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	04/13/2023

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 IN00404921, IN00405418 and IN00406167. Complaint IN00404921 - No deficiencies related to the allegation is cited. Complaint IN00405418 - No deficiencies related to the allegations are cited. Complaint IN00406167 - Federal/State deficiencies related to the allegations are cited at F656, F842 and F925. Survey dates: April 12 and 13, 2023 Facility number: 000526 Provider number: 155488 AIM number: 100266970 Census Bed Type: SNF/NF: 109 Total: 109 Census Payor Type: Medicare: 6 Medicaid: 75 Other: 28 Total: 109 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on April 19, 2023.	F 0000	/b>	
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans			

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

Shamika Palmer | RN, RDCO | 04/24/2023

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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	§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with			

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	the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on interview and record review, the facility failed to implement a plan of care for a resident (Resident E) who received pain medication for 1 of 3 residents reviewed for care plans. Findings include: The clinical record for Resident E was reviewed on 4/13/23 at 10:45 a.m. The diagnoses included, but were not limited to, displaced fracture of the first cervical vertebra and fracture of the right tibia/fibula. The physician's order, dated 3/10/23, indicated the resident was to receive Hydrocodone (narcotic pain medication) 5-325 mg (milligrams) every 6 hours for pain. The physician's order, dated 3/10/23, indicated to monitor the resident for pain every shift. The clinical record lacked documentation of a comprehensive care plan for pain. During an interview on 4/13/23 at 1:45 p.m., the interim DON (Director of Nursing) indicated if a resident was on pain medication, there should be a care plan in place for pain. On 4/13/23 at 1:45 p.m., the interim DON provided a current, undated copy of the document titled "Plan of Care Overview". It included, but was not limited to, "PoC...for the purpose of this policy the	F 0656	**F656** **Corrective action for the residents found to have been affected by the deficient practice:** Resident E was not harmed by alleged deficient practice. Residents E plan of care was updated to reflect use of pain medication. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents who receive pain medication have the potential to be affected by this alleged deficient practice. An audit was conducted to identify all residents who have routine or as needed orders for pain medication to ensure it was noted in their plan of care. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** DON/Designee educated Licensed Nursing Staff on facilities policy “Plan of Care Overview” to ensure	04/14/2023

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	Plan of Care, also Care Plan is the written treatment provided for a resident that is resident-focused and provides for optimal personalized care...It is the policy of this facility to provide resident centered care...The purpose of this policy is to provide guidance to the facility to support the inclusion of the resident...in all aspects of person-centered care planning...." This Federal tag relates to Complaint IN00406167. 3.1-35(a)(c)(1)		understanding of updating resident plan of care based on resident's current diagnosis or condition. **Corrective actions to be monitored to ensure the deficient practice will not recur:** The DON or Designee will review 5 residents weekly for 4 weeks, then 3 residents weekly for 4 weeks then 1 weekly for 4 weeks to ensure pain care plans are in place for residents with pain medication orders. The DON and/or 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. Date of compliance 4/14/23	
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility			

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	itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for-			

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	(i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.			
	Based on interview and record review, the facility failed to ensure residents' (Residents B and E) records accurately reflected the administration of routine and as needed narcotic medications for 2 of 3 residents reviewed for medical records. Findings include: 1. The clinical record for Resident B was reviewed on 4/12/23 at 2:18 p.m. The diagnoses included, but were not limited to, anxiety and chronic obstructive pulmonary disease. The physician's order, dated 1/5/23, indicated the resident was to receive Ativan (narcotic antianxiety medication) 1 mg (milligram) by mouth four times a day for anxiety at 5:00 a.m., 11:00 a.m., 5:00 p.m. and 11:00 p.m. Review of the March 2023 and April 2023	F 0842	**F842** **Corrective action for the residents found to have been affected by the deficient practice:** Resident B and E were not harmed by alleged deficient practice. A 14- day look back audit was complete to ensure resident B and E medication administration record accurately reflected administration of routine or as needed narcotic medication. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents who receive routine	04/14/2023

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	medication administration record lacked documentation of the administration of the medication on the following dates and times: - 3/17/23 at 5:00 p.m. - 3/22/22 at 5:00 p.m. - 3/24/23 at 5:00 a.m. - 4/03/23 at 5:00 p.m. - 4/05/23 at 5:00 p.m. - 4/11/23 at 5:00 a.m. The physician's order, dated 12/12/22, indicated the resident was to receive Morphine (narcotic pain medication) 0.5 ml (milliliters) four times a day for pain/shortness of breath at 5:00 a.m., 11:00 a.m., 5:00 p.m. and 11:00 p.m. Review of the March 2023 and April 2023 medication administration record lacked documentation of the administration of the medication on the following dates and times: - 3/17/23 at 5:00 p.m. - 3/22/22 at 5:00 p.m. - 3/24/23 at 5:00 a.m. - 4/03/23 at 5:00 p.m. - 4/05/23 at 5:00 p.m. - 4/11/23 at 5:00 a.m. During an interview on 4/12/23 at 4:08 p.m., LPN (Licensed Practical Nurse) 6 indicated when narcotics are administered, they should be signed off on the narcotic count sheet and the medication administration record. 2. The clinical record for Resident E was reviewed on 4/13/23 at 10:45 a.m. The diagnoses included, but were not limited to, displaced fracture of the first cervical vertebra and fracture of the right		or as needed narcotic pain medication have the potential to be affected by this alleged deficient practice. A 14-day lookback audit was complete on all identified residents to ensure medication administration record accurately reflected administration of routine or as needed narcotic medication. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** DON/Designee educated Licensed Nursing Staff and QMA's on facilities policy "Mediation Administration" with emphasis on accurately completion of medication administration record upon administration of routine or as needed narcotic medication. **Corrective actions to be monitored to ensure the deficient practice will not recur:** The DON or Designee will review 5 residents weekly for 4 weeks, then 3 residents weekly for 4 weeks then 1 weekly for 4 weeks to ensure as needed or routine narcotic medication given is signed off on residents Medication Administration Record. The DON and/or Designee will present the results of these audits monthly to the QAPI committee	

