTIE PRECEDED IYRILL R!OULATOR'I OiiL8C IDENTIP\'IHG INFORMATION)	ID PIIII!flX TAG	PRCMDER'S PI.NIOF CORRECTION (tACHCOAAEC1'M:ACTI0N SHOULD BE CROS8-RI!FDI!!NCIDTOTHEAPPROPR1ATE DEFICIENCY)	1111> CCIMPL&TDI OIIII
F 333	1con nued From page 9	F;I'		

On 07-06-18 at 5 PM, Interview of the director of nuraing (DON) revealed that rasklent #188 usually went to bed early around 8 PM. Therefol9, a change was made based on quaUty of life.

On 07-07-18 at 10 AM, Interview of the 'NA unit manager revealed lhat a change was made on 06-22-18 based on the spouse's request, which was made in December 2015. However, there was no Indication the resident was consulted as wall

On 08-22-16, a care plan meeting was held with resident #188 and an intardlsclpllnary team. The resident indicated that •rt was OK with going to bed around 10 PM or 11 PM".

On 07-08-18at 10NA, lnteNlawofresident#188 revealed hillher bedtime was around 11 PM. **Therefore, resident** #188 **should receive the** immed'1&ta release and extended ralaase anti-Parkinson medication at different time lnte,vals as the physician ordered on 06-09-16.

Office of Health Care Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(JU) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	CQ MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING	FINAL SURVEY COMPLETED
	215121		01/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NATIONAL LUTHERAN HOME	9101 VEIRS DRIVE ROCKVILLE, MD

(X4) ID PREFIX TAG	(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)	DATE
S000	10.07.02 Initial Citations - = =	S000		
	The following deficiencies are the result of an annual Medicare/Medicaid QIS recertification survey conducted on July 5, 6, 7 and 8, 2018, for the purpose of determining the facility's compliance with State COMAR requirements. Survey activities consisted a review of 70 medical records during stage 1 and 25 medical records during stage 2, observation of residents and staff practices, and interviews of residents, family members, and the ombudsman and facility staff.			
s 608, 10.07.02.12	0 Nsg SVcs;Care 24 Hr& per Day .12 Nursing Services. 0. Nursing Care-24 Hours a Day. There shall be sufficient licensed and supportive nursing service personnel on duty 24 hours a day to provide appropriate **bedside care** to assure that each patient: (1) Receives treatments, medications, and diet as **prescribed;** (2) Receives rehabilitative nursing care as needed; (3) Receivn proper care to prevent decubitul ulcer& and defotmitiea; (4) Is kept comfortable. clean, and well--groomed; (5) Is protected from accident, injury, and infection: (8) Is encouraged, aasistad, and trained in self-care and group activities. This Regulation is not met as evidenced by: Refer to CMS 2567	S608	**SEE CMS 2M7 Fio9 AND FII3**	813118

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X8) DATE
Jason Goldstein	Executive Director MHA	7/30/18

FORM CMS-2567(02-99) 076Y11 If continuation sheet 1 of 8

nRlra oi Health Care·Qualllh

STATEMENT 0, OEFIICl&NCIE8 • N\ID PLANOFCOAAECTIDN	(JU) PROIIIDEN8UPPumilCl..IA IDl!NTFICATION NUMBER: 215125	CX2) MUI.TIPLE C0NffiUCTIOH A.BUILDING:_____ 8. WINO	OC3) 1'ESUINEY CCMPLETED 07/08/2018

HAM& OF PR0\.1DER OR SUPPUER	8TAEET APDRESS, CfTY, STAT!. ZIPCODE
NATIONALLUTHERANHOME	fflt VEIRS DRIVE ROCKVILLE, MD 20850

