| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155488 | A. BUILDING 00<br>B. WING | 07/19/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| ROLLING HILLS HEALTHCARE CENTER | 3625 ST JOSEPH RD<br>NEW ALBANY, IN 47150 |

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| F 0000<br><br>Bldg. 00 | This visit was for Investigation of Complaints IN00411826, IN00411201, IN00410934, IN00409810, and IN00407159.<br><br>IN00411826- No deficiencies related to the allegations are cited.<br>IN00411201- No deficiencies related to the allegations are cited.<br>IN00410934- State deficiencies related to the allegations are cited at 9999.<br>IN00409810- Federal/State deficiencies related to the allegations are cited at F584.<br>IN00407159- Federal/State deficiencies related to the allegations are cited at F580 and F684.<br><br>Unrelated deficiency cited.<br><br>Survey dates: July 17, 18, and 19, 2023.<br><br>Facility number: 000526<br>Provider number: 155488<br>AIM number: 100266970<br><br>Census Bed Type:<br>SNF/NF: 104<br>Total: 104<br><br>Census Payor Type:<br>Medicare: 4<br>Medicaid: 94<br>Other: 6<br>Total: 104<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed on July 27, 2023. | F 0000 | **Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the State of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law.**<br>**The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the complaint survey conducted on July 17-21st 2023. Please accept this plan of correction as the provider's credible allegation of compliance.The facility would like to respectfully request a desk review.** | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Chante Williams | Executive Director | 08/11/2023 |

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

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| F 0580 SS=D Bldg. 00 | 483.10(g)(14)(i)-(iv)(15)<br>Notify of Changes (Injury/Decline/Room, etc.)<br>§483.10(g)(14) Notification of Changes.<br>(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-<br>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;<br>(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);<br>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or<br>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).<br>(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.<br>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-<br>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or<br>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.<br>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident | | | |

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| | representative(s).<br><br>§483.10(g)(15)<br>Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).<br>Based on record review and interview, the facility failed to ensure prompt physician and family notification of a new area of skin impairment for 1 of 4 residents reviewed for notification. (Resident B)<br><br>Findings include:<br><br>The record for Resident B was reviewed on 7/17/23 at 11:03 a.m. The diagnoses included but were not limited to, Alzheimer's disease, memory deficit following cerebrovascular disease, osteoarthritis of right shoulder, unsteadiness on feet, muscle weakness, need for assistance with personal care, cognitive communication deficit, and difficulty walking.<br><br>The care plan, dated 5/28/21 and last revised 3/23/23, indicated the resident was at risk for altered skin integrity related to immobility and poor vascularity. The interventions included, but were not limited to, complete weekly skin checks.<br><br>The physician's order, dated 3/15/22, indicated staff were to conduct the resident's weekly skin assessments.<br><br>The weekly skin assessment, dated 4/17/23, | F 0580 | **Corrective action for the residents found to have been affected by the deficient practice:**<br>**Resident B was not harmed by this alleged deficient practice. Resident B family and MD were notified about impairment in skin, any new orders were carried out per MD order, that included measurement and monitoring orders, care plan was updated as indicated.**<br><br>**Corrective action taken for those residents having the potential to be affected by the same deficient practice:**<br>**All residents have the potential to be affected by this alleged deficient practice.**<br>**DON/Designee completed a look back of clinical documentation for the last 30 days and any residents found to have noted new impairment in skin, had notification made to MD and RP and orders** | 08/21/2023 |

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| | indicated the resident had no areas of skin impairment.<br><br>The nurse's note, dated 4/22/23 at 4:38 a.m., indicated the resident had a "large red-purple bruise" to her right rear shoulder observed when the CNA (Certified Nurse Aide) was getting her ready that morning.<br><br>The record lacked documentation of any notification to the physician or the resident's family of the resident's bruising on 4/22/23.<br><br>The skin-grid non-pressure assessment, dated 4/23/23 at 7:05 p.m., indicated the resident had a new area of dark purple discoloration to the right rear shoulder.<br><br>The nurse's note, dated 4/23/23 at 7:41 p.m., indicated the resident was observed to have a large discoloration to the right shoulder. The physician was notified and gave new orders to obtain an x-ray. The resident's family member was at the bedside and was aware.<br><br>The care plan, initiated on 4/24/23, indicated the resident had an actual impaired skin integrity that included discoloration to the right shoulder. The interventions included, but were not limited to, notify provider if no signs of improvement on current wound regimen.<br><br>During an interview on 7/19/23 at 12:15 p.m., Resident B's family member indicated she was in the facility on 4/23/23 and found a bruise on the resident's shoulder. No one knew how it happened and no one called her. Then a day or so later, she spoke with the Executive Director, and they told her they thought she may have fallen, but again no one informed her until she came in | | **implemented per MD as indicated.**<br><br>**Measures/systemic changes put into place to ensure the deficient practice does not recur:**<br>**DON/Designee educated staff related to facilities policy "Monitoring a Wound" with focus on notification to appropriate parties, MD and RP when new impairment in skin is noted.**<br><br>**Corrective actions to be monitored to ensure the deficient practice will not recur:**<br>DON/Designee will review clinical documentation 5x's weekly x's 4 weeks, then 3x's weekly x's 4 weeks, then 2x's weekly x's 4 weeks for any change in condition wounds and ensure notification to MD and RP is made.<br>The DON/Unit Manager/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required. | |

