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	05/16/2024

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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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00432699 and IN00432743. Complaint IN00432699 - No deficiencies related to the allegations are cited. Complaint IN00432743 - Federal/State deficiency related to the allegations is cited at F728. Survey dates: May 9, 10,13, 14, 15, and 16, 2024 Facility number: 000526 Provider number: 155488 AIM number: 100266970 Census Bed Type: SNF/NF: 108 Total: 108 Census Payor Type: Medicare: 4 Medicaid: 83 Other: 21 Total: 108 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on May 22, 2024.	F 0000	**The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the Annual and complaint survey conducted on May 9th-May 16th 2024. Please accept this plan of correction as the provider's credible allegation of compliance.** **The facility would like to respectfully request a desk review.**	
F 0558 SS=E Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Chante Williams	Executive Director	06/03/2024

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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	accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. Based on observation, record review, and interview, the facility failed to ensure the resident's call lights were within reach for 10 of 108 residents observed for call light placement. (Residents 20, 77, 256, 60, 47, 91, 11, 38, 46 and 94) Findings include: 1. During an observation on 5/10/24 at 8:15 a.m., Resident 20's call light was laying on the floor underneath the resident's bed. No staff were present in the resident's room. The record for Resident 20 was reviewed on 5/16/24 at 9:18 a.m. The resident's diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease), major depressive disorder, difficulty walking, muscle wasting and atrophy, the need for assistance with personal care, cognitive communication deficit, dysphagia and dementia. The Quarterly MDS (Minimum Data Set) assessment, dated 3/18/24, indicated the resident was rarely or never understood. The resident required the use of a wheelchair for mobility. 2. During an observation on 5/9/24 at 8:30 a.m., Resident 77's call light was laying on the floor underneath the resident's bed. No staff were present in the resident's room. During an observation and interview on 5/10/24 at 8:15 a.m., Resident 77's call light was laying underneath the resident's pillows out of reach from the resident. No staff were present in the	F 0558	/bcorrective> Call bell was immediately placed within reach for the residents identified. (Residents 20, 77, 56, 60, 47, 91, 11, 38, 46 and 94) There was no negative outcome as a result of this deficient practice. /bcorrective> A complete call bell audit was conducted to assure all call bells properly placed and within reach. No discrepancies noted. /bcorrective> All staff educated on Resident Rights policy, emphasizing on assuring call bell within resident reach. /bmeasures> The DON/designee will complete visual resident room audits to assure call bell is within reach. These audits will be completed 5x weekly for four (4) weeks; 3x weekly for four (4) weeks and then weekly for four (4) months. The results of these audits/observations will be reported, reviewed and trended for compliance and further follow up through the facility QAPI Committee for a minimum of 6 months and then randomly thereafter.	06/10/2024

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	resident's room. The record for Resident 77 was reviewed on 5/16/24 at 9:20 a.m. The resident's diagnoses included, but were not limited to, the need for assistance with personal care, unsteadiness on her feet, muscle weakness, difficulty walking, the need for assistance with personal care, and cognitive communication deficit. The Quarterly MDS assessment, dated 2/27/24, indicated the resident was severely cognitively impaired. The resident required the use of a wheelchair for mobility. 3. During an observation on 5/9/24 at 9:40 a.m., Resident 256's call light was at the foot of his bed between the mattress and the foot board. No staff were present in the resident's room. The record for Resident 256 was reviewed on 5/16/24 at 9:00 a.m. The resident's diagnoses included, but were not limited to, type 2 diabetes mellitus with neuropathy, cardiac implants and grafts, atrial fibrillation, the use of anticoagulants, a history of transient ischemic attach and cerebral infarction, pulmonary emboli, and cognitive communication disorder. The Quarterly MDS (Minimum Data Set) assessment, dated 2/6/24, indicated the resident was cognitively intact. The resident required the use of a wheelchair for mobility. The resident had upper and lower extremity functional limitations on one side. 4. During an observation on 5/9/24 at 9:30 a.m., Resident 60's call light was at the head of his bed out of reach from the resident. No staff were present in the resident's room.			

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	The record for Resident 60 was reviewed on 5/16/24 at 9:00 a.m. The resident's diagnoses included, but were not limited to, nontraumatic intracerebral hemorrhage, acute respiratory failure, cerebral edema, hemiplegia (partial paralysis on one side of the body) and hemiparesis following a cerebral infarction affecting the left non- dominant side, the need for assistance for personal care, and dementia. The Quarterly MDS assessment, dated 2/6/24, indicated the resident was cognitively intact. The resident required the use of a wheelchair for mobility. The resident had upper and lower extremity functional limitations on one side. 5. During an observation and interview on 5/9/24 at 9:30 a.m., Resident 47's call light was clipped to the privacy curtain and hid behind the curtain. The resident indicated he was in a lot of pain. He was waiting for someone to come into his room so he could tell them he needed pain medication. No staff were present in the resident's room. During an observation and interview on 5/10/24 at 8:16 a.m., the call light for Resident 47 was underneath his bed laying on the floor. He indicated a call light would come in handy. Right now he just yells out if he needs anything. The resident wasn't aware he had a call light. No staff were present in the resident's room. The record for Resident 47 was reviewed on 5/16/24 at 9:00 a.m. The resident's diagnoses included, but were not limited to, hemiplegia and hemiparesis following a cerebral infarction, acquired absence of the right leg below the knee, type 2 diabetes mellitus, the need for assistance with personal care, dysphagia, and cognitive			