(X4J ID TAG PREFU(	SUMMARY STATDIENT OF OEfICIENCE8 REGULATORY OR L8Ct0ENTIFYING INl'ORMATION) (MCH o&PICIENCV MU8T81 PRECIDEO BY FULL	ID TAO PREFIX	PROVIDER'S PIAN OF 00RRECTl0N CROSS-ftEFEA&NC&D101HEAPPROJIAIATE (EACH CORRECTNEACTIOM8HaULDBE O!FICIENCV)	A 11111 G!IIU1I
S10501	Continued From page 1	81050	**1. WhalCOff9Ctlve action wl1be•c: 'llad for th080 rosldanta found *to* have ltotn aflac:tacl' by the** deflClcnt prac:ta?	INNI
81050.	10.07.02.18 Social Work Svcs	S1050	**Ac:amact"81 been enc:uted (etrec:llw AugUlt** 1, 2018) v.f1h 8 qualiled IOdal work CDIWlant (LCSW-C) to provide 1uffldenl hours of consuhallan to auure lhat the sadal ltMCII IIBff meat lhe rnedcally ntllllled IOdal and emollOnal needl oflhl l'BSldtnll ofllle Vllage at RodMle.	
	,18 **Soc:ial Work SenAcas.**		2. How,au wll ldantify other realdenta haWlg tl\e patentlal ta be effedad by lh1 1111118 deffclont p,actlce end what canectlve action wtll be taken? All rasldenll hive lie pa1mlll tobe dldad tr, lie ume deflc:lent practice. Themote, the *cortraded* IUpervlaian by Ille qualifled IIGClal work candant wlD canlnue unllJ1he Soc:lal SeNlcel Manager obtains her cellfflcatlon. lndlar anolher c:ertifted aodal wgr1cer II lmd la awnee the p,ogrem.	
	• A. Services Provided. The facility shall provide or make arrangements for services to identify and meet the patlerlrs medically related social and emotional needs.		3. **MlitmeP\U'W** wlll **llNtpUt** Into placo ar w11at syllemlc changes you wfll make10 anaure Ulat the dllffclent l(lf'8Ctk:e dctN not NCUf? In Older *to* ensure that this daea not re(U', HLIIIIIII Rescuca staff•be ln-eeMced on the need far a CISl1llled IIOdll worker to CM flee sodal NIVfcea. and the quelllllc:lfon of LCSW wll be added lolha Job dac:llpllon for a IOdal aeNlces aupenitsar.	
	B. Designated Staff Responsibility. A member of, the faclity's staff shan be assigned responslblNty for aoclal services. If the deslgnee Is not a certlfted social worker, the facility shaff effect an agrnmant with a qualified social work consultant. The agreement shall provide for sufflelent hours of consultation to asaure that the staff'& aervlces meet lha medically related IOCial and emotional needs of thapatients.		4. Haw the CGnctlwt actlon(a) wlll bl monitored ta e111Ure the deficient pradce wll not recw, **l.e.,** what quatlty ua111ance program wlll be put Into place? Tomonllor Ulla corredlor1, p,oaf of ctuallled lodal WOfk CIIIIIUllanl's conmtadon wlll be repcllted ta QA carmittee monthly rar Vlree momhl.	
	C. Social History. Th• written soclal history shall be initiated within 7 days aftar admil&ion. The history shal be as complete as possible and shan include: **(1) Social data about personal and** famlly **background** to **provide understanding** of the patient **and how he functions; and (2) Information regarding** current **personal and** family circumstances **and attitude& as** they refate ta patient's mness **and care.**			
	D. Records. Records shall **include:** (1) SOClat history; and (2) Recommandatfonamade by **the social work** consultant, If **applicable.**			
	e. Space. Facilities shall provide: (1) Space for social work personnel, sslble to patient&, **medlca and** other staff: (2) Privacy for interviews.			
	This Regulation is not met **es evidenced** by: **Bas on review** of the quallfrcatipns or tl:le			

Aiillhc.ara 111ilfi:

STATEMENT OF NCIES AND PIAN OF CORRECTION	()(t> PR0VIO&RISUPPUE IDEHTIFICAT10N NUMl9t	()(2) MULTIII.E CONSTRUC110N A, BUII.DINGf_____	CXJ)Di"M COMPLETED
	215121	a.WIHQ._._	0710812O16

NAAE OF PROVIDER OR SUPPUER	5TilEETADDRESS. Cm', STATE, ZIPCODE.
NATIONAL LUTHERAN HOME	1701 VEIRS DRIVE - ..... J\ l:(VILLE. MD 28

0W,ID I PAERX TAO	SUMMARY STATEME.NT OFDE'ICIENCIE8 (EACH DVICIENCYMUSTBEPRECmEDBYRILL REGULATORY OR LSC mEHTIFVING INFORMATION)	ID PREFIX TAG	PR<MDER'8PlANCf CORREC1tON (EACH WTM:ACTIDN SHOULD Bl! CROSI-REFERENCEDTO THEAPPROPRIAT£ DEFICIENCY)	+
81050, Conti F page 2-	-	S1050		

1 Director of aoclal services, It was determJned the Director s not **a certffled social** worker (LCSW).

Further Interview wllh the Olrec:tor of Nursing. on 07-08-16 at 1 **PM, revealed** that the facility did not have an agreement with **a qualfied** social work consultant, LCSW ; to provide consultation ID assure that the staff services met the medlcally related social and emOliOnal needs of the residents.

