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	02/21/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00372056. Complaint IN00372056 - Substantiated. Federal/State deficiencies related to the allegations are cited at F741, F755, and F689. Survey dates: February 14, 15, 16, 17, 18, and 21, 2022. Facility number: 000526 Provider number: 155488 AIM number: 100266970 Census Bed Type: SNF/NF: 99 Total: 99 Census Payor Type: Medicare: 12 Medicaid: 80 Other: 7 Total: 99 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 4, 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.***	
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment.			

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

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	02/21/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	(ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on observation, record review, and interview, the facility failed to ensure timely revision of the care plan to reflect new fall interventions for 1 of 27 resident's whose care plans were reviewed. (Resident 39) Findings include: During an observation, on 2/14/22 at 10:00 a.m., Resident 39 was in a high backed wheelchair with anti-tippers in his room. The head of his bed was against the wall, with both sides open to the room. There were no skid-strips observed anywhere in the resident's room or bathroom. The clinical record for Resident 39 was reviewed	F 0657	**1. Resident 39 was not harmed by the alleged deficient practice. Resident 39 had their fall care plan reviewed and updated with the appropriate interventions that reflect an accurate plan of care.** **2. Any resident that resides in the facility that had a fall has the potential to be affected by the alleged deficient practice. Any resident that had a fall in the last 30 days has had their plan of care reviewed to ensure intervention(s) have been added to the plan of care to**	03/23/2022

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	02/21/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	on 2/17/21 at 11:11 a.m. Diagnoses included, but were not limited to, dementia, non displaced fracture of right ulna styloid process, muscle weakness, unsteadiness on feet, need for assistance with personal care, difficulty walking, and aphasia following cerebral infarction. The Admission MDS (Minimum Data Set) assessment, dated 9/3/21, indicated the resident was severely cognitively impaired, required extensive assistance of 1 person with all ADL's (activities of daily living) including bed mobility, transfer, walking, locomotion, toileting and personal hygiene. The nurse's note, dated 9/1/21 at 12:27 p.m., indicated the resident could not hold his position in his chair and slid out onto the floor. The IDT (Interdisciplinary Team) follow-up note, dated 9/2/21 at 11:46 a.m., indicated the root cause of the incident was the resident being unable to maintain his trunk control. An intervention for OT (Occupational Therapy) to evaluate the resident's need for a possible high-back wheelchair was put into place. The note indicated the care plan was updated. The care plan, dated 9/3/21, indicated the resident was at risk for falls related to gait and balance problems, impaired cognition, incontinence, medications, safety awareness, difficulty in walking, and unsteadiness on his feet. The only interventions listed on the care plan were for staff to assess risk for falls on admission, readmission, quarterly, and as needed, observe medication for side effects that may increase risk for falls, and physical and occupational therapy to evaluate as needed.		**reflect accuracy.** **3. DON/Designee will complete in service training with all licensed staff on the facilities policy identified as, "Care Plan Overview" with emphasis on adding fall interventions to the plan of care to reflect accuracy.** **4. DON/Designee will conduct an audit of residents with a fall to ensure their plan of care reflects accuracy on the following schedule: 5 residents weekly for 1 month, then 3 residents weekly for 1 month, then 5 residents a month for 1 month.** **DON/Designee is responsible for the compliance. The results of these audits will be reviewed in Quality Assurance Committee monthly meeting for 6 months or until 100% compliance is achieved x 3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	

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	02/21/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	The clinical record lacked documentation of any revision to the care plan with the new interventions. The physician's note, dated 11/22/21 at 7:50 p.m., indicated the resident had an unwitnessed fall when he was trying to transfer. The IDT follow-up note, dated 11/23/21 at 12:11 p.m., indicated the root cause of the resident's fall was self transferring. The note indicated an intervention of skid strips and bed against the wall was put into place, and the care plan was updated. The clinical record lacked documentation of any revision to the care plan with the new interventions. The nurse's note, dated 1/24/22 at 5:43 p.m., indicated the therapy had informed the nurse of the resident having a black eye. The resident indicated he'd caught himself on the bar in his bathroom but did not fall. During an interview, on 2/18/22 at 5:52 p.m., the RDCO (Regional Director of Clinical Operations) indicated interventions should be implemented immediately, and they should be added to the care plan. During an interview, 2/21/22 at 1:55 p.m., the Staffing Development Coordinator indicated she was a part of the IDT team and participated in fall reviews. They tried to do the reviews the day after the fall, or the next business day. She participated in fall reviews, and care plans were normally updated immediately upon IDT review. The Fall Prevention and Management Policy,			