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	communication disorder. The Quarterly MDS assessment, dated 3/27/24 indicated the resident was moderately cognitively intact. The resident required the use of a wheelchair for mobility. The resident had upper and lower extremity functional limitations on one side. During an interview on 5/16/24 at 12:00 p.m., CNA (Certified Nursing Aide) 3 indicated the residents' call lights should always be within the residents reach. If a resident could not use their call light, staff would still put the call light within their reach and check on the resident frequently. During an interview on 5/16/24 at 12:15 p.m., CNA 6 indicated the residents' call lights should always be within the residents reach. The call light should never be clipped to the privacy curtains or on the floor out of reach. 6. During an observation of resident call light placement on 5/9/24 between 9:30 a.m. and 10:15 a.m., Resident 91 was sitting in his wheelchair with his upper legs propped up his on bed. The resident's call light was hanging on the wall across from his bed out of reach. No staff were present in the resident's room. The record for Resident 91 was reviewed on 5/10/24 at 1:00 p.m. The resident's diagnoses included, but were not limited to, bilateral below the knee amputations, peripheral vascular disease, amputation of right index finger to knuckle, depression and anxiety. The Quarterly MDS assessment, dated 3/29/24, indicated the resident was alert and oriented. The resident required the use of a wheelchair for mobility.			

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	7. During an observation of resident call light placement on 5/9/24 between 9:30 a.m. and 10:15 a.m., Resident 11 was asleep in her bed. The resident's call light was underneath the top of the mattress at the head of the bed out of the resident's reach. No staff were present in the resident's room. During an observation of resident call light placement on 5/9/24 between 1:45 p.m. and 2:10 p.m., Resident 11 was asleep in her bed. There was no call light in sight or staff present in the resident's room. During an observation of resident call light placement on 5/16/24 between 8:30 a.m. and 8:45 a.m., Resident 11 was laying in her bed with her eyes open and at times looking around. The resident's call light was on the floor under the bed. No staff were present in the resident's room. The record for Resident 11 was reviewed on 5/10/24 at 12:30 p.m. The resident's diagnoses included, but were not limited to, Parkinson's disease without dyskinesia, bipolar disorder, Alzheimer's disease, and major depressive disorder. The Quarterly MDS assessment, dated 3/7/24, indicated the resident had severe cognitive impairment. The resident had lower extremity functional limitations on both sides. 8. During an observation of resident call light placement on 5/9/24 between 9:30 a.m. and 10:15 a.m., Resident 38 was observed asleep in her bed. The resident's call light was hanging off the side of the bed towards the floor. The resident's call light was out of the reach of the resident. No staff			

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	were present in the resident's room. During an observation of resident call light placement on 5/9/24 between 1:45 p.m. and 2:10 p.m., Resident 38 was asleep in her bed. the resident's call light was on the side rail below the level of the mattress out of the resident's reach. No staff were present in the resident's room. The record for Resident 38 was reviewed on 5/9/24 at 2:00 p.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease, dementia, anxiety, depression, and chronic obstructive pulmonary disease. The Significant Change MDS assessment, dated 2/17/24, indicated the resident had severe cognitive impairment. The resident required the use of a wheelchair for mobility. 9. During an observation of resident call light placement on 5/9/24 between 9:30 a.m. and 10:15 a.m., Resident 94 was observed lying on his bed looking around. The resident's call light was on the floor behind his bed. No staff were present in the resident's room. During an observation of resident call light placement on 5/9/24 between 1:45 p.m. and 2:10 p.m., Resident 94 was lying awake in his bed. The resident's call light was laying across the nightstand out of reach of the resident. No staff were present in the resident's room. During an observation of resident call light placement on 5/16/24 between 8:30 a.m. and 8:45 a.m., Resident 94 was laying in his bed with his eyes open. The resident's call light was on the floor by the bed. No staff were present in the resident's room.			

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	The record for Resident 94 was reviewed on 5/13/24 at 9:15 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus, dementia and depression. The Admission MDS assessment, dated 1/31/24, indicated the resident had moderate cognitive impairment. The resident had upper extremity functional limitations on one side. 10. During an observation of resident call light placement on 5/9/24 between 1:45 p.m. and 2:10 p.m., Resident 46's was asleep in her bed. the resident's call light was on the floor under her roommate's bed. No staff were present in the resident's room. During an observation of resident call light placement on 5/16/24 between 8:30 a.m. and 8:45 a.m., Resident 46 was asleep in her bed. The resident's call light was under the roommate's bed. No staff were present in the resident's room. The clinical record for Resident 46 was reviewed on 5/15/24 at 1:22 p.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease. mood disorder, chronic obstructive pulmonary disease, major depression and cognitive communication deficit. The Significant Change MDS, dated 3/26/24, indicated the resident had severe cognitive impairment. The resident had lower extremity functional limitations on one side. On 5/14/24 at 1:06 p.m., the Executive Director (ED) presented a copy of the facility's current policy titled "Resident Rights". The policy included, but was not limited to, "Policy: It is the			