The facility is not in complanoe with COMAR **10.07.02.18 B.**

S1070, 10.07.02.19 PatlentACIMlleS S1070 (SEE **2517 FZ41**

•,9 Patient ActMtfes.

A. Activities Program. The faaRty shall provide for a program of struduracl and unstructured activities, designed and monitored appropriately to meet the day-to-day needs and Interests of each patient, to encourage self-care, resumption of normal activities, **and maintenance of** an optional level of psychosocial functioning.

B. Staffing. A staff member quaBfied by axpertenoe or training shaft be appointed 1D be responsible for the activities program. If tha dasfgnee is not a q..alfied patient ecllvides coordinator as defined InRegulation .OW, the Department may approw the daslgnee based on the person's education, perfonnance, and expelience.

C. If tha Department detennlnes that an effective ipt0gram Is not maintained consultation may be required as specified by the Department

D. Restrictions on Participation Oocumented on Chart. The physician shaU note on the, Patlenrs

Offlbt·t,f HAllllh•C°RrR•tl 1u;iRIU•

STATBMI!HTOFDEFICt&NCIES AND PLAN Of CORRECTION	0(1) - PRCMD IDENTFICATION NUMBER:	loa, MULTIPLE OONSTRUCTIOif. BUii.DiNG:	tX3) auRVEY - OOMPI.ETED
	215121	'&.WING	07/0812018

NAME 0, PRCM0ER OR SUPPLIER	STREET ADDRESSi CITY, STATe, ZIP CODE
NATIONAL LUTHERAN HOM!	1701 VEIRS DRIVE OC !,l,E. MD 20850

0(4) IC) PREfUC TAO	SUMMARY STATEMENT OF.DEFIQENCES (EACH DEFICIENCI' MUST BE PRfCEDED BY FUll. REGUIATORV OR LSCIDSffIFYING INFORMATION)	ID PREfl)C TAB	PROVIDER'S PIAN OF CORRECT10H (EACHC0Rft!CTNEAC'T10N 8HOUID Bl: CROS8-REFERENCEDTO nEAPPROP,U,.TE l>EFICIEHCY)	COMPI.ffl
s1010	Continued F,om page 3 chart any reslrictlons applicabJe to the pallenfs partleipation In the activities program. **E.** Objective. The activities shall be designed to promote the general health, physical, soc:ial, and manlal well-being of the patients. **F.** Space, Supplies. Adequate space and a variety of supplies and equipment shall be provided by the faclity to satisfy the appropriate individual activity needs of patients. This Regulation Is not met as evidenced by: Refer to CMS 2667 F248	s1010		
S1730	10.07.02.37 **E Cara** Planning; Organization Of plan .37 care Planning. E. Organization of care Plan• (1) Problems andneeds shall be Identified, **based** upon the Interdisdplnary assessment The care plan shall address all or the resklenrs spaclal care requintments sary t9 lmpn,ve or maintain the realdenfs status. The interdlsciprinary team &hall Incorporate resident inpul Into the care plan. (2) The team shall establish goals ror each problem ar need Identified. The goal shaD be reaflltic, practical, **and tailored** to the rasldent's needs. Goal outcome &hall be measurable In time ar degree, or bath. (3) Approaches to acc:ompUthlng each goa18hall be established. Approaches &hall communicate the WOik to be done, by wham It ts to be done,	S1730	SEE CNIS 2517 FZ71	ar.vta

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215121		07/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NATIONAL LUTHERAN HOME	9701 VEIRS DRIVE ROCKVILLE, MD

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S1730	Continued From page 4	S1730		

1 and how frequently it is to be performed

This Regulation Is not met as evidenced
• Refer to CMS 2587
F279

S1834	10.07.02.45 C QA Pgm; Committee	81834	

•45 Quality Assurance Program.

• C. The nursing facility shall establish a quality assurance committee that includes at least
(1) A director of nursing;
(2) An administrator;
(3) A social worker;
(4) A medical director;
(5) A dietitian: and
(6) A geriatric nursing assistant of the facility.

This Regulation Is not met as evidenced by:
Based on review of administrative records and interview with the quality assurance (QA) manager, it was determined that the facility failed to ensure attendance of a geriatric nursing assistant (GNA) to the monthly QA meetings. The findings include:

On 07-08-18, review of the sign In sheets for the monthly QA meetings and Interview with the QA manager revealed that a GNA attended only 1 of 6 meetings In the past 6 months. On 07-08-16 about 10 AM, Interview with the QA manager revealed they have tried to have a GNA representative attend, but have not been successful on a regular basis.

