STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155488	A. BUILDING 00 B. WING	03/18/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00346914, IN00346820, and a COVID-19 Focused Infection Control Survey. Complaint IN00346915 - Substantiated. Federal/State deficiencies related to the allegations are cited at F686, F740, F744, and F758. Complaint IN00346820- Substantiated. No deficiencies related to the allegations were cited. Survey dates: March 16, 17, and 18, 2021 Facility number: 000526 Provider number: 155488 AIM number: 100266970 Census Bed Type: SNF/NF: 98 Total: 98 Census Payor Type: Medicare: 12 Medicaid: 69 Other: 17 Total: 98 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 29, 2021.	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.** **The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the complaint survey conducted on March 16, 17, 18, 2021. Please accept this plan of correction as the provider's credible allegation of compliance.** **The facility would like to respectfully request a desk review.** **William Jackson, LNHA**	
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers.			

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

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	Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on record review and interview, the facility failed to ensure treatments were completed as ordered for 1 of 3 residents reviewed for pressure ulcers. (Resident D) Findings include: The clinical record for Resident D was reviewed on 3/17/21 at 9:15 a.m. Diagnoses included, but were not limited to, cognitive communication deficit, difficulty in walking, and dementia with behaviors. The Quarterly MDS (Minimum Data Set) assessment, dated 11/19/20, indicated the resident was severely cognitively impaired. The care plan, dated 7/19/18 and last revised on 1/24/20, indicated the resident was at risk for falls related to the need for hands on staff assistance with ADL's (Activities of Daily Living), psychotropic medications use and confusion with dementia. The resident had falls on 5/27/20, 10/21/20, and 11/21/20. The care plan, dated 11/4/18 and last revised on 1/24/2020, indicated the resident had a potential for alteration in mood/behavior related to major depression, bipolar disorder, insomnia,	F 0686	**F686 Treatment/Svcs to Prevent/Heal Pressure Ulcer** **Corrective action for the residents found to have been affected by the deficient practice:** Resident D continues to reside in the facility **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents who have treatment orders for pressure ulcers have the potential to be affected by the deficient practice. A 30 day look back of Treatment Administration Records for residents with pressure ulcers has been completed to ensure treatments have been completed as ordered. Any identified concerns were immediately addressed. **Measures/systemic changes put into place to ensure the deficient practice does not**	04/17/2021

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	hallucinations, anxiety, and schizoaffective disorder. The resident had the potential for hallucinations, delusions, sad facial expression, tearfulness, pacing, repetitive speech, repetitive movements. Behaviors included, but were not limited to, yelling and screaming. The care plan, dated 1/6/20 and last revised on 1/14/20, indicated the resident had a pressure ulcer to the coccyx. The interventions included, but were not limited to, Administer treatments as ordered and monitor for effectiveness. The nurse's note, dated 1/6/2020 at 5:06 p.m., indicated the resident had an open area to the coccyx. The NP (Nurse Practitioner) was notified with new orders received. The Skin Grid Assessment, dated 1/6/20, indicated the resident had a new house acquired pressure ulcer to the coccyx. The wound measured 3.5 cm long (centimeters) by 2.0 cm wide by 0.2 cm deep and was unstageable. Eschar was present and the wound bed was necrotic. The treatment orders were to cleanse the wound with normal saline, pat dry, and cover with hydrocolloid dressing every three days and as needed for soilage. The diagnosis and risk factors were dementia, weight loss, and poor nutrition. The Treatment Administration Records for January 2020 indicated the following treatment, with a start date of 1/6/20 and an end date of 1/22/20, was for staff to cleanse the coccyx with normal saline, pat dry, apply hydrocolloid dressing every three days. The clinical record lacked documentation of the treatments on 1/12/20, 1/15/20, 1/18/20, and 1/21/20. On 1/27/2 the wound measured 2 cm by 2.5 cm by		**recur:** The Director of Nursing/Unit Managers/ Designee held an in-service for the facility staff to provide education and expectations regarding “Skin Care & Wound Management Overview policy” **Corrective actions to be monitored to ensure the deficient practice will not recur:** The Director of Nursing/Unit Manager/Designee will audit 5 residents a week for 4 weeks, then 3 residents a week for 4 weeks, then 1 resident a week for 4 weeks to ensure pressure wound treatments have been completed as ordered. This will continue for no less than 3 months and compliance is maintained. The Director of Nursing/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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	0 and was unstageable, the treatment was changed to cleanse with normal saline, pat dry, apply Santyl and cover with a dry dressing. On 2/10/20 the wound measured 2.5 cm by 2.5 cm by 0.4 cm deep. Undermining was documented at 5 o'clock at 0.4 cm. The treatment was changed to cleanse with wound cleaner, pack with Dakins soaked gauze and cover with border foam dressing. The Treatment Administration Records for February 2020 indicated the following treatment, with a start date of 2/13/20 and an end date of 3/2/20, was for staff to apply Dakins (1/2 strength) solution 0.25%. to the coccyx topically every day shift for wound to the coccyx. Cleanse area with wound cleaner, pack with Dakins soaked gauze and cover with border foam dressing. The clinical record lacked documentation of the treatments on 2/14/20, 2/17/20, 2/21/20, and 2/28/20. On 3/6/20 the wound measured 2 cm by 2 cm by 1.8 cm and was a stage IV. The treatment was changed to cleanse the wound with normal saline, pack wound with calcium alginate and cover with a foam dressing daily. The Treatment Administration Records for March 2020 indicated the following treatment, with a start date of 3/20/20 and an end dated of 3/26/20, was for staff to apply Santyl ointment 250 units/grams to the coccyx topically every day shift. Cleanse with normal saline, pat dry, apply Santyl to wound bed, pack wound with calcium alginate, and cover with non-adherent border gauze. The clinical record lacked documentation of the treatment on 3/20/20. On 4/6/20 the wound measured 1.3 cm by 0.5 cm			

