

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/24/2024

FORM APPROVED

OMB NO. 0938-039

| | | | | | | | |
|---|---|---|--|---|--|--|----------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155488 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | | X3) DATE SURVEY COMPLETED 08/29/2024 | |
| NAME OF PROVIDER OR SUPPLIER ROLLING HILLS HEALTHCARE CENTER | | | | STREET ADDRESS, CITY, STATE, ZIP COD 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 | <p>This visit was for the Investigation of Complaints IN00438775 and IN00440995.</p> <p>Complaint IN00438775 - No deficiencies related to the allegations are cited</p> <p>Complaint IN00440995 - Federal/State deficiency related to the allegations is cited at F689.</p> <p>Survey dates: August 28 and 29, 2024</p> <p>Facility number: 000526 Provider number: 155488 AIM number: 100266970</p> <p>Census Bed Type: SNF/NF: 101 Total: 101</p> <p>Census Payor Type: Medicare: 2 Medicaid: 83 Other: 16 Total: 101</p> <p>This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on September 4, 2024.</p> | | | F 0000 | <p>Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. The facility cordially requests paper compliance regarding alleged deficient practices.</p> | | |
| F 0689 SS=D Bldg. 00 | <p>483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on observation, interview and record review, the facility failed to ensure fall interventions were in place for 1 of 3 residents reviewed for accident hazards. (Resident C)</p> | | | F 0689 | <p>Corrective Action for the residents found to have been affected by the deficient practice:</p> | | 09/16/2024 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Cheryl Fagundo

RNDON

09/11/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 30 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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| | <p>Findings include:</p> <p>The clinical record for Resident C was reviewed on 8/28/24 at 12:50 p.m. The resident's diagnoses included, but were not limited to, Parkinson's disease and epilepsy.</p> <p>The care plan, dated 3/4/22, indicated the resident was at risk for falls and to apply non-skid strips to the left side of the bed.</p> <p>During an observation with the DON (Director of Nursing) on 8/28/24 at 2:53 p.m., the care planned intervention of non-skid strips to the left side of Resident C's bed were not in place.</p> <p>During an interview on 8/28/24 at 2:43 p.m., the DON indicated if the intervention was on the resident's plan of care, they should be in place.</p> <p>On 8/29/24 at 10:10 a.m., the Executive Director provided a current, undated copy of the document titled "Fall Prevention and Management". It included, but was not limited to, "It is the policy of this facility to provide resident centered care that meets the...needs...of the residents. Fall prevention...is the process of identifying risk factors that can minimize the potential for falls and also a process to manage a resident's care if a fall occurs...."</p> <p>This Citation relates to Complaint IN00440995</p> <p>3.1-45(a)(2)</p> | | | | <p>Resident C was not harmed by the alleged deficient practice.</p> <p>Non-skid strips were immediately put in place on the left side of the bed per plan of care.</p> <p>Corrective action taken for those residents having the potential to be affected by the same deficient practice:</p> <p>All residents have the potential to be affected by the alleged deficient practice. The IDT audited all residents fall care plans and visually validated interventions were in place.</p> <p>Measures/systemic changes put into place to ensure the deficient practice does not recur:</p> <p>DON/designee educated IDT on companies fall management policy, emphasizing on assuring to verify all fall interventions are in place when any changes are made. Educated nursing staff on companies fall management policy, emphasizing to assure fall interventions are in place per care plans.</p> <p>Corrective actions to be monitored to ensure the deficient practice will not recur:</p> <p>DON/designee will audit 5 residents weekly times 4 weeks, 3 residents a week for 4 weeks and 1 weekly for 4 weeks to verify all</p> | | |

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| | | | | | fall interventions are in place as care planned. DON/Designee will report on audits monthly to the interdisciplinary team for 3 months during the QAPI Meeting. The IDT will determine if the audits are necessary to continue after 3 months with 100% compliance. | | |