1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?
GNAs will be notified In a Town Hall Meeting of the Importance of their attendance at QA meetings for both their benefit and for regulatory compliance.

2. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?
All residents have the potential to be affected by the deficient practice. GNA will be trained on the importance to attend QA meetings and will sign an attendance sheet.

3. What measure will be put into place or what system change will occur to ensure that the deficient practice does not recur?
GNA will be scheduled each month to attend QA and will sign an attendance sheet.

How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?
The QA Manager will complete an audit monthly x3 to monitor GNA attendance.

nl Health Cam. Qualit1i"

STATEMEN1' OP DEFICIENCIU ' AND PIAN OF COMECTION	(X1) PRCMDEAISW'PUEfUCUf\ IJ£Nnl'ICAl10N NUUBEft	(X2) MULTIJ'LE CONSTRUC:rioN A. BUILOING:	(X3) TE SUA\IEY COMPl.EI'ED
	211125	I.WING	JRIPJI201I

NAME Of PftOVIDl!R OR SUPPU!A	STREEI' ADDRESS. cm. 8TAlE. ZIPCODE
NATIONAL LUTHERAN HOME	9701 V&RS DRIVE JOCKVILLE. MD. 20850.

0(4) ID SUMMMY STATEMENf OF D&FICIINCIES PROVIDER'S PIAN OF CORRECTION

PREFIX TAG	(IW:H DEFICl!NCY MUST Bl! PRECEDED BY RAL REGULATORY OR UC IDENTIFYING IHFOIVMTIONJ	PREFIX TAG	(l!ACN CORRECTIVE ACTIONSKOULD 8E CROS&REFI!RI!NCED TO THE N'PAOPAPI.TE DER!=	um;
S18851 Continued From page 5		81885	·1. What coffllCllve actlori wlll lie accompliahocl forUlose raldenla found to have llton affec10d by llle deflident prattlce? NDrealdera were llll'eded bJ.,. 1'adllle'l failure ID post the Slafllng asslgnmenl on the unll.	718HB
s1eas! 10.07.02.48 Posting of Staffing		S1885	Z. How you,..ldantlfy OChur rnfdenlll having the polllllaI lo ba llfflctlcl by the Hffl8 dellc:lant pn1clk:a and'Mlltcomtellveecdaftwlllllelllutn? The Dnctar of Quality AAlnnt:a completad 11'1 aulll of staffing being posted an lhe 5lftts at the tme llllt the delident pradlce WU brought ID lhe DfreclOr of Nurslng'a attenllon and 2 Potomac stalling MS corrected and polled GUlidlt *olfie* nura{ng llallon.	
.48 Posting of Staffing.			3. What moaurn wtlbe putlnto plflce or What ayatemlc cflangoe you wlll malca to ensuroUnit tho deficient practice doos nol recur? i:>ncto, of Nlnlng ln-lervlced **mllllgffl and lUJMlMSonl** onposingoftllfflng assignment on lhe unh. The Olredar af **Mining .uo,** deslgnee **-alMervlce** Iha **llcansed runes** on poslblg of **llflllng Qllgnmat ontheunHa. llHerw:eswllbe** complete **as *ol*** l-3-18.	
A A nurs;ng home shall post on each ftaor or unit of the nursing home, for each shift, a notice that explains the ratio of licensed and unlicensed staff to residents.			**4.** Howtha **COJIK1Ml acdDn(1)** wlJ **be monltan,d to ensur. 1h11 dllflclant pnaCIJca** wfll **not**NCVr, **Le.,** wll8I quality **aaunmce proaram WII** INI **put Into place?** The Dlreclar *al* Nursing or dalgnn"'111 conduct *random* aUdlla af **posUng r, fltafflng llllgnmerd** an lhe **Wliia ensurfng oompllance. Flndilga** WII be Nlpaited lO fadlllyQually **Aluance C0nmttae** monlhly r3.	
B. The posting on each floor shall include: (1) Names of the staff members on duty and the n10m numbers af the residents lhal each is assigned;				
(2) Name *ot* the **charge nurse or** person incharge of lhe unit; and				
(3) Name of the medicine aide or person responsible for medication administration.				
C. The posting be on a form provided er app,oved by lhe Department.				
1. This Regulatfon Is not met as evfdenced *t,J;* f Based on observatiOn during tour an 07.0>16 at ' 6:30 PM, 1 of the 5 nursing units. 2 Potomac Nursing Unit. had no evidence of staffing being posted to Inform residents and visitor& of staff names who are on duty and their respective assignments. This was also observed on. 01-0&-1e, a AM-4 PM. 01-01-1e, a AM-4 PM anc1 07-08-16 ,BAM -3 PM.				
On 07-08-16 at 8:30 AM, fntervfew with the Director of Nutsfng revealed there was a posting of the total number and actual hout8 of both licensed and unllcensed nursing staff directly responsible for resident care per shift. This Is a fiat with numbers of staff and hours without any names or hours the staff work. This posting was evident next to the main elevator on the Terrace Floor and the 1st floora'nty. "l"herawasno				

unmof Health-Cirt1.0uil it v.