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| | and saw it herself. She was the one who found the bruise. She took a photo of it and asked the nurse on duty about it but didn't know how or when it happened. She asked the Executive Director to come down and she didn't come, but she got a call from her on the following Monday, and she did apologize for staff not notifying her. The bruise was so big there was no way they could have missed it.<br><br>During an interview on 7/18/23 at 12:45 p.m., the DON (Director of Nursing) indicated her expectation would be for the staff to do a change in condition and to notify the physician and family when an area was observed. She would expect family and the physician to be notified the day it was identified. She was not aware of the note on 4/22/23, and she would have expected notification to be documented on 4/22/23. They did notify the family and physician, but did not do so timely.<br><br>During an interview on 7/19/23 at 9:59 a.m., the RDCO (Regional Director of Clinical Operations) indicated she would expect nurses to notify the physician when new areas of impairment were identified.<br><br>During an interview on 7/19/23 at 11:13 a.m., the Wound Nurse indicated she was the wound nurse for the past year and a half. She tried to follow up on bruising. The resident's bruise happened on a weekend and she assessed it when she came back to work. She felt it was larger than palm-sized, and was probably hand sized.<br><br>During an interview on 7/19/23 at 11:22 a.m., Unit Manager 8 indicated the bruise was located on Resident B's right shoulder. The resident's family member brought it to their attention and they | | | |

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| | checked it out. The family member was in the room and noticed the resident's bedside table was broken and had called the aide in to see it. She was not sure if the family member found it or the nurse found it. The bruise was pretty big, approximately palm-sized. It was probably about 3 inches in length by 3 inches in width if she had to remember. She reviewed the record and indicated there was no documentation of physician notification or family notification when the bruise was documented on 4/22/23. There should have been physician and family notification immediately. She wouldn't have waited 24 hours. Notifications were supposed to be documented in the nurses note.<br><br>The facility was unable to determine who the nurse was that first documented the bruise on 4/22/23. It was an agency staff member and had no name on their electronic signature.<br><br>The nurse who documented the bruise on 4/23/23 was unavailable for interview.<br><br>The most current, but undated, Monitoring A Wound policy, provided on 7/19/23 at 11:00 a.m., included, but was not limited to, "... Resident/patient skin condition is also re-evaluated with change in clinical condition... 5. Report any new skin impairments to supervisor... 8. Communicate any changes to care giving staff..."<br><br>This Federal tag relates to Complaint IN00407159.<br><br>3.1-5(a)(2)<br>3.1-5(a)(3) | | | |
| F 0584 SS=E | 483.10(i)(1)-(7)<br>Safe/Clean/Comfortable/Homelike | | | |

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| Bldg. 00 | Environment<br>§483.10(i) Safe Environment.<br>The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>The facility must provide-<br>§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.<br>(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.<br>(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.<br><br>§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;<br><br>§483.10(i)(3) Clean bed and bath linens that are in good condition;<br><br>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);<br><br>§483.10(i)(5) Adequate and comfortable lighting levels in all areas;<br><br>§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and | | | |

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| | §483.10(i)(7) For the maintenance of comfortable sound levels.<br>Based on observation and interview, the facility failed to ensure a safe and sanitary environment for 3 of 4 halls observed for environment. (100 Hall, 300 Hall, and 400 Hall)<br><br>Findings include:<br><br>1. During a tour of the facility on 7/17/23 at 9:48 a.m., the following concerns were observed:<br><br>- In Room 315 the bathroom was observed to have a very strong odor of urine. The toilet had no bolt covers and both bolts were rusted. There was a large brown stain surrounding the toilet and a puddle of water leaking out around the wax ring of the toilet. There were 43 gnats observed all over the walls and on the light fixture, the mirror, and in the sink. There was no trash bag in the can, and it had a brown substance dripping down the inside of the trashcan. The resident's blinds were missing several slats, with multiple portions where the parking lot was visible through the closed blinds due to missing slats. There were several gnats flying in the room, on the wall, and crawling up the TV cord.<br><br>- In Room 310 the toilet had rusted floor bolts with a brown substance built up around the base of the toilet. An area of linoleum, approximately 2 feet long by 2 inches wide, was missing at the doorway to the bathroom.<br><br>- In Room 307 the toilet was offset with rusted floor bolts. There was liquid around the base of the toilet with heavy brown staining to the floor.<br><br>- In Room 404 the floors throughout the room were sticky and covered in debris. The toilet had | F 0584 | **Corrective action for the residents found to have been affected by the deficient practice:**<br>No residents were affected by this alleged deficient practice.<br><br>**Corrective action taken for those residents having the potential to be affected by the same deficient practice:**<br><br>All residents have the potential to be affected by this alleged deficient practice.<br>The housekeeping supervisor/designee completed a full house audit of all rooms to include common area to identify any areas of concern related to sanitation and any areas identified were immediately corrected.<br>The maintenance director/designee completed a full house audit of all rooms including common areas to identify any areas requiring repair and any areas of concern related to repairs were identified, a maintenance requested was initiated and all concerns are repaired or in process of repair.<br><br>**Measures/systemic changes put into place to ensure the deficient practice does not recur:**<br>The Executive | 08/21/2023 |