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	02/21/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	dated 5/25/21, provided on 2/17/22 at 3:30 p.m., by the Executive Director, included, but was not limited to, "... If the resident is identified to be at risk for falls, a care plan should be initiated that includes a plan to potentially diminish the risk for falls... The care plan should be reviewed and updated as needed with each change of condition... The IDT team should review all information for all falls at the next Daily Clinical Meeting... The care plan should be reviewed to identify if interventions are appropriate or if new interventions should be added..." 3.1-35 (a)(e)			
F 0677 SS=E Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, record review and interview, the facility failed to maintain the resident's dignity related to personal hygiene, and personal clothing for 3 of 4 residents reviewed for activities of daily living. (Residents 206, 207 and 54) Findings include: 1. During an observation, on 2/14/22 at 12:00 p.m., Resident 206 was observed laying in his bed with just a brief on. He was curled on his right side, and it looked like he was naked. The resident was observed to look disheveled and had long facial hair with stains. His hair had not been combed and was sticking up on his head. During an observation 2/16/22 at 9:18 a.m.,	F 0677	**1. Resident 206, 207, and 54 were not harmed by the alleged deficient practice. Resident 206, 207, and 54 that were reviewed for ADL care, and Personal Hygiene ensure that resident dignity and choices are maintained.** **2. All residents residing in the facility have the potential to be affected by the alleged deficient practice. An audit was conducted on all residents residing in the facility to ensure they were groomed, appropriate hygiene, and**	03/23/2022

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	02/21/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	Resident 206 was observed laying at the foot of his bed. He had a bloody abrasion on his forehead hairline. The resident had a large amount of dried blood on the right sleeve of his sweatshirt. Blood approximately the size of a quarter was on the resident's sheet. A large blood smear was observed on the resident's floor. The QMA (Qualified Medication Aide) came into the room and indicated she was going to get the resident's weight. She did not acknowledge the blood on the resident. During an observation on 2/17/22 at 3:39 p.m., Resident 50 was in resident 206's room holding a water pitcher. Resident 206 was at his roommate's dresser. He was going through the dresser and then drank form his roommates water pitcher. Resident 206's brief was laying in the floor soiled with urine. He did not have a shirt on. His bed was soiled with a red food substance. The resident's blue shirt was also soiled with a red food substance. The resident laid down in his soiled bed. PCA (Patient Care Aide) 16 was present in the room and observed Resident 206 drink from his roommate's water pitcher and she did not remove it from the resident's room. She failed to assist resident 206 with patient care. The clinical record for Resident 206 was reviewed on 2/16/22 at 9:00 a.m. The diagnosis included but was not limited to, dementia without behavioral disturbance. The Admission MDS (Minimum Data Set) assessment, dated 1/10/22 indicated the resident was severely cognitively impaired. The care plan, dated 1/10/22 and revised on 2/15/22, indicated the resident had ADL (Activities of Daily Living) self-care deficit.		**clothing. Any resident found in need of ADL care, personal hygiene, or clothing was immediately corrected to meet the standards for level of care.** **3. DON/Designee will complete in-service training with all staff on the facilities policies identified as, "Unit Supervision" and "Routine Care" with emphasis on ensuring residents ADL care and personal hygiene needs are met.** **4. DON/Designee will conduct an audit via observation of residents to ensure ADL care, Dignity and personal Hygiene needs meets resident's choice based on the following schedule: 10 residents weekly x 4 weeks, then 5 residents weekly for 4 weeks, then 5 residents monthly x 1 month.** **DON/Designee is responsible for the compliance. The results of these audits will be reviewed in Quality Assurance Committee monthly meeting for 6 months or until 100% compliance is achieved x 3**	