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	policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. Safety of residents,...is a top priority. The purpose of this policy is to guide employees in the general principles of dignity and respect of caring for residents, including the...safety of other residents, visitors and staff...Procedure: 1. The residents will be treated with dignity and respect including but not limited to:...c. To have a method to communicate needs to staff: i. Call light or bell access will be within reach of the resident as one method to communicate needs to staff..." Cross Reference F565 3.1-19(u)(1)			
F 0565 SS=E Bldg. 00	483.10(f)(5)(i)-(iv)(6)(7) Resident/Family Group and Response §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly			

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	upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. Based on interview and record review, the facility failed ensure Administration was taking resident concerns seriously or being visible to the residents for 11 of 13 Resident Council meetings (3/23, 4/23, 5/23, 6/23, 7/23, 9/23, 10/23, 1/24, 3/24. 4/24, and 5/24). This deficient practice had the potential to affect 108 of 108 residents currently residing in the facility. Findings include: 1. The Resident Council meeting held on 3/21/23, the residents indicated their concerns were not resolved or acted upon for the following: - There was no improvement in Administration taking the resident's concerns seriously. The residents heard the same excuse over and over. - Nothing was being done about the lack of staff. - The resident's indicated they saw nursing staff walking past the resident's rooms who needed	F 0565	/b> Education provided with activities director on Resident Council and Grievance Policies emphasizing on communication with ED/Department heads on concerns expressed by residents at resident council meetings timely. Review of resident council meeting minutes for the months 3/23, 4/23, 5/2, 6/23, 7/23, 9/23, 10/23, 1/24, 3/24, 4/24 and 5/24 and all concerns addressed. There was no negative outcome as a result of this deficient practice. /b> The ED/DON was invited to attend Resident Council meeting to validate concerns expressed were resolved. Residents stated concerns resolved and thankful.	06/10/2024

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	assistance. It was hard to get a nurse to come and see what residents needed at night. - The meals were not being balanced out with the residents' diet. When the ticket said double portions, they were not getting it every meal. The residents were still hungry. The residents were receiving the same meals over and over. - The laundry was not putting the clothes in the right closet and they were not getting their clothes back. The documentation lacked a response from the responsible department heads. 2. The Resident Council meeting held on 4/18/23, the resident concerns indicated the following were not resolved or acted upon: - Issues continued with the nursing staff. - The nurses were telling the residents they did not have time to make appointments for them. - Housekeeping was not mopping the floor or cleaning the restroom. - The clothes were missing and had bleach marks on them. The response given to the nursing concerns indicated a daily 10:00 a.m. meeting would be held to discuss issues. The documentation lacked a response from Laundry or Housekeeping related to the other concerns. 3. The Resident Council meeting held on 5/23/23, the residents indicated the following concerns were not resolved or acted upon: - Nursing shortage. - The food was cold and if someone ordered an		/b> The ED/Social Worker/designee(s) will provide education to all staff on Grievance policy emphasizing importance of reporting concerns timely. /b> The ED/Social Worker/designee(s) will attend monthly resident council meetings to discuss concerns, provide updates on resolutions, and gather feedback and create a clear and accessible communication channel for residents. Use feedback to make ongoing improvements and ensure resident needs and preferences are consistently met. Review of grievances will be completed weekly for 3 months then every other week for 3 months to assure addressed and follow up completed timely. The results of these audits/observations will be reported, reviewed and trended for compliance and further follow up through the facility QAPI Committee for a minimum of 6 months and then randomly thereafter.	

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	alternate, it was not served. - The resident's clothes were missing. The Dietary Manager responded to the food concern on 5/24/23. She indicated food temperatures were taken at every meal, but the food carts were seen sitting in the hallway for 30 minutes, which meant the heat bases had stopped working. The nursing staff were to come to the kitchen instead of sending the resident to get the requested items. The Director of Nursing (DON) was present in this Resident Council meeting, but no response was given to address the staff shortage. The documentation lacked a response from Laundry on the missing clothes. 4. The Resident Council meeting held on 6/20/23, the residents indicated the following concerns were not resolved or acted upon: - The CNAs (Certified Nurse Aides) and nursing talked bad to the residents. - There was a nursing shortage. - Housekeeping would not empty the trash cans. - The clothes were not being put back into the right closets. The documentation lacked a response from the department heads. 5. The Resident Council meeting held on 7/11/23, the resident's indicated the following concerns were not resolved or acted upon: - The residents felt that Administration needed to get to know the residents needs. - The residents felt that dietary needed to go			

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	around and ask what the residents wanted to eat, because they were not getting what they ordered. The documentation lacked a response from the department heads. 6. The Resident Council meeting held on 9/19/23, the residents indicated the following concerns were not resolved or acted upon: - There was too much turnover of nursing staff; some of the CNAs were "lazy." - The food was "nasty"; they were served too much fish. - The laundry never brought the clothes back, they lost the clothing, and they mixed the clothing up. - The nurses and CNAs were talking "nasty." - The night shift was not answering the call lights. - The nursing staff were talking while standing by the 100 Hall doors, which bothered the residents who were trying to sleep. The documentation lacked a response from the department heads. 7. The Resident Council meeting held on 10/18/23, the resident's indicated the following concerns were not resolved or acted upon: - The CNAs and nurses were yelling down the halls at each other and it woke the residents up. - A nurse was giving the residents the wrong medication. - The food was cold and tasted awful. The DON responded to the concern on 10/18/23 and indicated a staff inservice had been completed.			