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| | no bolts and there was brown matter spotted on floor throughout the restroom.<br><br>- In Room 411 there was a very large hole in the drywall behind the toilet which was approximately 1 foot tall by 8 inches wide, with the internal plumbing and wood exposed. The dry wall sheeting was peeling and exposing the wall board and the white dry wall substance. The toilet red staining appearing to be drops of blood to the back of seat. There was thick brown substance smeared on the toilet seat, inside toilet, and on the external surface of the toilet. There was a brown ring around toilet base. The floor bolts were exposed, and approximately 2 to 3 inch long exposed screws which bent and jutting up from the toilet were exposed. There were three gnats in the room.<br><br>- In Room 109 the toilet was off set from the visible wax ring. The bolts were rusted with brown staining.<br><br>- In Room 111 the blinds in the window had several missing slats and there was urine in the toilet.<br><br>- The floors throughout the entire 100 Hall were sticky, with shoes observed of staff and residents to be sticking to the floor. Wet floor signs were in place, but the floor was dry and there were visible shoe tread prints on the floors.<br><br>- In Room 123, currently unoccupied, there was a strong musty odor in bathroom. The base board in bathroom was missing with the wall board exposed and crumbling. The paint was bubbling up and away exposing the underlying wall board and baseboard missing on both sides of the bathroom door. There was a bowel movement in | | director/DON/designee completed education with housekeeping supervisor and housekeeping employees and maintenance director and maintenance staff regarding facilities policy "Residents Rights"<br><br>**Corrective actions to be monitored to ensure the deficient practice will not recur:**<br>Housekeeping supervisor and/or designee will observe 10 resident's rooms daily 5x's a week x's 4 weeks, then 5 resident's rooms daily 5x's a week x's 4 weeks, then 3 resident's rooms 5x's a week x's 4 weeks to ensure room is clean and sanitary.<br>Maintenance director and/or designee will observe 5 resident's rooms daily 5x's a week x's 4 weeks, then 3 residents rooms daily 5x's a week x's 4 weeks, then 2 residents rooms daily 5x's a week x's 4 weeks for any repairs needed, when repair concerns are noted a maintenance request will be initiated and area of concern will be repaired in a timely manner if parts are needed to order to complete repair, concern will not be closed out until parts have arrived and repairs can be made.<br>The DON/Unit Manager/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are | |

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| | the toilet.<br><br>2. During a follow-up tour of the 100 Hall with the Housekeeping Supervisor, on 7/18/23 at 9:10 a.m., the following concerns were observed:<br><br>- The floors throughout the unit were sticky and the Housekeeping Supervisor indicated he could see the floors were sticky throughout the unit. He had not noticed it before, he indicated he could actually see the foot tracks on the floor.<br><br>- In Room 123, currently unoccupied, the toilet had a bowel movement and paint bubbling. The Housekeeping Supervisor indicated the paint bubbling up was from water damage, but he didn't know where it would be from.<br><br>During a follow-up tour of the facility on 7/19/23 at 8:40 a.m. The following concerns were observed:<br><br>- In the hallway there was a very strong odor of urine, from about midway. The odor got stronger the closer to Room 315.<br><br>- In Room 315 there was a puddle of liquid and brown ring remained around the toilet. The blinds remained broken and a visitor in the parking lot was able to be seen through the closed blinds. There were 10 gnats flying around in the bathroom.<br><br>- In Room 310 the toilet had rusted floor bolts with a brown substance built up around base of the toilet. An area of linoleum, approximately 2 feet long by 2 inches wide, was missing at the doorway to the bathroom.<br><br>- In Room 307 the toilet was offset with rusted | | identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required. | |