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	02/21/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	Interventions included, but were not limited to, required physical of one with toileting, bed mobility, eating and transfers. 2. During an observation, on 2/16/22 at 9:18 a.m., Resident 54 was lying in bed with only a brief on. The resident was visible from the hallway, and it appeared he did not have any clothes on. The resident did not have bed linens covering him. The clinical record for Resident 54 was reviewed on 2/16/22 at 9:15 a.m. The diagnosis included but was not limited to dementia with behavioral disturbance. The Quarterly MDS assessment, dated 12/10/21 indicated the resident was moderately cognitively impaired. The care plan, dated 2/6/22, indicated the resident had an ADL Self Care Performance Deficit related to dementia. Interventions included, but were not limited to, required assist with mobility to destinations when out of room. Cue for posture and walker use. The resident required hands on weight bearing per two staff participation to use toilet/incontinence care/clothing management and post toileting hygiene. 3. During an observation, on 2/17/22 at 10:51 a.m., Resident 207 had 3 small spots of blood on the floor beside her bed. There was a moderate amount of dried blood on her pillowcase. The resident had staples in the back of her head. Her hair was matted together with dried blood. The clinical record for Resident 207 was reviewed on 2/17/22 at 1:30 p.m. The diagnosis		**consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	

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	02/21/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	included, but was not limited to, laceration to left temporal parietal scalp with approximately eight staples in place. The care plan, dated 2/16/22, indicated Resident 207 had actual impaired skin integrity that included a bruise to the left shoulder and a surgical incision to the back of the head. Interventions included, but were not limited to, evaluate surgical incision characteristics, measure areas at regular intervals, monitor areas for signs of infection, monitor areas for signs of progression or declination, notify provider if no signs of improvement on current wound. During an interview, on 2/21/22 at 9:15 a.m., RSD (Resident Service Director) indicated everyone should be up and dressed every day. Their hair needed to be combed and needed to look good. The men should be shaved on shower days or as needed. The resident's clothes should be clean and free from stains. The Executive Director provided a current copy of the document titled, Resident Rights and Privileges, dated 8/21/18 and revised on 5/30/19 which included, but was not limited to, " ...Resident with dementia and/or dementia-related diagnosis will be treated with the same respect and dignity and afforded the same resident right regardless of diagnosis, severity of condition or payment source including but not limited to visual privacy for bathing\, ADL (Activities of Daily Living) care and toileting. Residents will be permitted and assisted to participate in facility activities as they are able and at a level they can actively participate in but will not be compelled to do so..."			

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	02/21/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	3.1-38(a)(2)			
F 0679 SS=E Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. Based on observation, interview, and record review, the facility failed to ensure an ongoing activity program to meet the interest of and support the physical, mental, and psychosocial well being of the residents. This deficient practice had the potential to affect 42 of 99 residents residing in the facility. (dementia unit) Findings include: 1. During an observation, on 2/14/22 at 11:30 a.m., there were some residents in the dining room, some residents walking in the hallway, and some in their own rooms. There were no structured activities being provided. During an observation, on 2/14/22 at 11:38 a.m., there were some residents in the dining room, some residents walking in hall, some in other resident rooms, and some in their own rooms. There were no structured activities being provided.	F 0679	1) Facility will continue to provide an ongoing program to support residents in their choice of activities, both facility sponsored group/individual activities and independent activities that are designed to meet the interest of and support the physical, mental and psychosocial well-being of each resident. Activities will be individualized, meaningful and incorporate resident's interests, hobbies and cultural preferences. There was no negative effect on the 42 residents this observation had the potential to effect. 2) Activity programming for all residents will be reviewed and updated by 3/23/2022. Facility will have one dedicated Activity staff member assigned to the memory impaired unit to provide	03/23/2022

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	02/21/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	During an observation, on 2/14/22 at 1:59 p.m., there were some residents in the dining room, some residents walking in hall, some in other resident rooms, and some in their own rooms. There were no structured activities being provided. During an observation, on 2/14/22 at 2:15 p.m., there were some residents in the dining room, some residents walking in hall, some in other resident rooms, and some in their own rooms. There were no structured activities being provided. During an observation, on 2/15/22 at 10:15 a.m., there were no structured activities being provided. Some of the residents were in the dining room where the TV was on, some residents were walking in the hall, some residents in other resident rooms, and some residents in their own rooms. During an observation, on 2/16/22 at 1:36 p.m., there were five residents in the dining area, three with drinks, two without, and the only staff in the dining room was a maintenance man working on the floor. There were structured activities being provided. During an observation, on 2/16/22 at 3:05 p.m., there were no structured activities being provided. Some of the residents were in the hall, some were in other resident rooms, and the majority of the residents were in their own rooms. During an observation, on 2/17/22 at 10:07 a.m., there were five residents in dining room, there were no drinks there were no structured activities being provided		meaningful activities to the residents residing on the unit. 3) The ED or designee will complete education with the Program Manager by 3/23/2022 on the expectation of Activity programming for the residents that reside at the facility. 4) The ED or designee will audit Activity programming on 4 residents 3 days per week for 4 weeks, 5 residents monthly for 2 months. The results of these audits will be reviewed in the monthly QAPI meeting and the QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