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	155488	A. BUILDING 00 B. WING	05/16/2024

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	The Dietary Manager responded to the concern on 10/18/23 and indicated the manager will do audits daily on meal service to ensure proper food temperatures and taste. 8. The Resident Council meeting held on 1/16/24, the residents indicated the following concerns were not resolved or acted upon: - The kitchen served whatever they wanted. - The resident's clothes were missing. The Activity Director responded during the meeting that the kitchen had to go by a menu and that if the residents did not want what was on the menu, there were alternatives they could have. The residents were asked what clothes were missing and that the facility would replace the items for them. 9. The Resident Council meeting held on 3/19/24, the residents indicated the following concerns were not resolved or acted upon: - The resident's clothes were missing and the residents were receiving other people's clothes. The Activity Director responded to the residents during the meeting that the facility was checking on the missing clothes to see if they could find them. She further indicated all of Administration were going to be invited to the next meeting so the residents could know who they were and be able to answer any questions they may have. 10. The Resident Council meeting held on 4/24/24, the residents indicated the following concerns were not resolved or acted upon: - The resident's clothes were missing.			

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	The Activity Director responded during the meeting that she spoke with Laundry about the missing clothes and the facility would replace them. Some of the clothing was found. Activities and Laundry were going to take the residents' down to Laundry and look through the items to see if any of the clothing was theirs. The residents invited members of the Administration to attend the meeting and they failed to do so. 11. The Resident Council meeting held on 5/12/24, the residents indicated the following concerns were not resolved or acted upon: - A night shift aide could be verbally abusive. The aide was often found sleeping on the job or off their assigned hall looking in resident rooms on other halls. Administration was spoken to about the aide, but it was just brushed aside. - Resident 31 was supposed to be one on one at all times, but on several occasions had been left to roam the halls by himself. The resident was physically aggressive with both staff and other residents, including Resident 71. Administration was aware of the problems, but nothing was done about it. - No satisfaction from Management when concerns were voiced. A bunch of nonsense was given and the issue was not resolved. - The nursing staff told the residents they had to pass all the trays and feed all the residents who needed assistance before they would go to the kitchen to obtain a substitute meal and heat the food up for them. - The food was cold, tasted poorly, and was not very appealing when served. Bread was soggy from the vegetable juice on the same plate.			

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	Resident 71 showed a picture he took of a meal, which showed the baked beans and tomatoes and okra on the same plate with the juices surrounding the sloppy joe bun. - There was not enough snacks for everyone to have, they were not always offered, or the tray of snacks went to one particular hall and was never seen again. - They sometimes ran out of food. The didn't always get the substitutes the residents asked for because they were out of the item. - The nursing staff were not always making appointments for the residents. - The nurses were not assisting the residents when they need to be changed. They would tell the residents it was not their job and they would have to find an aide to help. - The call lights were not being answered timely. It took 1/2 hour to 2 hours to be answered. The staff would come in and turn off the light and indicated they would be right back, but did not return. The Activity Director indicated the 12 residents who attended this Resident Council meeting were alert and oriented. The review of the individual resident Grievance Logs between March 2023 and May 2024 indicated missing clothes, bleach on clothes, and not answering call lights were reported. During an interview on 5/9/24 at 12:42 p.m., Resident 66 indicated she did not have any of her clothes. Laundry and staff had not been able to find them, and she didn't have any more clothes to wear that fit. She indicated her name was inside her clothing and she needed her clothes. During an observation and interview, on 5/14/24 at 8:30 a.m., Resident 66 had 3 pairs of pants and 3 shirts in her closet. The resident indicated she had			

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	8 short sleeve shirts missing, 3 outfits she received for Christmas, and 3 pairs of pants were missing. Her name was on her clothing and the laundry had not found them. During an interview on 5/14/24 at 8:45 a.m., the Housekeeping Supervisor indicated they had been looking for Resident 66's clothing. At that time she was unable to find them. The resident told her she was missing pants and shirts. She had a lost and found and she was going to go through it to see if the resident had any clothing in it. Laundry would take the clothing and see if the resident could identify them. She indicated the facility would replace her clothing if they could not be found. The review of the Grievance/complaint Log, dated 5/14/24 at 11:00 a.m., indicated Resident 66's missing clothing were found and staff took them to the resident. During an interview 5/15/24 at 9:23 a.m., Resident 66 indicated she was told yesterday the staff had found her clothing and they were going to bring them to her. She indicated no one had found or brought her clothes to her. On 5/14/24 at 1:06 p.m., the Executive Director (ED) presented a copy of the facility's current policy titled Resident Council, dated effective 4/22/21. The policy included, but was not limited to, "Policy:...2. Duties of the Resident Council include:...c. Helping identify concerns;...e Helping individuals speak out about what's bothering them and helping to overcome fear of retaliation; f. Improving the atmosphere of the facility...4...Any concerns voiced at the meeting should be documented on the Concern Form and distributed to the appropriate Department Head. 5. Facility			

