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

FORM APPROVED
OMB NO. 0938-039

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	10/06/2022

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 the Investigation of Complaint IN00391563. Complaint IN00391563 - Substantiated. Federal/State deficiencies related to the allegations are cited at F656, F684, F697, and F755. Survey dates: October 5 and 6, 2022 Facility number: 000526 Provider number: 155488 AIM number: 100266970 Census Bed Type: SNF/NF: 105 Total: 105 Census Payor Type: Medicare: 4 Medicaid: 90 Other: 11 Total: 105 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on October 13, 2022.	F 0000	This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. Rolling Hills would like to request a desk review in lieu of a follow up revisit.	
F 0656 SS=D Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §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			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Joe Cox	Executive Director	10/28/2022

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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	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 the requirements set forth in paragraph (c) of this section.			
	Based on interview and record review, the facility failed to ensure a comprehensive plan of care was implemented for a resident (Resident C) with diabetes for 1 of 3 residents reviewed for care	F 0656	**Corrective action for the residents found to have been affected by the deficient practice:**	10/27/2022

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	plans. Findings include: The clinical record for Resident C was reviewed on 10/5/22 at 4:14 p.m. Diagnosis included, but was not limited to, diabetes. Review of the resident's care plan lacked documentation of a plan of care related to his diagnosis of diabetes. During an interview on 10/6/22 at 12:42 p.m., the interim Director of Nursing indicated the resident should have had a diabetic care plan in place. On 10/6/22 at 2:52 p.m., the interim Director of Nursing provided a current copy of the document titled "Plan of Care Overview" with a revision date of 7/26/18. It included, but was not limited to, "PoC...Care Plan is the written treatment provided for a resident that is resident-focused and provides 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 IN00391563 3.1-35(a) 3.1-35(c)(1)		Resident C could not be identified as resident was part of a confidential complaint survey. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents with diagnosis of diabetes have the potential to be affected by this alleged deficient practice. An audit has been conducted on all residents with diagnosis of diabetes to ensure comprehensive care plan is in place. Any resident found without diabetic care plan had their care plan immediately corrected to reflect an accurate plan of care. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** The Regional Resident Care Coordinator has educated the Resident Assessment Coordinator on the facility's policy identified as, "Plan of Care Overview" with emphasis on developing resident centered care plans to reflect resident's current diagnoses. The DON/Designee have educated nursing staff on the facility's policy "Plan of Care Overview" with emphasis on developing resident centered care plans to reflect resident's current diagnoses. **Corrective actions to be**	

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			monitored to ensure the deficient practice will not recur: The DON and/or Designee will audit 3 resident's daily x's 4 weeks, then 2 resident's weekly x's 4 weeks, then 1 resident's monthly x's 4 months with current or new diagnosis of diabetes to ensure comprehensive care plan is in place. The DON and/or Designee will present the results of these audits monthly to the QAPI committee for no less than 6 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.	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.			
	Based on interview and record review, the facility failed to ensure a resident's (Resident B) blood sugar was monitored and insulin administered as ordered; to ensure a physician's order was in place prior to removing a PICC (peripherally	F 0684	**Corrective action for the residents found to have been affected by the deficient practice:** Resident B and C could not be	10/27/2022

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	inserted central catheter) line (Resident B); and to ensure a resident's (Resident D) pulse was checked prior to the administration of a high risk medication for 2 of 3 residents reviewed for quality of care. Findings include: 1.a. The clinical record for Resident B was reviewed on 10/5/22 at 2:17 p.m. Diagnoses included, but were not limited to, osteomylitis and diabetes. Review of the meal service schedule indicated Resident B would have received breakfast at 7:30 a.m. and dinner at 5:30 p.m. The hospital discharge orders, dated 9/30/22 at 12:53 p.m. indicated the following orders: -Insulin Lispro (short acting insulin) per sliding scale 3 times a day before meals subcutaneously -Insulin Lispro, administer 5 units subcutaneously with breakfast -Insulin Galrgine (long acting insulin), administer 20 units subcutaneously every morning -Insulin Galrgine, administer 10 units subcutaneously at bedtime Review of the September 2022 medication administration record lacked documentation of the resident's blood sugar check or any insulin administered prior to dinner or at bedtime on 9/30/22. The October 2022 meal consumption record lacked documentation of a breakfast meal consumed on 10/1/22. Review of the October 2022 medication		identified as they were part of a confidential complaint survey. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents who require monitoring of blood sugars, who have orders for insulin administration, PICC lines in place, and who have high risk medications ordered that require a pulse to be assessed have the potential to be affected by alleged deficient practice. An audit was conducted for the last 14 days for residents that receive blood sugar monitoring to ensure all physician ordered blood sugar monitoring was completed and documented. Any resident identified as not having this completed was assessed and had their physician and family notified and any new orders were transcribed and completed per orders. An audit was conducted for the last 14 days for residents that receive insulin to ensure all physician ordered insulin was administered and documented. Any resident identified as not having insulin administered per MD orders was assessed and had their physician and family notified and any new orders were transcribed and completed per orders.	