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	02/21/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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

During an observation, on 2/17/22 at 2:35 p.m., there were no structured activities being provided. Most of the residents were in bed.

During an observation, on 2/17/22 at 3:45 p.m., there were no structured activities being provided. Most of the residents were in bed.

During an observation, on 2/18/22 at 11:30 a.m., there were no structured activities being provided. Some of the residents were walking in the hall, and most of the residents were in their rooms.

During an observation, on 2/18/22 at 3:20 p.m., there were no structured activities being provided. There were three residents observed in the dining room with the TV on. Some of the residents were walking in the hall, and most of the residents were in their rooms.

During an observation, on 2/18/22 at 4:37 p.m., there were no structured activities being provided.

A February 2022 Activity Calendar was provided on 2/15/22 at 9:38 a.m., and indicated activities were to be conducted as follows:

- On 2/14/22 at 10:00 a.m. Snack; 10:30 a.m. Music Motion; 11:30 a.m. Soothing Sounds; 1:30 p.m. Coffee and Chronicle; 2:30 p.m. Valentine Party; 4:30 p.m. Soothing Sounds; 5:30 p.m. watching television.

- On 2/15/22 at 10:00 a.m. Snack; 10:30 a.m. Music Motion; 11:30 a.m. Soothing Sounds; 1:30 p.m. Coffee and Chronicle; 2:30 Snowball Transfer; 3:30 What's in the bag; 4:30 Soothing

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	02/21/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	Sounds; 5:30 p.m. watching television. - On 2/16/22 at 10:00 Snack; 10:30 Music Motion; 11:30 Soothing Sounds; 1:30 Coffee and Chronicle; 2:30 p.m. Snowball painting; 3:30 p.m. Sensory Bin; 4:30 p.m. Soothing Sounds; 5:30 p.m. watching television. - On 2/17/22 at 10:00 a.m. Snack; 10:30 a.m. Music Motion; 11:30 a.m. Soothing Sounds; 1:30 p.m. Coffee and Chronicle; 2:30 p.m. Social Hour; 3:30 p.m. Sensory Bin; 4:30 p.m. Soothing Sounds; 5:30 p.m. watching television. - On 2/18/22 10:00 a.m. Snack; 10:30 a.m. Music Motion; 11:30 a.m. Soothing Sounds; 1:30 p.m. Coffee and Chronicle; 2:30 p.m. Puff Paint Snoflakes; 3:30 p.m.Guess the sent; 4:30 p.m. Soothing Sounds; 5:30 p.m. watching television. During an interview on 2/15/22 at 9:34 a.m., the RSD (Resident Services Director) indicated she was over the dementia unit. She indicated activities were hand written on the board because they changed daily. She indicated she also had to type written activities on another board. She indicated the facility activity director would visit the unit for two hours every day and do snack and exercise. 2. During an observation, on 2/15/22 at 9:36 a.m., Resident 51 was observed wandering the halls. There were no structured activities being provided. There were no staff in sight. During observations from 2/14/22 to 2/18/22 no activities were observed with the residents. The activity calendar listed the same activities every day. Residents observed in the dining room were sitting in their wheelchairs with no staff present			