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	by 0 and was a stage IV with tunneling at 5 o'clock at 0.5 cm. the treatment was to clean with normal saline, pat dry, apply santyl pack with calcium alginate and cover with border gauze. The Treatment Administration Records for April indicated the following treatment, with a start date of 4/3/20 and an end date of 4/16/20, was for staff to apply a Hydrofera Blue 4 by 4 pad (wound dressing) to the coccyx topically every day shift for wound to coccyx. Moisten Hydrofera blue with wound cleanser before packing in wound. The clinical record lacked documentation of the treatments on 4/10/20 and 4/15/20. On 4/20/20 the wound measured 2.5 cm by 2.0 cm by 1.0 cm and was a stage IV. There was foul purulent exudate (pus/drainage). The treatment was changed to cleanse with wound cleaner, pat dry, apply pack with santyl soaked dressing and cover with a border gauze. On 7/6/20 the wound measured 1.5 cm by 0.5 cm by 0.4 cm and was at a stage IV with tunneling at 2 o'clock at 0.4 cm. The treatment was changed to cleanse the wound with wound cleaner, pack the wound with hydrofoam and apply dry dressing. The Treatment Administration Records for July through December 2020 indicated the following treatment, with a start dated of 7/15/20 and an end dated of 12/3/20, to Cleanse with wound cleaner, pat dry, pack with calcium alginate and cover with border gauze every day for day shift. The clinical record lacked documentation of the treatment on 8/11/20, 8/12/20, 9/16/20, 9/22/20, and 12/3/20. On 10/29/20 the wound measured 0.8 cm by 0.4 cm. The treatment was to use silver alginate and cover with a dry dressing.			

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	On 11/4/20 the treatment was changed to cleanse with wound cleaner and pat dry. Apply calcium alginate and cover with border gauze dressing every day. On 11/18/20 the wound measured 1.0 cm by 0.9 cm by 0 and was unstageable. On 11/25/20 the treatment was to cleanse with wound cleanser, pat dry, and cover with a border gauze dressing every day until healed. During an interview, on 3/18/21 at 10:00 a.m., the IP (Infection Preventionist) she indicated Resident D's area to the coccyx was found on 1/6/20. It looked like a scab and was not open. The facility changed the treatment to the calcium alginate on 2/12/20. Once the wound doctor started coming back into the facility, he changed the dressing orders weekly. At 10:25 a.m., the IP indicated cared for Resident D while she was on the red zone. The resident had a decline in health in January of 2020. During her decline she was admitted to Hospice services. At that time she did have quarter side rails to assist with turning while in the bed. She was on Hospice from January to September. The bedrails were discontinued in September because she came off Hospice and back to her normal baseline. The review on 3/18/21 at 1:15 p.m., of the Skin Care & Wound Management Overview policy reviewed on 4/20/17, included, but was not limited to, "...Skin care and wound management program includes, but is not limited to: Daily monitoring of existing wounds...Implementing of prevention strategies to decrease the potential for developing pressure ulcers...4. Develop a care plan with individualized interventions to address risk			