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| | floor bolts. There was liquid around base with heavy brown staining to the floor.<br><br>- In Room 404 the floors throughout the room were sticky and covered in debris. The toilet had no bolts and brown matter spotted on floor throughout the restroom.<br><br>- In Room 411 there was a very large hole in the drywall behind the toilet which was approximately 1 foot tall by 8 inches wide, with the internal plumbing and wood exposed. The dry wall sheeting was peeling and exposing the wall board and the white dry wall substance. The toilet red staining appearing to be drops of blood to the back of seat. There was thick brown substance smeared on the toilet seat, inside toilet, and on the external surface of the toilet. There was a brown ring around toilet. The floor bolts were exposed, and approximately 2 to 3 inch long exposed screws which bent and jutting up from the toilet were exposed. There were two gnats in the room. There were streaks of a brown substance smeared on the wall behind the resident's bed.<br><br>- In Room 109 the toilet was off set from the visible wax ring. The bolts were rusted with brown staining.<br><br>- In Room 11 the blinds in the window had several missing slats and there was urine in the toilet.<br><br>- The floors throughout the entire 100 Hall were sticky, with shoes observed of staff and residents to be sticking to the floor. Wet floor signs were in place, but the floor was dry and there were visible shoe tread prints were on the floors.<br><br>- In Room 123, currently unoccupied, there was a strong musty odor in bathroom. The base board in | | | |

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| | bathroom was missing with the wall board exposed and crumbling. The paint was bubbling up and away exposing the underlying wall board and baseboard missing on both sides of the bathroom door.<br><br>During a confidential interview, from 7/17/23 to 7/19/23, Resident K indicated her toilet was not bolted down. It was nasty and not cleaned. The blinds were missing for a long time and the gnats had been going on for a while and she wished the facility would get rid of them.<br><br>During a confidential interview, from 7/17/23 to 7/19/23, Resident R indicated his family member was the last person to clean the restroom and it had been quite a while ago.<br><br>During a confidential interview, from 7/17/23 to 7/19/23, Resident U indicated the bathroom had been leaking and with a brown stain for a long while.<br><br>During an interview on 7/18/23 at 9:15 a.m., the Housekeeping Supervisor indicated the Housekeeping Services did not have access to the system to report maintenance concerns, so they would report it to the nurses or the aides. They did not have a paper trail to show their requests. He had noticed it in some of the rooms. They had issues with gnats on the 100 Hall. Some of the residents liked to urinate on the floor and in garbage cans. He went to one room to empty the trash and there was gnats everywhere and it was just full of urine. The aides and all administrative staff know the housekeepers could not mess with bodily fluids. They had reported concerns with gnats. They sprayed, but it was recurring in certain rooms where they had urination problems. It was mainly on the 100 Hall. The staining to the | | | |

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| | tiles for the most part came up when they stripped and waxed, but he felt it would be better if it was replaced. A lot of them were stained with rust, some were so bad the tile would start to ripple. For Room 315 they stripped and waxed her floor and it was still smelling the same way. The resident would urinate in her clothes and she dried them over the window unit and it would blow out in the hallway. Nursing needed to be cleaning up the urine and stool, and the blood. He hadn't noticed the floors on the 100 Halls being sticky. He had seen the air conditioner unit cover off in one resident's room but he hadn't reported it. He thought the sticky floors were due to the resident's back on the 100 Hall. Sometimes they would urinate on their socks and would walk around on the hall in the dirty socks. The offset toilets were contributing to the housekeeping struggles. They only had one maintenance worker, and he was not able to catch up on everything or even survey the building. He was supposed to have a helper.<br><br>During an interview on 7/19/23 at 11:38 a.m., the Maintenance Director indicated he had gotten multiple work orders on toilets. He had noticed pretty much every toilet in the facility needed replaced. He had only been there for three months but he planned on replacing all of them. He hadn't noticed any issues with the tiles, but all of it would be replaced as he worked on the toilets. He did not have an assistant at the moment. The one he had quit 2 weeks prior. They had ordered blinds but they were the wrong size and had to be sent back. He had asked for them to go to a home improvement store and buy the pull down blinds, but they said they were too expensive. He had addressed it multiple times with the prior and current Executive Directors. The blinds had been an issue since he had started at the facility in | | | |

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| | April. He had been aware of concerns with the toilets since he started, but he had been going through and fixing them. There were so many of them he had not been able to get to them all. It was something he guessed they could contract out. He was not aware of the air conditioner unit cover being off at that time. He was aware someone kept pulling it off and setting it next to the bed. The cover would be upright and standing next to the bed. He had talked to the nurses and aides on the hall and made sure to tell them to be conscientious that the resident was taking it off and to put it back. The baseboards needed a lot of attention. He was not aware of any large gaping holes in the wall. He was running thin and had been since he started. Staff had not been putting things in the reporting system or in the binder he had started for those who didn't have access to the reporting system. He had in-serviced staff on the reporting system and binder but they still were not doing it. He wasn't going behind his former assistant and checking his work. He found out he was just checking them off and not doing them.<br>3. During an observation on 7/17/23 at 9:48 a.m., the following concerns were observed:<br><br>- In Room 104 there were several missing slats in the blind.<br><br>- In Room 106 there were several missing slats in the blind.<br><br>- In Room 110 the air conditioning unit's front cover was missing, and the inside of the air conditioner was exposed including the coated wires.<br><br>- In Room 113 the lower bottom half of the resident's bed was lower than the head of the bed. The nurse attempted to raise the lower half of the | | | |