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	02/21/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	and the television was on. The residents were not engaged in watching television. No equipment or supplies were available for activities. A resident was observed with his head and shoulder leaning over the side of a leaned back recliner and another resident was trying to help sit him up. There were no staff in sight. During an observation 2/18/22 at 2:50 p.m., the activity calendar indicated the residents were supposed to be having an activity called paint the snowflake. There were no activities going on and several of the residents were in bed. During an interview, on 2/18/22 at 4:21p.m., CNA (Certified Nursing Aide) 9 indicated she tried to provide activities for the residents. Some of the residents were severely impaired and she had a difficult time coming up with activities. She wished there were more activities for the residents to do. During an interview on 2/21/22 at 9:15 a.m., the Resident Services Director indicated sometimes she would be unable to activities due no help. The Executive Director provided a current copy of the document titled, Resident Rights and Privileges, dated 8/21/18 and revised on 5/30/19 which included, but was not limited to, " ...Resident with dementia and/or dementia-related diagnosis will be treated with the same respect and dignity and afforded the same resident right regardless of diagnosis, severity of condition...Residents will be permitted and assisted to participate in facility activities as they are able and at a level they can actively participate in..." 3.1-33(a)			

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	02/21/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 0689 SS=G Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure appropriate interventions were identified and implemented to prevent accidents for 3 of 10 residents (Residents C, D, and E) reviewed for accidents, which resulted in Resident C and Resident E sustaining fractures to their wrists. Findings include: 1. During an observation, on 2/14/22 at 10:00 a.m., Resident C was observed in a high-backed wheelchair with anti-tippers in his room. The resident would attempt to converse with nonsensical speech and was only oriented to person. The head of his bed was against the wall, with both sides open to the room. There were no skid-strips observed anywhere in the resident's room or bathroom. The clinical record for Resident C was reviewed on 2/17/21 at 11:11 a.m. Diagnoses included, but were not limited to, cerebral infarction, chronic obstructive pulmonary disease, dementia, non-displaced fracture of right ulna styloid process, muscle weakness, unsteadiness on feet, need for assistance with personal care, difficulty walking, and aphasia following cerebral	F 0689	**1. Residents C, D, and E had their plan of care reviewed, updated, and interventions implemented, if appropriate, to assist with prevention of falls. MD and families were updated on any new interventions that were implemented.** **2. Any resident that resides in the facility that had a fall has the potential to be affected by the alleged deficient practice. Any resident that had a fall in the last 30 days has had their plan of care reviewed to ensure intervention(s) have been added to the plan of care to reflect accuracy and that the appropriate intervention had been implemented per the plan of care. Any resident identified to not be in compliance was immediately corrected.**	03/23/2022

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	02/21/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	infarction. The Admission MDS (Minimum Data Set) assessment, dated 9/3/21, indicated the resident was severely cognitively impaired, could not recall, required extensive assistance of 1 person with all ADL's (activities of daily living) including bed mobility, transfer, walking, locomotion, toileting and personal hygiene. His balance during transitions from seated to standing position, walking, turning when walking, and moving on or off the toilet was not steady and only able to stabilize with human assistance. He used a wheelchair. He was frequently incontinent of both bowel and bladder. He had a fall in the last month prior to admission and had one fall since admission. The nurse's note, dated 9/1/21 at 12:27 p.m., indicated the resident was returned to his room by therapy and left sitting next to his bed in his wheelchair. A CNA (Certified Nurse Aide) went into the room and the resident was unable to hold his position in his chair and slid out onto floor. The CNA indicated the resident did not hit his head. There was no injury. The IDT (Interdisciplinary Team) follow-up note, dated 9/2/21 at 11:46 a.m., indicated the root cause of the incident was the resident being unable to maintain his trunk control. An intervention for OT (occupational therapy) to evaluate the resident's need for a possible high-back wheelchair was put into place. The note indicated the care plan was updated. The care plan, dated 9/3/21, indicated the resident was at risk for falls related to gait and balance problems, impaired cognition, incontinence, medications, safety awareness,		**3. DON/Designee will complete in service training with all staff on the facilities policy identified as, "Fall Prevention and Management" and "Care Plan Overview" with emphasis on updating the plan of care accordingly and implementation of appropriate interventions per the plan of care.** **4. DON/Designee will conduct an audit of residents with a fall to ensure their plan of care reflects accuracy on the following schedule: 5 residents weekly for 1 month, then 3 residents weekly for 1 month, then 5 residents a month for 1 month. Additionally, the DON/Designee will conduct an audit via observation to ensure interventions identified on the plan of care have been implemented based on the following schedule: 5 residents weekly for 1 month, then 3 residents weekly for 1 month, then 5 residents a month for 1 month.** **DON/Designee is responsible for the compliance. The results of these audits will be reviewed in Quality Assurance Committee monthly meeting for**	