STATEMEHT OF DEFICIENCtES AND Pl.AN Of CORRECTION	(X1J PRCMDERI8UPPUERICUA IDENnFICATION NUMBER:	0(2) MULTIPLECONSTiaJCTION A BUILDING: _____	(XS) DAT! SURVEY COMPLETED
lz	215125	WIN !I	07 IOll2011.

NAME OFPROVIDER OR SUPPUER	STREET ADD"9S.CITY, STATE, ZIPCOOE
NATIONAL LUTHERAN HOME	9701 VBRS DRIVE ROCKVILLE, IIID .20850

(M)ID PREFIX TAG	SUMMARY STATIMIEHT OF DI!I'ICI!NCIES (EACH DEFICIENCY MUST BE PRECEDED BY RILL REGULATORY OR I.SC IDI!NTIl'YINO INFOAMATIONI	ID PREFIX TAG	PRCMDER'i PLAN OI'CORRECTION (EACH CORRECTIVE ACTION SHOOLD BE CROSIMW'ERENC&OTO **TH!APPROPRIATI: DEFICIENCY)**	1+
S1885	I Continued From page 8	S1885 •		

posting of the staff names and thelr assignments that were visible to visitors and residents an this uni. A smau notice was Inside the nursing station behind the chan rack that needed to be moved to be able to read the sc:hedule. Th!S was not easily accessible to visitors or resldet1ts.

: The facility is not in compliance with COMAR 10.07.02.48

S6075t 10.07.09.09 B Res BIi of RIghts;Imp!em, postings I 88075 **SEE CMS 21'7** F1&7 **71H111**

.oe Implementation of Residents' BiU of Rights.

A nursing facility sl;taU: .
B. Post conspicuously in a public place accessibre to residents:
I (1) The Residents' BIii of Rights In large, clearly : readable type;
(2) The nursing facmty's complaint procedures In large, clearty readable type:
(3) The nursing facility's statement of deficiencies for the most recent survey and any subsequent complaint Invesligatlona conducted federal or State surveyors and any plans of carrection In effect with respect to the survey or complaint Investigation findings: and
(4) Signs provided by the Department to notify the visiting public and residents:
(a) That complaints may be made to the Department or to the Office,
(b) How ta report an Instance of abuse of a resident to the Department. the Office, or law enforcement agencies, and
(c) How to file a complaint with State agencies and client advocacy **agencies,** such as the Ucensing and Certification Adminlstralian. the Office on Aging, the Older Americana Act Legal Selvlces ptOYiders, the Ma,vtand DISabllffles Law

Office of HUIIUL C8l'tiiuilih

8TATBENTOF aEACIENCIES ANO l"lAN OFCORRECTION	(XI) PROYIIJ!JWUPPUERJCUA IDEHTIFICATION NUMBER;	CX2) IIUL11fll.E CONsTIUJCTl0N fA BUI.OING:	OC3) TE &UJN£Y COMPLITED
	215125	B.11\nNO	07/08l2018

NME OF PROVlm!R OR SUPPLJI!R	STREET ADDRUS, CITY, STATE, ZIP CODE
NATIONAL LUTHERAN HOME	9701 VEIRS DRIVE ROCKVI , MD 20850

TAO	Sl,IMl,1MY STATEMI:NTO, DERCCENCIES (&ACH DEFICIINCY MUST BE PRECED!!D SY FULL RI!GUIATORY OR LSC ID.!NTIFYIHG INFORfMTION)	ID PRIN TAO	P.R<MDEA'S PIAN Of CORRECTION (EACH COMECTIVIAC110N SHOULD BE CROSS-REFERENCEDTOTHE N-PROPRIATE DEJ'ICI£NCV)	fXII CGfll'Lffl DA11£
8807&I	Continued F,om page 7 Center, sta1e Medicaid Fraud Unit, and the Legal Aid Bureau, Inc.: This **Regulation** Is not met **as evidenced** by; Refer to CMS 2587 F 167	**S8075**		

STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION	(JU) PROVIDERISUPPLIERICLIA IDENTIFICATION NUM8ER.	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215125	8WING	C 02/17121)16

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS. CITY, STATE,ZIPCOOE
NATIONAL LUTHERAN HOME	**9701 VEIRS DRIVE ROCKVILLE, MD 20850**

()(4) 10 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENC11:S (EACH DEFICIENCY MUST **BE PRECEDED BY** FIA.L REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	**PROVIDER'S PI.AN OF** CORRECTION (EACH CORRECTIVE ACTION SHOUt.O Be **CROSS-REFERENCED** TO THE **APPROPRIATE** DEFICIE"ICY)	Clt51 COMPIETION DATE

F 000 INITIAL COMMENTS

On February 17, 2016, as survey was conducted at this facility by the Office of Health Care Quality to investigate a facility reported Incident MO000096301. The survey activities consisted of observation of residents' behavior and facility staff practices, Interviews with the facility staff and review of residents' medical records. The following deficiency is the result of this visit.

Additionally complaint M000097340 was Investigated. This survey did not identify noncompliance with Federal or State requirements that were reviewed in relationshfp to this complaint

F 514 483.75(1)(1) RES SS=B RECORDS-COMPLETE/ACCURATE/ACCESSIBLE

The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented: readily accessible; and systematically organized.

The clinical record must contain sufficient information to Identify the resident; a record of the restdent's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:
Based on suNeyor review of the clinical records and interview of the facility staff, it was determined the facility l_taff failed to accurately

This Pliln of correction Is **p,e red and executed** because It

F 000 Is required11v theprovisions of theState and Federal regulilt1ons 1nd not because The Village ,t Rock11Hle il&rffS with the aneptlons and cltallons listed on the statement *o/* deficiencies. The Village at Rockllllle maintains that the alleged deficiencies *do* not, tndilllduaHv and coltectlllely,]eopardlie the health and safety of the reSldenls, nor are they of such character as lo limlt our capacity to render adequate care aspru:rlbed by regula!lon. ThIs Plan of Correction shaU operate as The Vliiage at Rockllllle's wrllten credible i!Uegatlon of compliant&. By Submitting this Plan of Correction, The Village at Rockvllle does not admit to the IICCUI'IC'f of deficiencies. This Plan of Correction Isnot meant to establish any standard of care, contract, oblIptlon, or poslt1on, and The Villlge at Rodcvllle, re$erve all rights to raise all poss!ble contentions and defenses In civil or crlmlnBl claim adlon or proceeding.

F 514 Corrective ntlon for resident affected : 4/15/16
Client111was assessed by Physicians and RN nurse manager illnd no negatllle outcome or further concerns were noted as a reS1.llt of the lncklent not having the correct date recorded and orno further document11tlon from daughter rqarding her not reporting btulse when she flllt **observed.**

Identification of others with thepotent tobe **affected:**
Dirl!Clor of Nursing completed an audit *o/* faclUl'{ reported Incidents to Maryland Department of Health and Mental tfyglene submitted Infast thllt'f davs to ensure date I t an alleged Incident occurred was correctly documented and that statements from parties Involved were documented
Gue5t and Residents Involved In fadllty self reports have the potential to be affeded,

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE Executive Director | (X6) DATE 4/13/16

Any deficiency stale/menl **ending** with an asterisk (1 denotes • dericlency llllich the Institution may be excused from correcting providing it Is lfelermlfed that other safeguards prbvide sufficient protection lo the patients. (Sea InswcUom.) Except for nursing home1, the findings slated abolle are disclosable 90 days following lhe dale of surwy whether or not a ptand correction is ptOlllded. For nursing homes, lhe above findings and plans of correction ere diSCIOsable 1, days following the date lhese document1 are **made available** to the facility. If **deficiendas are** cited, **an appl'0¥8d** plan of correction Is requlsite to continued program pa11icipalion.

STATEMENT OF DEFICIENCIES AND PI.AH OF CORRECTION	(X1 I **PRO\/IDERISUPPLIER/CIIA** 1DENTIFICATIONNUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215125	**B** IMNG	C **02/17/2CJ16**

NAME OF PRO'o1DER OR SUPPLIER	STREET ADDRESS. CITY, STATE. ZIP CODE
NATIONAL LUTHERAN HOME	9701 YliIR8 DRIVE ROCKVILI.E, MD 20850

IX4JID PREFIX TAG	SUr.HAAY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDEO eV FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	10 PREFIX TAG	PAOW>ER'S PLAN OF CORRECTION (EACH COAA£CTIVE ACTION SHOULD BE CR0SS-REF ENCED TO llIE APPROPRIATE DEFICIENCY)	I I **COMPLETION DATE**

F 514 Continued From page 1

document Information related to a facility reported incident for resident #1. This finding was evident for 1 of 3 residents selected for review during this complaint survey and relates to a facility reported incident MO00098301. The findings **Include:**

On 02-17-16, **review** of the facility reported incident MD00096301 involving resident #1 revealed that the date entered for the date of the incident was 10-01-15. This is the date placed on the self report sent to the Maryland Office of Health Care QuaHty on 10-07-15, 6 days later.