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| | bed to make it level with the head of the bed. The lower half of the bed would not raise.<br><br>- In Room 114 there were several missing slats in the blinds.<br><br>- In Room 306 the toilet and floor tiles had brown substances and had a foul odor. The bathroom sink leaked, and the drain would not drain the water out. Seven gnats were observed on the walls in the resident's bathroom.<br><br>- In Room 309 there was a large brown substance which appeared to be feces observed on the side of the toilet.<br><br>- In Room 312 there were several brown substances observed on the bathroom walls and around the toilet. The floor tiles were stained with a brown substance. The bathrooms had a foul odor of urine.<br><br>- In Room 313 there were several brown substances observed on the bathroom walls and around the toilet. The floor tiles were stained with a brown substance. The bathroom had a foul odor of urine.<br><br>- In Room 403 the sink was leaking with a steady stream of water.<br><br>- In Room 406 the trash was observed on the bathroom floor. There was a wet and foul-smelling brief laying on the floor in the corner of the bathroom. The toilet had a large bowel movement in the stool and the toilet had not been flushed. The odor was strong and foul smelling.<br><br>- In Room 410 there were four large areas of missing slats in the blinds. | | | |

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| | During a confidential interview, from 7/17/23 to 7/19/23, Resident VV indicated the sink had been leaking for about 2 years and he had told maintenance, but nothing had been done.<br><br>During a confidential interview, from 7/17/23 to 7/19/23, Resident O indicated housekeeping cleaned his room and bathroom once a week. He could not use the bathroom sink because the water would not drain properly. He told the maintenance man, but nothing had been done to fix it.<br><br>During a confidential interview, from 7/17/23 to 7/19/23, Resident Q indicated in the evening the sun came through the holes in the blinds. The sun shined right on his feet and it felt like his feet were burning. The room got hot and then it was difficult to cool it back down. He had made the facility aware.<br><br>During a confidential interview, from 7/17/23 to 7/19/23, Resident P indicated when the sun came through the broken blinds, he was unable to use his computer due to the glare. He was unable to position his computer so he could observe the screen so he had to turn the volume on and listen. The room got hot when the sun was shining through the blinds.<br><br>During an interview on 7/18/23 at 8:50 a.m., the Housekeeping Supervisor indicated there were five housekeepers for the facility. There would be one housekeeper on each hall. One housekeeper would be there from 6:00 a.m. to 2:00 p.m., and four housekeepers from 8:00 a.m. to 4:00 p.m. The facility was trying to schedule a housekeeper from 11:00 a.m. to 7:00 p.m., but due to the budget he wasn't sure that was going to happen. At that time | | | |

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| | no one from housekeeping was responsible for the cleaning after 4:00 p.m. The nursing staff had their own cart, and they were responsible to clean up. The cart would be fully stocked. The bathrooms would be cleaned daily. If there was a mess the housekeeper would inform the CNAs (Certified Nurse Aides), and they were responsible for cleaning the toilet. Certain rooms would be deep cleaned on a five to seven step cleaning plan, which included bathrooms. He had noticed problems with the maintenance in the bathrooms. They did not have a reporting system to inform maintenance. They would inform nursing and they were supposed to file a report to the maintenance department. He had noticed leaking, rusty tiles around the toilets and odors in the bathrooms. Having one shift of housekeepers made it difficult to keep up with the cleaning.<br><br>This Federal tag relates to Complaint IN00409810.<br><br>3.1-19(a)(4) | | | |
| F 0602 SS=D Bldg. 00 | 483.12<br>Free from Misappropriation/Exploitation<br>§483.12<br>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.<br>Based on interview and record review, the facility failed to ensure residents were free from misappropriation and exploitation of personal property for 3 of 4 residents reviewed for misappropriation of property. (Residents L, M, and N) | F 0602 | This deficiency was sited past non compliance and our alleged date of compliance for this deficiency is 7/11/23. | 08/21/2023 |