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	factors...8. Modify goals and interventions as indicated." This Federal tag relates to Complaint IN00346915. 3.1-40(a)(2)			
F 0740 SS=D Bldg. 00	483.40 Behavioral Health Services §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health 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. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. Based on record review and interview, the facility failed to monitor and document episodes of behaviors and interventions for 1 of 3 residents reviewed for behavioral health services. (Resident D) Findings include: The clinical record for Resident D was reviewed on 3/16/21 at 9:37 a.m. Diagnoses included, but were not limited to, dementia with behavioral disturbance, hallucinations, schizoaffective disorder, major depressive disorder, anxiety disorder, and bipolar disorder. The care plan, dated 11/4/18 and last revised on 1/24/20, indicated the resident had a potential for alteration in mood/behavior related to major depression, bipolar disorder, insomnia,	F 0740	**F740 Behavioral Health Services** **Corrective action for the residents found to have been affected by the deficient practice:** Resident D continues to reside in the facility **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents who have behaviors have the potential to be affected by the deficient practice. A 30 day look back of progress notes has been completed to ensure monitoring, documentation and interventions are in place for	04/17/2021

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	hallucinations, anxiety, and schizoaffective disorder. The resident reported feeling down, trouble sleeping, feeling tired. The resident had the potential for hallucinations, delusions, sad facial expression, tearfulness, pacing, repetitive speech, repetitive movements. Behaviors included, but were not limited to, yelling and screaming. Interventions included, but were not limited to, minimize potential for disruptive behavior, non-pharmacological intervention attempts, including talking, activities, family visits, rest, comfortable lighting, rule out pain, provide a quiet area, and discourage caffeine. The care plan, dated 10/10/19 and last revised on 1/24/20, indicated the resident was on antidepressant medication related to depression, interventions included, but were not limited to, monitor, document, and report to physician as needed ongoing symptoms of depression unaltered by antidepressant medications. Symptoms included but were not limited to, anger, negative mood and comments, agitation, and attention seeking. The psychiatric progress note, dated 8/26/20, indicated the resident was seen for assessment and management of dementia and schizoaffective disorder. Staff reported her behaviors were managed with no outbursts and the resident was redirectable as needed. She exhibited no distress. The behavior monitoring log indicated the resident had no behaviors from 8/26/20 to 9/22/20. The nurse's notes lacked documentation of any episodes of yelling or inability to redirect from 8/26/20 to 9/22/20. The POC (Point-of-Care) responses from 8/26/20		residents identified as having behaviors. Any identified concerns were immediately addressed. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** The Director of Nursing/Unit Managers/ Designee held an in-service for the facility staff to provide education and expectations regarding “Behavior Management Policy and Procedure”. **Corrective actions to be monitored to ensure the deficient practice will not recur:** The Director of Nursing/Unit Manager/Designee will review progress notes 5 days a week for 4 weeks, then 3 days a week for 4 weeks, then 1 day a week for 4 weeks to ensure monitoring, documentation, and interventions are in place for residents identified as having behaviors. This will continue for no less than 3 months and compliance is maintained. The Director of Nursing/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	

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	to 9/22/20, indicated the resident only had behaviors of yelling on August 28, 2020 and September 22, 2020, but lacked documentation of any non-pharmacological interventions or notification to the nurse of the behaviors. The September 22, 2020 behavior of yelling was documented after the psychiatric progress note. The psychiatric progress note, dated 9/22/20, indicated the resident was seen for a routine psychiatric visit. Staff reported the resident was yelling out frequently and was unable to be redirected. During an interview, on 3/17/21 at 11:11 a.m., the Psychiatric APRN (Advanced Practice Registered Nurse) indicated usually the facility would have behavior monitoring in place and she would review the notes before making any decisions to increase medications. During an interview, on 3/17/21 at 11:19 a.m., the SSD (Social Services Director) indicated all behavior monitoring was located on the resident's MAR (Medication Administration Record). CNA's (Certified Nursing Aide) could also document behaviors in POC. If a resident was having increased behaviors she would expect to see documentation in the progress notes or the behavior monitoring. During an interview, on 3/17/21 at 1:03 p.m., the DON (Director of Nursing) indicated she expected to see documentation of behaviors in the POC documentation. The Behavior Management Policy and Procedure, last revised 4/8/16, included, but was not limited to, " ... It is the policy of this facility to identify and safely manage residents who are exhibiting		monitoring is required.	