Further review of the investigation revealed that staff interviews and assessment for resident #1 took place on 10-06-15 and 10-07-15. This is considered a delay in reporting the incident.

On 02-17-16 at 12 noon, interview with the Director of Nursing (DON) revealed that the Incident was reponed to staff on 10-06-15 on the evening shift, but resident #1 reported it had occurred a few days prior. The staff member completing the report placed the date as 10-01-15. a few days prior due to the residenrs statement This is Inaccurate documentation. The date *that* the Incident is reponed to staff is the date of the Incident and the other information about the time of occurrence is placed in the body of the complaint. The exact date the resident was referencing was unknown.

In addition, further review of the self report revealed resident #1's daughter noted she had seen a bruise a few days earlier. There is no further documentation about Interview with the daughter and why the bruise was not reported.

On 02-17-16 at 3 PM interview with the DON

F514 Measures to **pm,ent reoccurrerice:**
Dlrtctor of Nllt$lng ln•sel\'ked nurse INM8ffl and supervisors on aa:uratetv compl1t1ns facmty repo,u, placing emphasis on limellne of date of occurrence and obtaining detailed lnttrYlews. To ensure that **the** hl1hest practlcal care IS **being** Rendertd to our1uest/resldents, Director of Nurslna and or The Quality Assurance Director will complete an auellt of facility self reports, ensurtna t t reports have correct dates11$ted andlntet"lllew statements from en parties lrwolwd In allegation.

Monllorll'llcorrtctive1ctlon:
Quality Assurance *Director* wtllconduct random audits **of** facUity seff reporu toensure acwrate clltes and documematlon Is compk!ted.
Findings will be reported *to* facUlty quality assurance committee monthly x3

STATEMENT OF **DeFICfeNCES ANO PLAN OF co,tAECTION**	(XI) **PROVIDER/SUPPLIER/CUA** IDENTIFICATION NUM8£A	(X2) MULTIPLE CONSTftUCTION	(X3) DATE SURVEY COMPI.£1'£0
	215125	A. BUILDING _____ B. WING _____	C 02/1712016

NAME PROVIDER OR SUPPLIER	STREET ADDRESS. CITY. STATE. ZIP cooe
NATIONAL LUTHERAN HOME	9701 VEIAS DRIVE ROCKV1LLE, **MD ioa50**

(X4)10 PREFIX TA.G	**SUMMAAY STATEMENT** OF DEFICIENCIES (EACH OEFICIENCV **MUST8EPRECED!!DBY** FULL RI!GUIATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	**PAOVIOER'S PI.AN** OF CORRECTION (EACH CORRECTIVE ACTION SHOUU> 8E CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5▶ DATE

F 514 Continued From page 2 F 514

revealed the resident repealed different stories of wh t occurred to family members and other staff. However, this information about changing the story of the incident was not documented.

Information that was obtained from other sources such as family to assiSt in the determination of \he outcome of the incldenl was never documented in the clinical record or investigation Information provided to the state.

Office_g_fl**ealth Care Quality**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	()(1) PROVIDERI$UPPUER/CI1" IDENTIFICATION NUM8£R.	(X21MU&.TIPIE CONSTRUCTION A.BU I L D I NG	(X3l DATE SURVEY COMPLETED
	215125	8WING	C 02/1_7l2016

NAME OF PfIOVIDER OR SUPPLIER	STREET ADDRtlSS. CITY, STATE. ZIP CODE
NATIONAL LUTHERAN HOME	9701 **VEIRS DRIVE** **ROCKVILLE, MD 20850**