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	should follow the "Resident Grievance Procedure" for any concerns identified." The ED also presented a copy of the facility's current policy titled Resident Grievance Indiana, dated effective 6/19/18. The policy included, but was not limited to, ":...Policy: It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of residents. This facility will provide a venue for residents...to voice concerns, complaints, or grievances to facility leadership and external parties...Procedure: 1. Prevent Ongoing Violations: a. Upon receipt of an oral, written or anonymous grievance submitted by a resident, the Grievance Official will take immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated, if indicated...3. Investigation: a. The Grievance Official will complete an investigation of the resident's grievance...4. Time Frame: a. The grievance review will be completed in a reasonable time frame consistent with the type of grievance but not to exceed 30 days. 5. Grievance Decision: a. Upon completion of the review, the Grievance Official will complete a written grievance decision that includes the following: i. The date the grievance was received. ii. A summary of the statement of the resident's grievance. iii. The steps taken to investigate the grievance...vi. Whether any corrective action was or will be taken. vii. If corrective action was or will be taken, a summary of the corrective action. If corrective action will not be taken, then an explanation of why such action is not necessary...6. Resident Notification: a. The Grievance Official will meet with the resident and inform the resident of the results of the investigation and how the resident's grievance was resolved or will be resolved, if applicable..."			

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	Cross reference F804 and F558 3.1-3(l)			
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. 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 interview and record review, the facility failed to identify a resident's right heel pressure ulcer prior to the wound being first identified as an open blister, no longer holding fluid for 1 of 3 residents reviewed for pressure ulcers. (Resident 8) Findings include: The record for Resident 8 was reviewed on 5/14/24 at 2:10 p.m. The resident's diagnoses included, but were not limited to, non-traumatic intracerebral hemorrhage, hemiplegia (partial paralysis on one side of the body) and hemiparesis, dementia, anxiety disorder, unsteadiness on feet, assistance with personal care, difficulty walking, and cognitive communication disorder.	F 0686	/b> Resident 8 no longer resides in facility. /b> Skin assessment completed on all residents with no new skin impairments noted. /b> All licensed nurses, CNAs and QMAs educated on wound prevention policy emphasizing importance of reporting new skin impairment immediately and nurses to initiate MD/family notifications, assessments, treatments and careplans. /b>	06/10/2024

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	The Quarterly MDS (Minimum Data Set) assessment, dated 2/29/24, indicated the resident's cognition was moderately impaired. The resident required substantial or maximal staff assistance with his ADL's (Activities of Daily Living). The care plan, dated 3/23/23, indicated Resident 8 had impaired skin integrity or altered skin integrity related to immobility. The interventions included, but were not limited to, apply barrier creams post incontinent episodes, complete skin at risk assessment upon admission, readmission, quarterly, and as needed, weekly skin checks, ensure the resident was turned and repositioned, and provide an appropriate off-loading mattress. The review of the CNA (Certified Nursing Aide) shower records, dated 4/29/24, 5/2/24, and 5/7/24 indicated Resident 8 did not have any current or new skin issues. The skin/wound note, dated 5/7/24 at 2:27 p.m., indicated Resident 8 was seen for wound rounds related to a skin area to the right plantar foot. The resident was observed to have a pressure wound of a blister to the right heel. The blister was observed to no longer be holding fluid, the outer skin of the blister remained intact. The new orders were received for a betadine-soaked gauze to be applied daily and to be secured with kerlix. The physician's order, dated 5/7/24, indicated staff were to complete a daily wound assessment and to document the abnormalities in the progress notes every day shift and every night shift for the area to the right heel. The NP (Nurse Practitioner) Wound Evaluation, dated 5/7/24, indicated the resident had a new		The DON/Designee will complete a second skin assessment on 5 residents that are at risk for skin impairment to validate skin assessment was completed accurately \3x a week for four (4) weeks, then weekly for four (4) weeks, then every other week for 2 months, then monthly for 2 months. The results of these audits/observations will be reported, reviewed and trended for compliance and further follow up through the facility QAPI Committee for a minimum of 6 months and then randomly thereafter.	