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	behaviors related to psychiatric diagnosis ... Procedure ... 1. Assess for problematic/dangerous behaviors ... f. Problematic/dangerous behaviors may include but are not limited to: i. Yelling/screaming ... 3. Document the assessment of the behavior in the electronic medical record ..." This Federal tag relates to Complaint IN00346915. 3.1-43(a)(1)			
F 0744 SS=D Bldg. 00	483.40(b)(3) Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on observation, record review, and interview, the facility failed to implement appropriate interventions for residents with dementia related to behaviors and falls for 2 of 3 residents reviewed for dementia care. (Residents D and B) Findings include: 1. During an observation, on 3/16/21 at 9:30 a.m., Resident B was observed coming out of another resident's room carrying unknown items wrapped in a blue pad. The resident was walking unsupervised and had a large hematoma to the left side of her face. During an observation, on 3/17/21 at 1:15 p.m., the resident was walking without assistance or supervision of staff while in the hallway carrying 2 small cups of chocolate milk, and 2 plastic trash bags. The resident started to fall forward and	F 0744	**F744 Treatment/Service for Dementia** **Corrective action for the residents found to have been affected by the deficient practice:** Resident D continues to reside in the facility Resident B no longer resides at the facility **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents who have falls, behaviors, and a diagnosis of dementia have the potential to be affected by the deficient practice. A 30 day look back of residents with falls, behaviors, and a diagnosis of dementia has been	04/17/2021

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	grabbed the handrail in the hall to prevent from falling. Staff were not within sight. The clinical record for Resident B was reviewed on 3/17/21 at 10:00 a.m. The Quarterly MDS (Minimum Data Set) assessment, dated 1/19/21, indicated the resident was severely cognitively impaired. Diagnoses included, but were not limited to, dementia with behavioral disturbance, major depressive disorder and anxiety disorder. The current care plan, dated 719/18 and revised on 2/14/20, indicated Resident B was at risk for falls. Interventions included, but were not limited to encourage resident to lie in her bed, lock bed brakes, move room closer to nurse's station, observe medications for side effects that may increase risk for falls, and parameter mattress. The care plan lacked documentation the care plan was updated and revised after fall events. The nurse's note dated 8/28/20 at 11:53 a.m., indicated Resident B had an unwitnessed fall. The resident stated she did not hit her head. She was trying to go to the bathroom. She seemed to have an incontinent episode overnight. The nurse toileted the resident and applied non-skid foot wear. Staff changed linens on bed. Later in the day the resident got very weak and unsteady on feet, and was unable to hold herself up to sit in bed. The resident complained of being tired. Resident was very HOH (Hard of Hearing), and seemed worse during the shift. A Fall Detail note, dated 11/27/20 at 7:15 a.m., indicated Resident B had an unwitnessed fall in the resident's room. She was walking, and the reason for the fall was not evident. The Fall Detail indicated no documentation for a safety evaluation and safety teaching before the fall.		completed to ensure appropriate interventions have been implemented. Any identified concerns were immediately addressed. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** The Director of Nursing/Unit Managers/ Designee held an in-service for the facility staff to provide education and expectations regarding “Behavior Management General” **Corrective actions to be monitored to ensure the deficient practice will not recur:** The Director of Nursing/Unit Manager/Designee will audit 5 residents a week for 4 weeks, then 3 residents a week for 4 weeks, then 1 resident a week for 4 weeks to ensure appropriate interventions have been initiated for residents who have falls, behaviors, and a diagnosis of dementia. This will continue for no less than 3 months and compliance is maintained related to concerns related to staff to resident abuse. Any identified concerns will be immediately addressed. The Director of Nursing/Designee will present the results of these audits monthly to the QAPI committee for no less than 3	