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	administration lacked documentation of the resident's blood sugar checked or any insulin administered on the morning of 10/1/22. b. The progress noted, dated 10/1/22 at 9:25 a.m., indicated the resident was leaving AMA (against medical advice) and that the resident's PICC line would have to be removed. The PICC line was removed and pressure dressing applied. The nurse practitioner was notified of the situation. The clinical record lacked documentation of a physician's order to remove the PICC line. During an interview on 10/6/22 at 12:42 p.m., the interim Director of Nursing indicated if the staff checked the resident's blood sugar, it was not documented and should have been documented. During an interview on 10/6/22 at 1:02 p.m., RN (Registered Nurse) 4 indicated she had obtained a verbal order from the nurse practitioner and that the orders were discontinued prior to her putting the order in. On 10/6/22 at 3:52 p.m., RN 4 indicated when blood sugars were obtained and insulin administered, it should be documented on the medication administration record. Review of the resident's orders indicated they were discontinued on 10/1/22 at 2:12 p.m. 2. The clinical record for Resident D was reviewed on 10/6/22 at 11:35 a.m. Diagnosis included, but was not limited to, paroxysmal atrial fibrillation. The care plan, dated 3/1/22, indicated the resident had atrial fibrillation. Medications were to be administered as ordered, check the resident's pulse prior to administration and hold if the resident's pulse was below 60.		An audit was conducted for the last 14 days for residents that receive high-risk medications that require a pulse to be assessed to ensure a physician order was in place to assess the pulse, supplemental documentation was in place to ensure accurate documentation of the pulse, and that a pulse was obtained. Any resident identified as not having this completed was assessed and had their physician and family notified and any new orders were transcribed and completed per orders. An audit was conducted for the last 14 days for residents that have had a PICC line discontinued to ensure all a physician order was in place prior to discontinuation. Any resident identified as not having this in place had their physician and family notified. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** DON/Designee have educated nursing staff on facilities policy “Medication Administration” with emphasis on monitoring of blood sugar, administration of insulin, obtaining orders for removal of PICC lines, and supplementary documentation for a pulse for high	

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	The physician order, dated 4/1/22, indicated the resident was to receive Digoxin 125 mcg (micrograms) in the morning for heart health. Review of the medication administration record indicated between 9/1/22 and 10/3/22, the resident's pulse was not obtained prior to the administration of the Digoxin. During an interview on 10/6/22 at 12:42 p.m., the interim Director of Nursing indicated the pulse should be obtained prior to the administration of Digoxin. On 10/6/22 at 2:52 p.m., the interim Director of Nursing provided a current copy of the document titled "Medication Administration" dated 8/3/2010. It included, but was not limited to, "Definitions...MAR: Medication Administration Record - the legal documentation for medication administration...Policy...It is the policy of this facility to provide resident centered care that meets the...physical...needs...of the residents...Medications will be charted when given...Medications will be administered within the time frame...For medications to be taken around meals...Before meals...Provide medications thirty (30) minutes before meal time...Record pertinent information prior to giving medication...Apical pulse recorded...." On 10/6/22 at 2:52 p.m., the interim Director of Nursing provided a current copy of the document titled "Physician Orders" dated 8/3/2010. It included, but was not limited to, "Definitions...MAR...Medication Administration Record...the legal medical record...Policy...It is the policy of this facility to provide resident centered care...A provider may give a medical order over		risk medications. **Corrective actions to be monitored to ensure the deficient practice will not recur:** The DON and/or Designee will audit 5 resident's daily x's 4 weeks, then 5 resident's weekly x's 4 weeks, then 5 resident's monthly x's 4 months to ensure compliance. The DON/Designee will audit 5 resident's blood sugar monitoring daily x's 4 weeks, then 5 resident's weekly x's 4 weeks, then 5 resident's monthly x's 4 months to ensure compliance. The DON/Designee will audit 5 resident's receiving insulin daily x's 4 weeks, then 5 resident's weekly x's 4 weeks, then 5 resident's monthly x's 4 months to ensure compliance. The DON/Designee will audit 5 resident's pulse assessment and documentation prior to administration of a high risk medication daily x's 4 weeks, then 5 resident's weekly x's 4 weeks, then 5 resident's monthly x's 4 months to ensure compliance. The DON/Designee will audit 5 resident's PICC line orders prior to discontinuation to ensure the order for discontinuation is in place x's 4 weeks, then 5 resident's weekly x's 4 weeks, then 5 resident's monthly x's 4 months to ensure compliance.	