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	tibia/fibula. The physician's order, dated 3/10/23, indicated the resident was to receive Hydrocodone (narcotic pain medication) 5-325 mg every 6 hours as needed for pain. The controlled drug administration record for March 2023 and April 2023 indicated the narcotic pain medication was administered on the following dates and times: - 3/26/23 at 6:00 a.m. - 3/26/23 at 12:00 p.m. - 3/26/23 at 6:00 p.m. - 3/27/23 at 2:00 p.m. - 3/29/23 at 5:39 p.m. - 3/29/23 at 11:00 p.m. - 3/30/23 at 8:00 p.m. - 3/31/23 at 5:00 p.m. - 4/01/23 at 9:00 p.m. - 4/02/23 at 8:00 p.m. - 4/03/23 at 9:30 a.m. - 4/03/23 at 3:30 p.m. - 4/03/23 at 8:00 p.m. - 4/05/23 at 3:00 p.m. - 4/05/23 at 8:00 p.m. - 4/06/23 at 8:00 p.m. - 4/07/23 at 5:15 a.m. - 4/07/23 at 8:00 p.m. - 4/10/23 at 10:00 a.m. - 4/12/23 at 9:00 a.m. - 4/12/23 at 8:00 p.m. The medication administration record for March 2023 and April 2023 lacked documentation of the administration of the medication. On 4/13/23 at 2:35 p.m., the Regional Director of Clinical Operations provided a current copy of the		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. Date of compliance 4/14/23	

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	document titled "Medication Administration" dated 8/3/2010. It included, but was not limited to, "MAR: Medication Administration Record - legal documentation for medication administration...It is the policy of this facility to provide resident centered care...Medications will be charted when given....Documentation of medication will be current for medication administration...." This Federal tag relates to Complaint IN00406167. 3.1-50(a)(1)(2)			
F 0925 SS=D Bldg. 00	483.90(i)(4) Maintains Effective Pest Control Program §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. Based on observation, interview and record review, the facility failed to ensure an effective pest control was in place on the 100 hall related gnats for 3 of observations on the dementia unit. Findings include: On 4/12/23 at 12:45 p.m., there was a gnat observed flying in the hallway on the back of the 100 Hall. On 4/13/23 at 10:20 a.m., the following was observed in the shower room in the back of the 100 Hall: - Multiple gnats were flying around. - There were 2 fly traps hanging that were covered in gnats. -There were a multitude of dead gnats on the shower floor and the floor around the toilet .	F 0925	**F925** **Corrective action for the residents found to have been affected by the deficient practice:** No residents were harmed by this alleged deficient practice. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents who reside in facility have the potential to be affected by this alleged deficient practice. Facilities contracted Pest Control Service Provider was contacted and scheduled to treat facilities identified issue. **Measures/systemic changes put into place to ensure the**	04/14/2023

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	On 4/13/23, between 2:10 p.m. and 2:25 p.m., the following was observed: - There were 2 gnats observed in room 112. One gnat was crawling on the foot board and one crawling on the blanket of the the 2nd bed. -A gnat was observed crawling on the desk at the nurse's station. Review of the pest control logs lacked any documentation related to gnats on the 100 Hall. During an interview on 4/13/23 at 10:22 a.m., the Unit Manager indicated pest control had been in to spray a couple of times. They do not use the shower room as the water did not stay warm and it was a mess. During an interview on 4/13/23 at 12:58 p.m., the RDCO (Regional Director of Clinical Operations) and interim ED (Executive Director) indicated they were just made aware of the issue with the shower room on the unit this morning. The RDCO was told that there was an issue with warm water. Neither were sure how long there had been an issue as they were just told today. During an interview on 4/13/23 at 12:55 p.m., the Maintenance Director indicated there should be a pest control log at each of the nurse's stations where issues could be documented. During an interview on 4/13/23 at 1:58 p.m., LPN (Licensed Practical Nurse) 6 indicated the shower room in the back had not been used since she had worked at the facility, which was about 6 months ago. The gnat issue started about 3 months ago. Pest control did come in one time and said it may		**deficient practice does not recur:** DON/Designee educated staff on facilities policy “Pest Control” with emphasis on treatment per facility policy and as needed for identified issues. **Corrective actions to be monitored to ensure the deficient practice will not recur:** The DON or Designee will review 5 times weekly for 4 weeks, then 3 times weekly for 4 weeks then one time weekly for 4 weeks to ensure pest control books in are located in front office and each nurses station and are up to date and routine treatment is occurring per policy and treatment occurring with any identified issues. The DON and/or 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. Date of compliance 4/14/23	

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	take a while to see a change. The water in the shower room had low pressure and the water did not get warm enough so they had been given all showers in the shower room at the front of the hall. During an interview on 4/13/23 at 3:02 p.m., the ED indicated the pest log at the front desk was all they had. If there was an issue, staff would write it down and give to front desk to put in the log. On 4/13/23 at 2:35 p.m., the RDCO provided a current copy of the document titled "Pest Control" dated 9/15/21. It included, but was not limited to, "Procedure...If a problem should develop, the Environmental Services Director will contact...Pest Control for an additional visit...A problem list is hung at the nurse's station fro...Pest Control personnel to review before starting so special attention can be given to this area...." This Federal tag relates to Complaint IN00406167. 3.1-19(f)(4)			