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	On 11/27/20 at 8:49 a.m., the nurse walked into resident's room to obtain a 7:45 a.m. neurological check, and found the resident on floor in bathroom. Resident B was laying on her left hip with her legs stretched out. Her left arm was tucked under her body. Resident B stated that she was trying to go to the bathroom. A nurse's note, dated 12/1/20 at 4:16 p.m., indicated Resident B had a fall on 11/27/20 at 7:15 a.m., and on 11/27/20 at 8:49 a.m. A staff member found the resident in front of bathroom door. She had on regular shoes at time of fall, and the room was noted to be dark. A nurse's note, dated 12/2/20 at 6:07 p.m., indicated on 2/02/20 3:30 p.m., the resident had an unwitnessed fall in the hallway. The resident was in a hurry or rush at the time of the fall. The reason for the fall was not evident. The fall report indicated there was no safety evaluation completed or documented, and safety teaching prior to the fall. A nurse's note, dated 12/2/20 at 10:29 p.m., indicated on 12/02/20 at 7:07 p.m., the resident had an unwitnessed fall in her room. She was attempting to self toilet at time of the fall. The reason for the fall was weakness. The documentation indicated no prior falls. A nurse's note, dated 12/17/20 at 4:29 p.m., indicated Resident B had an unwitnessed fall in her room. She was self ambulating and the reason for the fall was not evident. The documentation indicated the resident had no prior falls. A nurse's note, dated 1/27/21 indicated the resident had a witnessed fall. Resident B hit her		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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	head on a cabinet during the fall. The resident was attempting to ambulate and had on someone's shoes that were not her own. A nurse's note. dated 2/2/21 indicated the resident was involved in a physical altercation with another resident and had to be moved to a new room and placed in 1 on 1 observation. A nurse's note, dated 2/5/21 indicated on 2/4/21 at 8:30 a.m., Resident B had a witnessed fall which occurred in the resident's room. She was ambulating, and the reason for the fall was not evident. The resident was attempting to self ambulate, and lost her footing, and fell to her buttocks. A Fall Detail report dated 2/12/21 at 3:00 p.m., indicated Resident B had a witnessed fall. The fall occurred in the resident's room. She was transferring herself. Her injuries included a hematoma to the left side of her head, due to falling on her face. A nurse's note, dated, 2/14/21 at 3:46 p.m., Resident B was up walking around and wandering from room to room. A nurse's note, dated, 2/23/21 at 4:06 p.m., Resident B had increased behaviors three times towards staff. She was cursing at staff, and picking up a pill crusher threatening to hit the nurse. A Fall Detail report, dated 3/6/21 at 5:52 a.m., indicated Resident B had a witnessed fall. The fall occurred in the resident's room. She was in a hurry or rush at the time of the fall. At 7:00 a.m., she had another fall. She had an abrasion to her left forehead area. She was attempting to stand and			

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	ambulate. The nurse could not get to her in time and she fell down to her left side. She hit her head on the same area as the fall on third shift. The area was the size of a golf ball, yellow and black. The resident was not able to sit up on her own. Her eye was blackening as well. During an interview on 3/17/21 at 11:30 a.m., QMA (Qualified Medication Aide) 7 indicated they tried to keep her out in the main areas. She stated "education does not work due to her dementia." She did better with certain employees, when they needed to do one on one with the resident. She was unable use to the call light due to her dementia. She tried to toilet herself, and tried to be independent. The resident did not participate in many activities. Staff would give her some tasks, like folding washcloths and cleaning tables. She did walk, but should not be left alone to walk. Her walking was unsteady. Resident B has had a decline in her health. Her dementia had gotten worse since her fall and hip fracture. She did walk around some before she broke her hip, but now the resident is too unsteady to walk by herself. She needed assistance to walk. She was in a wheelchair now, but she got up and tried to walk on her own. During an interview, on 3/17/21 at 1:30 p.m., the Resident Service Director for the dementia unit indicated the staff were supposed to assist Resident B to the bathroom. They gave her things to do with her hands. She did not use the call light because of her dementia. She indicated she felt the resident's dementia was worse since Covid and her hip fracture. The goal was to keep the resident safe, and free from falls. They encouraged the resident to use her wheelchair as much as possible. Educating the resident did not do any good due to her dementia. The care plans			