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| | Findings include:<br><br>1. The record for Resident L was reviewed on 7/17/23 at 10:37 a.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease, anemia, heart disease, hypertension, type 2 diabetes, stage 3 chronic kidney diseases, and protein-calorie malnutrition.<br><br>The Annual MDS (Minimum Data Set) Assessment, dated 5/18/23, indicated the resident was cognitively intact.<br><br>The review of the incident report, dated 7/9/23, indicated the resident had made allegations that an employee had borrowed money from him and had not paid it back. The staff member involved was a housekeeper.<br><br>During an interview on 7/18/23 at 10:30 a.m., Resident L indicated he loaned an employee twenty dollars three weeks ago. The employee was a housekeeper. She asked the resident for the money because she wanted to buy tobacco. The Housekeeper indicated to the resident she would pay him back and she never did.<br><br>During an interview on 7/18/23 at 11:32 a.m., the DON (Director of Nursing) indicated that the employee no longer worked at the facility. When she was interviewed, she adamantly denied taking money from the residents. The residents making the allegations were alert and oriented. She unsubstantiated the allegations because she had no solid proof the employee took the money. During the investigation she indicated they identified another resident. The resident indicated she gave the employee five dollars because she did not have lunch money that day. The resident | | | |

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| | indicated the employee did not ask for the money, she just gave it to her so she could get something to eat.<br><br>2. The record for Resident M was reviewed on 7/17/23 at 11:00 a.m. The diagnoses included, but were not limited to, major depressive disorder, muscle weakness, anxiety disorder, absence of the right leg below the knee, and heart disease.<br><br>The Quarterly MDS assessment, dated 3/23/23, indicated the resident was cognitively intact.<br><br>During an interview on 7/18/23 at 10:20 a.m., Resident M indicated an employee asked him for twenty dollars, but he only gave her ten dollars. She asked the resident for the money because she was hungry and she did not have any lunch money. He thought that was a little fishy, but he gave her the money. The employee did not pay back the money and he had not seen her since.<br><br>During an interview on 7/18/23 at 11:45 a.m., the ED (Executive Director) indicated the incident was unsubstantiated because there was no solid proof the employee took money from the residents. The employee denied taking the money. Even though three residents indicated they gave her money, she did not have solid proof the incident took place.<br><br>3. The record for Resident N was reviewed on 7/17/23 at 11:30 a.m. The diagnoses included, but were not limited to, type 2 diabetes, chronic respiratory failure with hypoxia, and cellulitis of the left and right lower extremities.<br><br>The Admission MDS assessment, dated 6/9/23, indicated the resident was cognitively intact. | | | |

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| | During an interview on 7/18/23 at 12:15 p.m., Resident N indicated she did give the employee five dollars so she could get something to eat. The employee said she was hungry and didn't have any money to buy lunch. She didn't want the staff member to go hungry, so she gave her five dollars to buy food. She did not expect to get the money back. She didn't know it was wrong to give the employee money until the DON came in and talked to her.<br><br>The Abuse & Neglect & Misappropriation policy, provided on 7/17/23 at 1:00 p.m. by the RDCO (Regional Director of Clinical Operations) included, but was not limited to, "...It is the intent of this facility to prevent the abuse, mistreatment, or neglect of residents or the misappropriation of their property, corporal punishment and/or involuntary seclusion and to provide guidance to direct staff to manage any concerns or allegations of abuse, neglect or misappropriation of their property... Mistreatement: In Indiana is defined as staff treating a resident inappropriately or exploiting a resident... Examples... acceptance from a resident or attempts to gain from a resident personal items money through persuasion, coercion, or solicitation..."<br><br>The deficiency cited was past non-compliance when the facility completed staff education dated 7/10/23 related to abuse and misappropriation of funds. A resident council meeting was conducted on 7/11/23. The Executive Director educated the residents on not giving money or loaning money to staff prior to the entrance of the survey.<br><br>3.1-28(a) | | | |
| F 0684 SS=D | 483.25<br>Quality of Care | | | |

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| Bldg. 00 | § 483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br>Based on record review and interview, the facility failed to ensure appropriate assessment and documentation of measurements and characteristics for a new area of skin impairment for 1 of 4 residents reviewed for skin impairments. (Resident B)<br><br>Findings include:<br><br>The record for Resident B was reviewed on 7/17/23 at 11:03 a.m. The diagnoses included but were not limited to, Alzheimer's disease, memory deficit following cerebrovascular disease, osteoarthritis of right shoulder, unsteadiness on feet, muscle weakness, need for assistance with personal care, cognitive communication deficit, and difficulty walking.<br><br>The care plan, dated 5/28/21 and last revised 3/23/23, indicated the resident had a risk for altered skin integrity related to immobility, and poor vascularity. The interventions included, but were not limited to, complete weekly skin checks.<br><br>The physician's order, dated 3/15/22, indicated staff were to conduct the resident's weekly skin assessments.<br><br>The weekly skin assessment, dated 4/17/23, indicated the resident had no areas of skin | F 0684 | **Corrective action for the residents found to have been affected by the deficient practice:**<br>Resident B was not harmed by alleged deficient practice.<br>Resident B had full assessment of new impairment in skin to include measurements and characteristics.<br><br>**Corrective action taken for those residents having the potential to be affected by the same deficient practice:**<br>All residents have the potential to be affected by this alleged deficient practice.<br>The facility completed a 30 -day look back of clinical documentation to ensure that all areas of new skin impairment had documented assessment with measurements and characteristics of impairment noted. Any found to not have required documentation were corrected immediately.<br><br>**Measures/systemic changes put into place to ensure the** | 08/21/2023 |

