

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 215092	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/04/2020
NAME OF PROVIDER OF SUPPLIER COLLINGSWOOD REHABILITATION AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP 299 HURLEY AVENUE ROCKVILLE, MD 20850	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		
F 0580 Level of harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor review of the clinical record, family and staff interviews, it was determined that the facility staff failed to immediately notify family of a resident concerning changes in the resident's condition. This finding was evident for 1 of 3 residents selected for review during this survey (Resident #1). The findings include: On 03-03-2020 a review of Resident #1's clinical record revealed the resident found on the floor on 02-22-2020 at 1:30 AM with a bleeding wound to the right upper brow and blood in the Foley catheter bag (a Foley catheter is a tube that helps drain urine from the bladder. The catheter is held in place in the bladder by a small, water-filled balloon). The on-call physician was notified and provided orders to closely monitor the resident and provide a floor mat for safety. Staff #1 documented that Resident #1's family contact person, Emergency Contact #1 was contacted the same time as the resident's physician and notified about the injury that occurred at approximately 1:30 AM. On 03-03-2020 at 11:30 AM, surveyor telephone interview of Staff #1, an LPN, revealed that on 02-22-2020 at 1:30 AM, Resident #1 was found on the floor lying next to their bed atop a floor mat with a bleeding wound to the forehead. Staff #1 stated that despite the documentation, he/she did not contact Resident's #1 family on 02-22-2020 at 1:30 AM. On 03-03-2020 at 1:09 PM surveyor telephone interview with Emergency Contact #1 revealed he/she was not contacted about Resident #1's injury until 8:22 AM. Family contact #1 stated Had I been contacted when the fall occurred, I most definitely would have insisted on a transfer at that time. Further review of the clinical record revealed documentation on 02-22-2020 at 8:30 AM that Resident #1 had a change of condition noting the resident with increased confusion, restlessness, blood in the Foley bag. New physician orders [REDACTED]. On 03-03-2020 at 3:00, surveyor interview with the Director of Nursing revealed no additional information.		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.