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	should be updated after any incident like a fall, resident to resident altercation or any changes. They needed to add new interventions, because the other interventions were not working. They monitored the care plans in the IDT (inter-disciplinary team) clinical meetings, and the care plan meetings. 2. The clinical record for Resident D was reviewed on 3/16/21 at 10:30 a.m. Diagnoses included, but were not limited to dementia with behavioral disturbance, hallucinations, schizoaffective disorder, major depressive disorder, anxiety disorder and difficulty walking. The Quarterly MDS assessment, dated 11/19/20, indicated the resident was severely cognitively impaired. The care plan, dated 7/19/18 and last revised on 1/24/20, indicated the resident was at risk for falls related to the need for hands on staff assistance with ADL's (Activities of Daily Living), psychotropic medications use and confusion with dementia. Interventions included,but were not limited to, resident needed a safe environment. The nurse's note, dated 5/27/20 at 9:30 a.m., indicated the nurse was called to the unit regarding a fall. Upon entering the resident room, the nurse observed the resident lying on the right side of her bed, on her left side, with her left arm under her body. Her right arm was resting on her right side and her legs were outstretched. The bed was in the lowest position, non skid socks were on her feet at the time. The resident denied hitting her head, but neurological checks were initiated. The nurse asked the resident what she was trying to do, and she was unable to state accurately related to dementia diagnosis.			

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The nurse's note, dated 5/28/20 at 1:43 p.m., indicated the IDT team had reviewed the fall and an intervention of encouraging the resident to ask for staff assistance would be placed on the care plan.

The care plan lacked documentation of any revision after the fall on 5/28/20.

The nurse's note, dated 10/21/20 at 7:00 p.m., indicated the resident was found on her knees outside of the bathroom door in her room.

The clinical record lacked documentation of any IDT review or new interventions after the fall on 10/21/20.

The Fall Detail report dated, 11/21/20 at 12:00 p.m., indicated the resident had a witness fall in their room. The resident was in a hurry or rush at the time of the fall.

The nurse's note, dated 12/1/20 at 4:29 p.m., indicated the IDT had reviewed the fall and a new intervention to toilet the resident every two hours would be added to the resident's care plan.

The care plan lacked documentation of any revision after the fall on 12/1/20.

During an interview, on 3/18/21 at 10:25 a.m., the IP (Infection Preventionist) indicated she cared for Resident D while she was on the red zone. She indicated the facility did not use fall mats. The resident had a decline in health in January of 2020. During her decline she was admitted to Hospice services. At that time she did have quarter side rails to assist with turning while in the bed. She was on Hospice from January to September. The

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	bedrails were discontinued in September because she came off Hospice and back to her normal baseline. On 11/20 she was up with assistance. They educated the resident to use the call light. At times she would get up on her own to go to the bathroom. On the 1st she jumped up off the bed when the lunch tray was brought in and she fell on her face and got a laceration. She would startle very easy. She would make repetitive statements and schizophrenia behaviors. The IP nurse indicated she was always compliant for her. On 3/18/21 at 1:05 p.m., the DON (Director of Nursing) provided a current copy of the document titled Behavior Management General, dated 5/28/19. The policy included, but was not limited to, "... It is the policy of this facility to identify and safely manage residents who are exhibiting behaviors related to psychiatric diagnoses or who may present a danger to themselves and others.... 2f. Problematic/dangerous behaviors may include but not limited to: i. yelling/screaming ii. Fighting iii. cursing iv. arguing v. biting vi. posing a danger to self or others vii. threatening self or others." On 3/18/21 at 1:05 p.m., the DON (Director of Nursing) provided a current copy of the document titled Dementia care Resident Rights and Privileges, dated 8/21/18, included but were not limited to, ..."C. Individual goals will be addressed on the care plan that meet the needs of the resident for quality of life and quality of care including safety and maximize independence and functioning." This Federal tag relates to Complaint IN00346915. 3.1-37(a)			

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F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be			