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| | impairment.<br>The nurse's note, dated 4/22/23 at 4:38 a.m., indicated the resident had a "large red-purple bruise" to her right rear shoulder was observed when the CNA (Certified Nurse Aide) was getting her ready that morning.<br><br>The clinical record lacked documentation of any measurements or further description of the bruising.<br><br>The skin-grid non-pressure assessment, dated 4/23/23 at 7:05 p.m., indicated the resident had a new area of dark purple discoloration to the right rear shoulder. Under the measurements, the nurse documented "na" (meaning not applicable).<br><br>The nurse's note, dated 4/23/23 at 7:41 p.m., indicated the resident was observed to have a large discoloration to the right shoulder. The physician was notified and gave new orders to obtain an x-ray. The resident's family member was at the bedside and was aware.<br><br>The care plan, initiated on 4/24/23, indicated the resident had an actual impaired skin integrity that included discoloration to the right shoulder. The interventions included, but were not limited to, evaluate area characteristics, measure area at regular intervals, monitor areas for signs of progression or declination, and notify provider if no signs of improvement on current wound regimen.<br><br>The clinical record lacked documentation of any initial subsequent follow-up measurements of the size of the bruise.<br><br>During an interview on 7/19/23 at 12:15 p.m., Resident B's family member indicated she was in | | **deficient practice does not recur:**<br>DON/Designee educated licensed nursing staff regarding facilities policy “Monitoring a wound” with emphasis on assessments to include measurements and description of skin impairments.<br><br>**Corrective actions to be monitored to ensure the deficient practice will not recur:**<br>DON/Designee will review daily clinical documentation daily 5 x’s a week x’s 4 weeks, then 4x’s a week x’s 4 weeks, then 3 x’s a week x’s 4 weeks to ensure with any noted new impairment in skin that an assessment has been complete to include measurements and description of characteristics.<br>The DON/Unit Manager/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required. | |

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| ROLLING HILLS HEALTHCARE CENTER | 3625 ST JOSEPH RD<br>NEW ALBANY, IN 47150 |

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| | the facility on 4/23/23 and found a bruise on the resident's shoulder. No knew how it happened and no one called her. Then a day or so later, she spoke with the Executive Director, and they told her they thought she may have fallen, but again no one informed her until she came in and saw it herself. She was the one who found the bruise. The family member took a picture of the resident's bruise. She asked the Executive Director to come down and she didn't come, but she got a call from her on the following Monday, and she did apologize for staff not notifying her. The bruise was so big there was no way they could have missed it.<br><br>The photograph showed a large area of discoloration to the resident's posterior shoulder. There was diffuse red-purple bruising which started at the top of the resident's shoulder, and grew more concentrated at the middle portion of her shoulder blade. The bruising extended from the top of her shoulder to below her right shoulder blade in length, and in width extended from the middle of the resident's back to the resident's right shoulder blade.<br><br>During an interview on 7/18/23 at 12:45 p.m., the DON (Director of Nursing) indicated her expectation would be for the assessment to include a description of the area. She would expect the wound nurse to follow-up and conduct measurements. If the wound was larger than quarter or dime sized she would expect to see measurements.<br><br>During an interview on 7/19/23 at 9:59 a.m., the RDCO (Regional Director of Clinical Operations) indicated she would expect nurses to document measurements of areas of new skin impairments. | | | |

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| | During an interview on 7/19/23 at 11:13 a.m., the Wound Nurse indicated she was the wound nurse for the past year and a half. She tried to follow up on bruising. She could not recall how large it was, but it was larger than quarter size. Dark purple, as documented, would be an accurate reflection of the color of the bruise. It happened on a weekend and she assessed it when she came back to work. She felt it was larger than palm-sized, and was probably hand sized. It was something that she would have measured. She could not recall if they measured it. She would document the measurements in a skin grid.<br><br>During an interview on 7/19/23 at 11:22 a.m., Unit Manager 8 indicated the bruise was located on Resident B's right shoulder. The resident's family member brought it to their attention and they checked it out. She had measured the bruise and the measurements should be in the computer. She put a note in she thought. Anytime they found something they would measure it and document the measurements on the skin grid. Measurements were obtained for the purpose of seeing if the area was healing, if it got bigger, or if the resident got re-injured. They would conduct follow-up measurements. The bruise was pretty big, approximately palm-sized. . It was probably about 3 inches in length by 3 inches in width if she had to remember. There was no documented any measurements of the bruise in the record when the bruise was documented on 4/22/23.<br><br>The facility was unable to determine who the nurse was that first documented the bruise on 4/22/23. It was an agency staff member and had no name on their electronic signature.<br><br>The nurse who documented the bruise on 4/23/23 was unavailable for interview. | | | |