(X41ID PREFIX TAG	SUMMARY STATEMeNT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED aV FUU REGUIATORV OR I.SC ID&NTIFVING INFORMATIONI	ID PREFIX TAO	PROVIDER'S PIAN OFCORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS.REFERENCEDTOTHEAPPROPRIATE DEFICIENCY)	CX5l COMPLETE 0/ITE
S 000	10 .07.02 Initial comments On February 17, 2016. as survey was conducted at this facility by the Office of Health Care Quality to investigate a facility reported Incident MD000096301. The survey activities consisted of observation of residents' behavior and facility staff practices, Interviews with the facility staff and review of residents' medical records. The following deficiency is the result of this visit Additionally complaint M000097340 was investigated. ThJs survey did not identify noncompliance with State requirements that were reviewed in relationship to this complaint.	S000		
S1090	10.07.02.20 Clinical Records .20 Clinical Records. A Records for all Patients. Records for all patients shall be maintained in accordance with accepted professional standards and practices. B. Contents of Record. Contents of record shall **be:** (1) Identification and summary sheet or sheets Including patienfs name, social security number, armed forces status, citizenship, marital status, age, sex, home address, and religion; (2) Names, addresses. and telephone numbers of referral agencies (Including hospital from which admitted), personal physician, dentist, parents' names or next of kin, or authorized representative; (3) Documented evidence of assessment of the needs of the patient, of establishment of an appropriate plan of initial and ongoing treatment, and of the care and services provided; (4) Authentication of hospital diagnoses (discharge summary, report from patient's !_t!!l_nding physician, q_transfer form):	S1090	Please nif,__PoCfor FS14	4/15/16

OHCQ
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 4/13/16

STATE FORM OJ9411 — If continuation sheet 1 of 3

Q tm:e_ of He allb_ Cai:e Quality

STATEMENT OF DEFICIENCIES AND PIANOF CORRECTION	(XO PRO\IIOERISUPPI.IERICUA IOENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A.B UILDIN G _____	(1<3) DATE SURVEY COMPLETED
	215125	ING	C 02/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADOR£SS, Q TY, STATE. ZF CODE
NATIONAL LUTHERAN HOME	**9701 VEIRS DRIVE ROCKVILLE, MO 20850**

(X-4)10 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH OEACI£NCY MUST 8E PRECEot;D BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	**ID** PRE FUC TAG	**PROVIDER'S** OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROss-REFERENCED TO THE APPROPRIATE DEFICIENCY)	IX) COMPLUE OATI:
S1090	Continued From page 1	S1090		

(5) Consent forms when required (such as consent for admlnlStering lnvesttgatlonal drugs. for burial arrangements made in advance. for release of medical record Information, for handling of finances);
(6) Medical and social history of patient:
(7) Report of physical examination;
{8) Diagnostic and therapeutic orde rs:
(9) Consultation reports:
(10} Observations and progress notes:
(11) Reports of medication administration, treatments, and clinical findings;
(12) Discharge summary Including final diagnosis and prognosis;
(13) Discipline **assessment: and**
(14) Interdisclplnary care plan.

C. Staffing. An employee of the facility shall be designated as the person responsible for the overall supervision of the medical record service. There shall be sufficient **supportive** staff to accomplish all medical record functions.

D. Consultation. If the medical record supervisor is not a qualified medical record practitioner, the Department may require that the supervisor receive consultation from a person so qualified.

E. Completion of Records and Centralization of Reports. Current medical rec:Qrds and those of discharged patients shall be completed promptly. All clinical information pertaining to a patienrs stay shall be centralized in the patienrs medical record.

F. Retention and Preservation of Records. Medical records shall be retained for a period of not less than 5 years from the date of discharge or, In the case of a minor, 3 years after the patient becomes of age or 5 years. whichever is longer.

G. Current Records-locationand Fac:ilities. The facility shall maintain adequate space and

Office of Health Care Qualm

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDr.RISUPPLIERJCI.IA IDENTIFICATION NUMBER	(I(2) MULTIf'LE CONSTRUCTION	(JU) DATE StJRVEY COMPLETED
	215125	A.BU it.D iNG _____	C 02/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY. STATE. ZIP COOE
NATIONAL LUTHI!RAN HOME	9701 **VEIRS DRIVE** ROCKVILLE, MD 20850

CX.C)IO PREFIX TAG	SUMMARY STATEMENT OF OEFICltiHCltS (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S **PI.AN OF** CORRECTION !EACH CORRECTIVE ACTION SHOULD 8E CROSS.REFERENCED TO **THE APPROPRIATE** DEFICIENCY)	.)($, COMPLETE DATE
S1090	Continued From page 2	I s1000		

equipment. convenienUy located, to provide for efficient processing of medical records (reviewing, Indexing, filing, and prompt ,etrieval). H. Closed or Inactive Records. Closed or Inactive records shall be filed and stored in a safe place (free from fire hazards) which provides for confidentiality and, when necessary, retrieval.

This Regulation is not met as evidenced by:
Refer to CMS 2567
F514