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	extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on record review and interview, the facility failed to ensure resident was free of unnecessary psychotropic medication increases for 1 of 3 resident's reviewed for unnecessary psychotropic medications. (Resident D) Findings include: The clinical record for Resident D was reviewed on 3/16/21 at 9:37 a.m. The resident's diagnoses included, but were not limited to, dementia with behavioral disturbance, hallucinations, schizoaffective disorder, major depressive disorder, anxiety disorder, and bipolar disorder. The care plan, dated 7/1/18 and last revised on 6/3/19, indicated the resident used psychotropic medications related to dementia and schizoaffective disorder, and was at risk for adverse reactions. Interventions included, but were not limited to, administer medications as ordered. Observe/document for side effects and effectiveness. The care plan, dated 11/4/18 and last revised on 1/24/2020, indicated the resident had a potential for alteration in mood/behavior related to major depression, bipolar disorder, insomnia, hallucinations, anxiety, and schizoaffective disorder. The resident reported feeling down,	F 0758	**F758 Free from Unnec. Pxychotropic Meds/PRN Use** **Corrective action for the residents found to have been affected by the deficient practice:** Resident D continues to reside in the facility **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents who have an order for psychotropic medications have the potential to be affected by the deficient practice. A 30 day look back of residents who have an order for psychotropic medications has been completed to ensure the resident did not have an unnecessary increase in their psychotropic medications. Any identified concerns were immediately addressed. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** The Director of Nursing/Unit Managers/ Designee held an	04/17/2021

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	trouble sleeping, feeling tired. The resident had the potential for hallucinations, delusions, sad facial expression, tearfulness, pacing, repetitive speech, repetitive movements. Behaviors included, but were not limited to, yelling and screaming. The physician's order, with a start date on 7/31/18 and ended on 7/9/20, indicated the resident was receiving risperidone 2 mg (milligrams), one tablet by mouth two times daily for schizoaffective disorder. The physician's order, with a start date on 4/16/20 and ended on 9/22/20, indicated the resident was receiving Depakote tablet delayed release, 125 mg, one tablet by mouth at bedtime. The psychiatric progress note, dated 4/16/20, indicated the resident had new orders for Depakote 125 mg at bedtime. The assessment and plan indicated staff were aware of the plan of care, and to monitor for medication effectiveness and adverse reaction. The psychiatric progress note, dated 7/8/20, indicated the resident was seen by psychiatric services and new orders to reduce risperidone to 1.5 mg twice daily were given. The physician's order, which was transcribed into the resident's medical record on 7/10/20, and ended on 7/24/20, indicated to administer risperidone 3 mg, one half tablet daily related to schizoaffective disorder. The psychiatric progress note, dated 7/21/20, indicated the resident was being seen as a follow-up to the decrease of risperidone. The note indicated the resident was currently receiving		in-service for the facility staff to provide education and expectations regarding "Antipsychotic Second Clinical Review Policy". **Corrective actions to be monitored to ensure the deficient practice will not recur:** The Director of Nursing/Unit Manager/Designee will audit 5 residents a week for 4 weeks, then 3 residents a week for 4 weeks, then 1 resident a week for 4 weeks to ensure appropriate interventions have been initiated for residents who have falls, behaviors, and a diagnosis of dementia. This will continue for no less than 3 months and compliance is maintained related to concerns related to staff to resident abuse. Any identified concerns will be immediately addressed. The Director of Nursing/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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	risperidone 1.5 mg daily, however the physician had ordered 1.5 mg twice daily on their last visit. Social services was to follow up on the order change. The assessment and plan indicated to continue risperidone 1.5 mg daily. The physician's order, which was transcribed into the resident's medical record on 7/24/20 and ended on 8/18/20, indicated to administer risperidone 3 mg, one half tablet twice daily. The Significant Change MDS (Minimum Data Set) assessment, dated 8/18/20, indicated the resident only had verbal behaviors on 1 to 3 days during the assessment period. The physician's order, which was transcribed into the resident's medical record on 8/18/20 and ended on 12/11/20, indicated to administer risperidone 3 mg, one half tablet twice daily. The psychiatric progress date, dated 8/26/20, indicated the resident was seen for assessment and management of dementia and schizoaffective disorder. Staff reported her behaviors were managed with no outbursts and the resident was redirectable as needed. She exhibited no distress. The assessment and plan indicated the resident's chronic dementia and schizoaffective disorder were managed with risperidone 1.5 mg daily and no new orders to change the dosage were given. The psychiatric progress note, dated 9/22/20, indicated the resident was seen for a routine psychiatric visit. The assessment and plan indicated to continue risperidone at 1.5 mg daily. Staff reported the resident was yelling out frequently and was unable to be redirected. New orders were given to increase Depakote to 125 mg twice daily. Staff were aware of the plan of care			