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	the telephone...The nurse will transcribe the order into PCC...Verbal orders are accepted but will be input into PCC...." This Federal tag relates to Complaint IN00391563 3.1-37(a)		The DON and/or Designee will present the results of these audits monthly to the QAPI committee for no less than 6 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.	
F 0697 SS=D Bldg. 00	483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on interview and record review, the facility failed to ensure pain medication was administered to a resident (Resident B) with a pain score of 6 (moderate to severe pain) for 1 of 3 residents reviewed for pain management. Findings include: The clinical record for Resident B was reviewed on 10/5/22 at 2:17 p.m. Diagnoses included, but was not limited to, osteomylitis (bone infection) and status post amputation of the 4th and 5th toes. Review of the vital signs sheet for October 2022 indicated on 10/1/22 at 12:59 a.m., the resident had a pain score of 6 (moderate to severe pain level).	F 0697	**Corrective action for the residents found to have been affected by the deficient practice:** Resident B could not be identified as they were part of a confidential complaint survey. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents who have the potential to experience pain can be affected by the same alleged deficient practice. An audit was completed on all residents in house who have potential to	10/27/2022

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	The admission orders, dated 9/30/22, indicated the following orders for the resident: -Acetaminophen (Tylenol) 325 mg (milligrams), 2 tablets every 4 hours as needed for mild pain -Hydrocodone-Acetaminophen 5/325 mg, give 1.5 tablets orally every 4 hours as needed for moderate pain. Review of the October 2022 medication administration record lacked documentation of any pain medication administered to the resident for his pain. During an interview on 10/6/22 at 12:42 p.m., the interim Director of Nursing indicated there were no medications removed from the EDK/Cubix (emergency drug kit) on 9/30/22 or 10/1/22. She did not have an answer as to why staff did not provide the resident medication for his pain and should have given him something. The resident had an order for Tylenol which should be in the EDK. They did not have the Hydrocodone dose that was ordered, however, the staff should have called the physician to get a clarification order for something else. On 10/6/22 at 2:52 p.m., the interim Director of Nursing provided a current copy of the document titled "Pain Management and Assessment" dated 7/25/18. It included, but was not limited to, "Definitions...Neglect...neglect is the failure of the facility, its employees...to provide goods and services to a resident that are necessary to avoid...pain...Policy...It is the policy of this facility to provide resident centered care that meets the...physical...needs...of the residents...the facility must ensure residents receive the...care in accordance with professional standards...related to pain management...Procedure...Pain Scale for Assessing Pain...The Verbal-Descriptor Scale...For		experience pain, pain assessments were completed on those residents, those who were noted with complaints of pain had MD ordered pain medication administered and follow up assessment complete per licensed nurse. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** The DON/Designee has educated licensed nurses and qualified medication aides regarding facilities policy “Pain Management and Assessment” with emphasis on providing pharmacological intervention for noted pain and notifying the physician if pain was not managed by current prescribed medications or not available. The DON/Designee has educated the licensed nurses on the use of the facility’s EDK (emergency drug kit) ensuring that if medications have not arrived from pharmacy that the license nurse utilize the EDK for medications that are available in the EDK but have not arrived from pharmacy. **Corrective actions to be monitored to ensure the deficient practice will not recur:** The DON and/or Designee will	