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| | The most current, but undated, Monitoring A Wound policy, provided on 7/19/23 at 11:00 a.m., included, but was not limited to, "... Resident/patient skin condition is also re-evaluated with change in clinical condition... 10. Document daily monitoring on the treatment administration record (TAR). Document any complications/changes, as indicated, in the progress notes..."<br><br>This Federal tag relates to Complaint IN00407159.<br><br>3.1-47(a) | | | |
| F 9999<br><br>Bldg. 00 | 410 IAC 16.2-3.1-9 Personal property<br>g) The facility must inventory, upon admission and discharge, the personal effects, money, and valuables declared by the resident at the time of admission. It is the resident's responsibility to maintain and update the inventory listing of the resident's personal property.<br><br>Based on interview and record review, the facility failed to ensure the residents personal effects inventory documents were completed on admission and discharge for 3 out of 4 residents reviewed for admission and discharge. (Residents G, H, and J)<br><br>Finding include:<br><br>1. The record for Resident G was reviewed on 7/17/23 at 10:00 a.m. The diagnoses included, but were not limited to, dementia with behavioral disturbance, depression and anxiety disorder. | F 9999 | **Corrective action for the residents found to have been affected by the deficient practice:**<br>Residents G,H,J could not be identified as they were part of a complaint survey.<br><br>**Corrective action taken for those residents having the potential to be affected by the same deficient practice:**<br>All residents have the potential to be affected by this alleged deficient practice. Staff completed a full house audit to ensure all residents had completed inventory sheets, to include signature of staff completing and responsible party. Those residents who responsible party were unable or unwilling to sign had this | 08/21/2023 |

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| | The Quarterly MDS (Minimum Data Set) Assessment, dated 9/14/22, indicated the resident was severely cognitively impaired.<br><br>The record indicated Resident G was admitted on 10/18/21 and discharged on 1/12/23.<br><br>The record lacked documentation indicating the residents admission and discharge inventory personal effect document were signed and dated by the resident's responsible party and staff.<br><br>2. The record for Resident H was reviewed on 7/17/23 at 10:30 a.m. The diagnoses included, but were not limited to, end stage renal disease, kidney transplant, anxiety disorder, and hypertension.<br><br>The Quarterly MDS assessment, dated 5/1/23, indicated the resident was severely cognitively impaired.<br><br>The record indicated Resident H was admitted on 4/11/23 and discharged on 5/18/23.<br><br>The record lacked documentation indicating the residents admission and discharge inventory personal effect document was signed and dated by the resident's responsible party and staff.<br><br>3. The record for Resident J was reviewed on 7/17/23 at 10:45 a.m. The diagnoses included, but were not limited to, mycogardial infarction, type 2 diabetes, and cardiomyopathy.<br><br>The Quarterly MDS assessment, dated 10/28/22, indicated the resident was severely cognitively impaired. | | documented on inventory sheet.<br><br>**Measures/systemic changes put into place to ensure the deficient practice does not recur:**<br>DON/Designee educated direct care staff on accurate completion of inventory sheet upon admission or discharge to include residents and/or residents responsible party signature upon admission or discharge. Those responsible parties unable or unwilling to sign need to have that indicated on inventory sheet.<br><br>**Corrective actions to be monitored to ensure the deficient practice will not recur:**<br>DON/Designee will review 5 admission or discharges weekly x's4 weeks, then 3 admissions or discharges x's 4 weeks, then 1 admission or discharge x's 1 week to ensure accurate completion of inventory sheet.<br><br>The DON/Unit Manager/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required. | |

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| | The record indicated Resident J was admitted on 3/4/22 and discharged on 1/18/23.<br><br>The record lacked documentation indicating the residents admission and discharge inventory personal effect document was signed and dated by the resident's responsible party and staff.<br><br>During an interview on 7/19/23 at 8:53 a.m., LPN 5 (Licensed Practical Nurse) indicated when there was an admission or discharge the nurse completing the inventory sheet would get the signatures of the resident or the resident's family member. If the resident was not alert and oriented, then the family would sign and date the inventory form. The nursing staff would be responsible to notify the family to come in and sign the forms and pick up the resident's belongings.<br><br>During an interview on 7/19/23 at 10:15 a.m., the RDCO (Regional Director of Clinical Operations) indicated the Inventory of Personal Effects form probably should have been signed on admission and discharge.<br><br>This State tag relates to Complaint IN00410934. | | | |