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	pressure wound to the right heel. The wound length was 5.0 cm (centimeter) long by 4.0 cm wide and the depth was 0.1 cm. The pressure wound was acquired in the facility on 5/7/24. The pressure wound was a new wound. The epithelium dermis and subcutaneous tissue was exposed, the wound edges were attached, and the peri wound was fragile. The wound had a moderate amount of serosanguineous drainage. The treatment included cleansing the wound with wound cleanser, applying a betadine-soaked gauze, applying an abdominal pad and wrap with gauze. Daily dressing and as needed dressing changes were ordered. The physician's order, dated 5/9/24, indicated to cleanse the right heel with wound cleanser, betadine-soaked gauze, abdominal pad and rolled gauze as needed for soilage of the wound. During an interview on 5/15/24 at 1:00 p.m., the CNA 3 indicated that when the CNAs gave the residents a shower or a complete bed bath, they would be looking at the resident's skin for any pressure areas. She would report back to the nurse and the wound care nurse. She would document her findings on the resident's shower sheet and on the computer. During an interview on 5/15/24 at 1:25 p.m., the LPN (Licensed Practical Nurse) 5 indicated the nurses did weekly skin assessments and observed daily while providing care. During an interview on 5/15/24 at 2:20 p.m., Wound Care Nurse indicated Resident 8 had a Stage 3 pressure ulcer (Full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole [rolled wound edges] are often present). She indicated			

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	that the wound started out as a blister, and it popped. The blister was pulled away enough to see the wound bed. The resident required extensive staff assistance with his lower body mobility. The most current Skin Care and Wound management policy, included, but was not limited to, "... Each resident/patient is evaluated upon admission and weekly thereafter for changes in skin condition. Resident/patient skin condition is also re-evaluated with change in clinical condition, prior to the hospital and upon return from the hospital. Daily monitoring of existing wounds..." 3.1-37(a)			
F 0728 SS=E Bldg. 00	483.35(d)(1)-(3) Facility Hiring and Use of Nurse Aide §483.35(d) Requirement for facility hiring and use of nurse aides- §483.35(d)(1) General rule. A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless- (i) That individual is competent to provide nursing and nursing related services; and (ii)(A) That individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §483.151 through §483.154; or (B) That individual has been deemed or determined competent as provided in §483.150(a) and (b). §483.35(d)(2) Non-permanent employees. A facility must not use on a temporary, per diem, leased, or any basis other than a			

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	permanent employee any individual who does not meet the requirements in paragraphs (d)(1)(i) and (ii) of this section. §483.35(d)(3) Minimum Competency A facility must not use any individual who has worked less than 4 months as a nurse aide in that facility unless the individual- (i) Is a full-time employee in a State-approved training and competency evaluation program; (ii) Has demonstrated competence through satisfactory participation in a State-approved nurse aide training and competency evaluation program or competency evaluation program; or (iii) Has been deemed or determined competent as provided in §483.150(a) and (b). Based on record review and interview, the facility failed to ensure the CNAs (Certified Nurse Aides) tested for their licensure, prior to 120 days after of employment and worked past the 120 days for 6 of 33 CNAs reviewed. (CNAs 13, 14, 16, 15, 19, and 17) Findings include: During the review of the employee records on 5/15/24 at 11:10 a.m., the following was identified: -CNA 14 was hired on 9/6/23. -CNA 13 was hired on 8/2/23. Date of hire on the employee records indicate 5/3/23. -CNA 16 was hired on 2/10/20. -CNA 15 was hired on 8/2/23. -CNA 19 was hired on 3/29/23. -CNA 17 was hired on 6/29/23. -CNA 20 was hired on 6/21/23. During an interview on 5/15/24 at 1:25 p.m., the ED (Executive Director) indicated there wasn't a HR	F 0728	Past non-compliance	05/16/2024

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	(Human Resources) person up to 4/5/24 and the ED looked at all staff for licenses. She found that 8 facility staff who were licensed in Kentucky had not taken their CNA licensure test in the 120 days required in Indiana. All 8 staff were taken off of the work schedule until they passed their CNA licensure test. -CNA 13's 120th day was 11/29/23. She worked 70 days past her 120th day between 11/30/23 and 4/2/24. -CNA 14's 120th day was 1/3/24. She worked 21 days past her 120th day between 11/13/23 and 2/5/24. -CNA 16's 120th day was 7/26/23. She worked 137 days past her 120th day between 7/26/23 and 3/30/24. -CNA 15's 120th day was 11/29/23. She worked 51 days past her 120th day between 11/29/23 and 4/4/24. -CNA 19's 120th day was 7/26/23. She worked 102 days past her 120th day between 7/29/23 and 4/4/24. -CNA 17's 120th day was 10/26/23. She had worked 10/27/23. During an interview on 5/16/24 at 9:15 a.m., the ED indicated the facility had mobile HR 12, who came in 2 times weekly. On 5/16/24 at 9:32 a.m., the ED provided the last staff which was HR 11. Her hire date was 1/8/24 and she left the position on 2/6/24. The Frequently Asked Questions: Certified Nurse			

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	Aides, included, but was not limited to, "... 5. What steps area needed to certify an out-of-state certified nurse aide in Indiana?... Aide is allowed to work in Indiana for 120 days until they are on the Indiana registry..." The Past noncompliance began on the hire date of each CNA and the deficient practice was corrected by 4/5/24 after the facility implemented a systemic plan that included the following actions: The facility changed the process for monitoring staff for licensure, by placing the CNAs license on monthly planners. This citation relates to Complaint IN00432743 3.1-14(c)(1)			
F 0804 SS=E Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. Based on observation and interview, the facility failed to ensure meals were at appropriate temperatures and palatable for residents, during 3 of 3 meal test trays. This had the potential to affect 106 of 108 residents who ate meals at the facility. (100, 400, and 200 Hall Test Trays) Findings include:	F 0804	/b> Education provided to dietary staff on meal prep procedures to ensure a more accurate acceptable temp. There was no negative outcome as a result of this deficient practice. /b>	06/10/2024