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	and were to monitor for medication effectiveness and adverse reactions. The behavior monitoring log indicated the resident had no behaviors from 8/26/20 to 9/22/20. The nurse's notes lacked documentation of any episodes of yelling or inability to redirect from 8/26/20 to 9/22/20. The POC (Point-of-Care) responses between 8/26/20 and 9/22/20, indicated the resident only had behaviors of yelling on 8/28/20 and 9/22/20, but lacked documentation of any non-pharmacological interventions or notification to the nurse of the behaviors. The 9/22/20 behavior of yelling was documented after the psychiatric progress note. The physician's order, dated 9/22/20, indicated the resident's Depakote was increased to 125 mg twice daily. The psychiatric progress note, dated 11/4/20, indicated the resident was seen for a routine psychiatric visit. No new orders to increase risperidone were given. The Quarterly MDS assessment, dated 11/12/20 indicated the resident had no behaviors during the assessment period. During an interview, on 3/17/21 at 11:11 a.m., the Psychiatric APRN (Advanced Practice Registered Nurse) indicated when the medication error with the risperidone had occurred, she figured if the resident had tolerated that well, she would just leave it where it was. She was not sure what happened. She was originally on 2 mg of risperidone twice a day, and they had reduced her			

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	to 1.5 mg, twice daily. The order got transcribed as once a day instead of twice daily. She did not put those orders in. She put her orders in her note and gave it to social services who relayed it to the nursing staff. She did intend for the resident to continue at the 1.5 daily as reflected in the notes. The resident was seen on 7/21/20 and was prescribed 1.5 mg daily of risperidone. She did not see any changes, or any orders to increase it after the visit on 7/21/20. Usually the facility would have behavior monitoring in place. She would ask Social Services what was going on, and discuss with the staff that were present how the resident was doing, and she would review the notes before making any decisions to increase medications. During an interview, on 3/17/21 at 11:19 a.m., the SSD (Social Services Director) indicated her notes should be in the system in the clinical notes. She could not locate any notes in the clinical record. All behavior monitoring was located on the resident's MAR (Medication Administration Record) CNA's (Certified Nursing Aides) can also document behaviors in POC. If a resident was having increased behaviors she would expect to see documentation in the progress notes or the behavior monitoring. During an interview, on 3/17/21 at 1:03 p.m., the DON (Director of Nursing) indicated she had reviewed the record and she believed there had been a medication error in regards to the transcription of the risperidone. She expected to see documentation of behaviors in the POC documentation. At 2:02 p.m., the DON did not see the note to have Social Services follow up on the order and she did not have any orders to continue the dose at 1.5 mg. There should have been an order clarification. The Depakote was increased on 9/22/20, and the POC indicated she was yelling			

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	on that day. The interventions should be on the MAR. If not then they should be on the progress notes. She could see where staff would document on occasion she was yelling. During an interview on 3/18/21 at 10:53 a.m. the DON indicated when she goes through the progress notes, on 7/28/20 the Psychiatric APRN had the resident as taking risperidone 2 mg twice daily. She wrote an order to decrease it to 1.5 mg twice daily on 7/8/20. On 7/21/20 she wrote the order in her notes for risperidone 1.5 mg daily and social services to follow up on the risperidone dose. The facility had corrected the dose on 7/24/21. She had another progress note on 8/26/20 that said the resident was on risperidone 1.5 mg twice daily, but it also said in her progress notes that she was on risperidone 1.5 mg daily. They did not have a written order to continue the daily dose, they corrected it to the original order of twice daily. The psychiatric APRN's notes were contradicting themselves, because in one part of the note it said she was receiving the medication twice daily, and in another part it said she was receiving it daily. The Antipsychotic Second Clinical Review policy, dated 3/1/19, included, but was not limited to, "... Apropriate use of antipsychotic medications includes but is not limited to... a. Behavioral symptoms that present a danger to the resident or others b. Expressions or indications of distress that cause significant distress to the resident c. When the use of multiple non-pharmacological approaches have been attempted but did not relieve the symptoms which are presenting a danger or significant distress... Documentation to support the use of antipsychotics in this setting includes... b. Nursing staff is required to document supporting systems..."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155488	A. BUILDING 00 B. WING	03/18/2021

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

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	This Federal tag relates to Complaint IN00346915. 3.1-48(b)(2)			