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	example, "severe" is a 6 on the 1-10 pain scale...." This Federal tag relates to Complaint IN00391563 3.1-37(a)		audit 3 resident's daily x's 4 weeks, then 5 resident's weekly x's 4 weeks, then 2 resident's monthly x's 4 months to ensure with any noted documentation of pain, that pain medication was administered and assessed for effectiveness or the physician was notified if pain was not controlled. The DON/Designee will audit 3 new admissions weekly x 4 weeks, 2 new admissions weekly x 4 weeks, then 3 new admissions monthly x 4 months to ensure medications that are available in the EDK were utilized when appropriate. The DON/Designee will present the results of these audits monthly to the QAPI committee for no less than 6 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.	
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.			

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	§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.			
	Based on interview and record review, the facility failed to ensure medications were received timely for a resident (Resident B) who was to receive antibiotic therapy for 1 of 3 residents reviewed for pharmaceutical services. Findings include The clinical record for Resident B was reviewed on 10/5/22 at 2:17 p.m. Diagnoses included, but was not limited to, osteomylitis (bone infection) and status post amputation of the 4th and 5th toes. The hospital discharge note, dated 9/30/22 at 12:53 p.m., indicated the resident was to discharge	F 0755	**Corrective action for the residents found to have been affected by the deficient practice:** Resident B could not be identified as they were part of a confidential complaint survey. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents who receive medications from the pharmacy have the potential to be affected by this alleged deficient practice.	10/27/2022

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	to facility for IV (intravenous) antibiotic therapy. The resident had a diabetic foot ulcer with osteomylitis and was a status post amputation of the left 4th and 5th toes and the distal metatarsals. Wound cultures were positive for Proteus vulgaris and enterococcus faecalis, both of which are bacterial infections. The Admission note, dated 9/30/22 at 3:45 p.m., indicated the resident was to receive IV medications as direct nursing care. Review of the resident's facility admission orders, dated 9/30/22, indicated he was to receive Ampicillan, 2 grams, intravenously every 6 hours at 5:00 a.m., 11:00 a.m., 5:00 p.m. and 11:00 p.m. The resident was also to receive Cefepime, 2 grams, every 12 hours for an infection at 5:00 a.m. and 5:00 p.m. Review of the September 2022 and October 2022 medication administration record indicated the resident did not receive any antibiotic doses for 18 hours prior to discharge on 10/1/22 at 9:44 a.m. The progress note, dated 10/1/22 at 9:25 a.m., indicated the resident's family was upset because he had not received any medications and was educated that it could take up to 18 hours for the facility to receive some medications. During an interview on 10/6/22 at 12:42 p.m., the interim Director of Nursing indicated she did not have an answer as to why Resident B's medications were not ordered STAT. Best practice would have been to order the medications STAT so the antibiotic would have been at the facility within 4 hours. During an interview on 10/6/22 at 3:00 p.m., LPN		An audit was conducted for the last 14 days on residents who have had new orders obtained for medications to determine if the medication arrived timely and was administered. Those residents found out of compliance immediately had their physician and family notified and new orders were obtained as needed. **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 "Provider Pharmacy Requirements" with emphasis on medications not available in the EDK need to be ordered STAT to ensure timely administration of physician ordered medications. **Corrective actions to be monitored to ensure the deficient practice will not recur:** The DON and/or Designee will audit 5 resident's daily x's 4 weeks, then 5 resident's weekly x's 4 weeks, then 5 resident's monthly x's 4 months to ensure residents with new medication orders had their medication delivered timely and administered accordingly. The DON and/or Designee will present the results of these audits	

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	10/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	(Licensed Practical Nurse) 2 indicated she was unaware that she could order medications STAT. On 10/5/22 at 3:58 p.m., the Executive Director provided a current copy of the document titled "Provider Pharmacy Requirements" dated 9/2018. It included, but was not limited to, "Policy...Regular and reliable pharmaceutical service is available to provide residents with prescription medications...Procedures...Providing routine and timely pharmacy service as contracted, as well as emergency pharmacy service 24 hours per day, seven days per week...New medication orders are available for administration on the next routine delivery, unless otherwise requested by facility staff...." This Federal tag relates to Complaint IN00391563 3.1-25(a)		monthly to the QAPI committee for no less than 6 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.	