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	1. During an observation of the 100 Hall lunch test tray on 5/14/24 at 12:00 p.m., the following temperatures were obtained: -The baked ziti had a temperature of 145 degrees F (Fahrenheit). The appearance was palatable. The flavor was bland and salt was applied for more flavor. -The Caesar salad had a temperature of 65.6 degrees F. The appearance and flavor were appetizing. 2. During an observation of the 400 Hall lunch test tray on 5/14/24 at 12:25 p.m., the following temperatures were obtained: -The baked ziti had a temperature of 135 degrees F. -The Caesar salad had a temperature of 63.5 degrees F. 3. During an observation of the 200 Hall lunch test tray on 5/16/24 at 11:52 a.m., the following temperatures were obtained: The pepperoni pizza had a temperature of 168.8 degrees F. The pizza was appetizing and palatable in flavor. The baked ziti had a temperature of 131.5 degrees F. The dish had a lot of oregano and was palatable. The side salad with mushrooms had a temperature of 48.7 degrees F. The salad was appealing and had a good flavor with salad dressing. The mixed fruit had a temperature of 74.7 degrees F. The fruit was at room temperature per taste and was at a good consistency. At this time, the Dietary Manager, indicated the salad and fruit were pulled from the cooler, one cup at a time.		The Dietary Manager interviewed all residents to ensure all food is palatable, attractive and at a safe temperature. Concerns identified were addressed. Thermometers were calibrated. /b> The RD/designee will provide education to the dietary, nursing and department heads to ensure food temperatures are obtained at the start of the tray line and all meal trays served, stored and delivered safely and securely in order for all foods to maintain appropriate temperature and are palatable. /b> The RD/designee will audit 3 meals 5 xs a week for 2 months, 3 xs a week for 2 months, weekly for 2 months. The ED/DON/Dietary Manager will attend the resident monthly food committee to review the results of audits to ensure resident meal satisfaction. The results of these audits/observations will be reported, reviewed and trended for compliance and further follow up through the facility QAPI Committee for a minimum of 6 months and then randomly thereafter.	

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	155488	A. BUILDING 00 B. WING	05/16/2024

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	During an interview on 5/10/24 at 9:12 a.m., Resident 49 indicated the food could be better. He asked for a cheeseburger usually due to the quality of the food being an issue. During an interview on 5/10/24 at 10:01 a.m., Resident 69 indicated the facility didn't provide a hamburger to him. The breakfast was cold and the quality of the food was bad. During an interview on 5/10/24 at 10:10 a.m., Resident 21 indicated the food stinks here. They didn't know his likes and dislikes. He felt he had a weight loss due to not eating well. The facility had substitutes if he asked and if they had it. During an interview on 5/14/24 at 10:00 a.m., Resident 81 indicated the food was not good. There were many concerns about the food. During an interview on 5/14/24 at 10:02 a.m., Resident 44 indicated that staff told them, they had to pass all of the trays and feed all the residents before they would go to the kitchen to see about a substitute for them or to heat food up when it arrived cold. The food was always cold. It was very nasty in taste and the way it looked. During an interview on 5/14/24 at 10:04 a.m., Resident 71 indicated when they had sloppy joe with creamed corn. They were put right on the plate together. They put the vegetables on the tray and it always made the bread soggy and then he couldn't eat it. The resident showed a picture of the meal plate in which there was a sloppy joe on a bun, baked beans and what appeared to be tomatoes and okra. The baked beans and the tomatoes were juicy and had surrounded the sloppy joe bun on the plate.			

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	During an interview on 5/15/24 at 12:59 p.m., the Dietary Manager indicated this was nursing home week and that was why the menu changed. The dietician approved any changes made to the menu. A meeting was held 3 weeks ago for nursing home week and nurse's week and a decision was made to change the menu on 5/14/24 and 5/15/24. Tomorrow's menu would be what was on the resident menu list, which was pizza, salad, and garlic bread. The Food: Quality and Palatability policy, revised last on February 2023, included, but was not limited to, "Food will be prepared by methods that conserve nutritive value, flavor and appearance. Food will be palatable, attractive and served at a safe and appetizing temperature...4. The Cook(s) prepare food in accordance with the recipes, and season for region..." Cross Reference 565 3.1-21(a)(2)			
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with			

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	applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation and interview, the facility failed to ensure the kitchen was cleaned and in good repair 2 of 2 observations. This had the potential to affect 106 of 108 residents who consumed meals at the facility. Findings include: 1. During an interview and observation of the kitchen on 5/9/24 at 9:25 a.m., Server/Dishwasher 10 indicated the dishwasher was currently working, but it had not been previously. When it was checked, she indicated, "oh good it is working." The dishwasher was observed running. The wash cycle temperature was 145 degrees F (Fahrenheit) and the rinse cycle had a temperature of 170 degrees F. At 11:15 a.m., during observation of the kitchen ceiling the ceiling plaster around the vent had flaked off. The vent was over the preparation table and the flaked off areas were at each corner of the vent. The ceiling was brown stained along the left side of the vent. The two vents over the serving table at the end of the steamer were brown and grease covered. The back metal panel of the burners on the stove had brown streaks of grease. The ceiling around the vent in front of the stove and steam oven had been re-plastered with a bump and was cracked two feet, from the right corner of the vent to the light fixture.	F 0812	F-812 Food Procurement, Store/Prepare/Serve/Sanitary /b> Dishwasher was repaired immediately. Vents in kitchen cleaned and painted immediately. Area behind dishwasher was cleaned immediately. Roofing repairs completed. Drip pan removed and area cleaned. /b> Ceiling to its entirety will be completely repaired by 6/24/2024. Opening noted in wall behind dishwasher will be repaired by 6/24/2024. Cleaning schedule revised and implemented and being monitored. /b> Education with dietary staff on notifying ED/Maintenance director immediately for malfunctions and repairs needed. Revised cleaning scheduled provided along with Wash ware and Environment policies. /b> The ED/Designee will complete daily kitchen observations including validating dishwash temps are accurate 5 xs a week	06/24/2024

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	2. During an interview and observation on 5/10/24 at 8:55 a.m., the dishwater indicated a wash temperature of 150 degrees F and a rinse temperature of 187 degrees F. Cook 9 indicated it had been a couple of months since the dishwasher was repaired. There was a leak in the dishwasher and they fixed it. Grease (black dotted areas) was observed on the wall behind the dishwasher. The dishwasher read 152 degrees F on the second washing and 192 degrees F on the rinse cycle. Cook 9 indicated the problem was with the garbage disposal currently. The wall behind the disposal was opened up through to the outside wall panel. The opening was 9 inches wide and open from the sink down to the floor trim. Water was dripping from the soiled dish sink. Cook 9 indicated they had not had any problems lately, since a month ago. Maintenance did clean out the grease traps and the garbage disposal. At 9:02 a.m., the Dietary Manager indicated it was an old kitchen. It needed replacing. Then she indicated the ceiling just needed painting. Grease (black dotted areas) was around the small vent by the larger vent over the serving area. The ceiling panel over the produce sink had a black area in the corner of the wall. There was a plastic bag over the panel to prevent water from dripping down onto the produce counter. The Dietary Manager indicated the drip pan on the right side of the stove was stuck and had been this way since she started working at the facility. She felt it was probably loaded with food debris. She couldn't go behind the dishwasher to clean the grease, and it was a water leak that caused the wall opening behind the garbage disposal. During an interview on 5/13/24 at 12:46 p.m., the Dietary Manager indicated the dishwasher had grease still behind the dishwasher. There were		for 2 months, 3 xs a week for 2 months, weekly for 2 months. The results of these audits/observations will be reported, reviewed and trended for compliance and further follow up through the facility QAPI Committee for a minimum of 6 months and then randomly thereafter.	

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	maintenance issues and it needed painted. The temperature of the dishwasher wash cycle and rinse cycle- should be 160 degrees F and the rinse cycle should be 180 degrees F. Her logs of the dishwasher temperatures indicated 160 degrees F on the wash cycle and 180 degrees F on the rinse cycle every day. Once the dishes ran through the dishwasher, they were then set to air dry and then were ready for use. The temperatures fluctuated and the cooks had knowledge of the dishwasher temperatures. It was replaced within the last year. During an interview on 5/15/24 at 1:25 p.m., the ED (Executive Director) presented the quote from a roofing company. The quote indicated the existing roof shingles would be removed down to the deck around the flashing areas. If the wood needed to be replaced, the cost was indicated for the plywood and 1 inch by 8 inch roofing joists. The roofing company indicated they would lay down the ice and water guard around the leaking areas, and reflash the penetrations. The quote was obtained on 5/6/24. No repair date was indicated on the quote. The ED was unsure of the date for the roof replacement and indicated she would check with her corporate office. She returned and indicated the closest repair date would be 5/24/24. The kitchen ceiling was not in the quote for replacement and that would have to be replaced in house. The roof would have to be repaired first though. The Ware washing policy, revised February 2023, included, but was not limited to, "...1. The Dining Services staff will be knowledgeable in the proper technique for processing dirty dishware through the dish machine, and proper handling of sanitized dishware. 2. All dish machine water temperatures will be maintained in accordance with manufacturer recommendations for high			

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	temperature or low temperature machines..." The Environment policy, revised on September 2017, included, but was not limited to, "All food preparation areas, food service areas, and dining areas will be maintained in a clean and sanitary condition. 1. The Dining Services Director will ensure that the kitchen is maintained in a clean and sanitary manner, including floors, walls, ceilings, lighting, and ventilation... 4. The Dining Services Director will ensure that a routine cleaning schedule is in place for all cooking equipment, food storage areas, and surfaces..." 3.1-21(i)(3)			