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	02/21/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	difficulty in walking, and unsteadiness on his feet. The only interventions listed on the care plan were for staff to assess risk for falls on admission, readmission, quarterly, and as needed, observe medication for side effects that may increase risk for falls, and physical and occupational therapy to evaluate as needed. The physician's note, dated 11/22/21 at 7:50 p.m., indicated the resident had been found at 7:30 p.m., sitting on the floor after an unwitnessed fall. The resident indicated he was trying to transfer himself. His right elbow was swollen and painful, which he rated a 7 out of 10 on a numerical pain scale. His right elbow had a large contusion, at least 10 cm (centimeters) in diameter. The resident was sent to the hospital to rule out a right upper extremity fracture. The nurse's note, dated 11/22/21 at 11:00 p.m., indicated the nurse heard a noise and went down the hallway. The resident was observed sitting upright on the floor beside his bed leaning against the night table. He was alert, talkative, and stated, "I hurt my arm." His right arm was swollen. He was able to move all extremities well, but it was painful to move his right arm. The resident was sent to the hospital. The hospital report, dated 11/22/21, indicated the resident presented with a hematoma and pain to his right forearm and wrist. He had a nondisplaced fracture to the distal tip of the ulnar styloid. The physician's note, dated 11/22/21 at 11:50 p.m., indicated the resident returned from the hospital with a diagnosis of fracture to the right wrist and was wearing a splint.		**6 months or until 100% compliance is achieved x 3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	

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	02/21/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	The IDT follow-up note, dated 11/23/21 at 12:11 p.m., indicated the root cause of the resident's fall was self-transferring. The note indicated an intervention of skid strips and bed against the wall was put into place, and the care plan was updated. The nurse's note, dated 1/24/22 at 5:43 p.m., indicated the nurse was notified by therapy of the resident having a black eye. Upon investigation the resident did have a black eye to the right side. The area was observed to be black and dark blue in color, circling the entire right eye. The resident did not have any complaints of pain or trouble with vision at the time. The resident also showed the nurse a small, raised area to the right forearm. He stated he was going to the bathroom on his own and caught himself against the bar in the bathroom but did not fall. The IDT follow-up note, dated 1/25/22 at 10:07 a.m., indicated the resident was taking himself to the bathroom and lost his balance, catching himself on the railing. The root cause of the incident was the resident not asking for help with bathroom assistance. The note indicated the intervention put into place was to encourage the resident to ask for help with toileting and to use the call light in the bathroom, and the care plan was updated. During an interview, on 2/18/22 at 5:52 p.m., the RDCO (Regional Director of Clinical Operations) indicated if a resident was not able to comprehend direction education, then education would not be an appropriate intervention. If an intervention specified for the bed to be against wall, the resident's non-dominant side would be placed against the wall, not the head of the bed. Interventions			

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	02/21/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	should be implemented immediately, and they should be added to the care plan. 2. The clinical record for Resident E was reviewed on 2/18/21 at 10:00 a.m. Diagnoses included, but were not limited to, acute respiratory failure, chronic obstructive pulmonary disease, and congestive heart failure. The baseline 48 hour care plan, indicated the resident required supervision with bed mobility and transfers, extensive assistance of one person with toileting and personal hygiene. The admission note, dated 1/5/22 at 8:00 p.m., indicated the resident was admitted with a chief complaint of weakness, she walked occasionally during the day, but for very short distances with or without assistance and spent the majority of each shift in the bed or chair. The nurse's note, dated 1/5/22 at 8:00 p.m., indicated the resident required supervision to the bathroom and with ADL's. She was continent of bowel and bladder. The skin/wound note, dated 1/6/22 at 3:07 p.m., indicated the resident reported a history of weakness and gait instability, and she had impaired mobility. The post-fall evaluation, dated 1/8/22 at 3:00 a.m. indicated the resident required minimum assist with a gait belt, had a balance problem while walking, and had fallen attempting to go to the restroom. She slid from her bed to the floor due to instability with self transfers, she was wearing non-skid socks at the time of the fall. The resident was placed in bed with assistance of 2 staff members, and offered a bed pan due to			

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	02/21/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	instability. The nurse's note, dated 1/8/22 at 3:10 a.m., indicated the resident was observed to be sliding out of bed when attempting to transfer to the bathroom. The writer watched the resident slide to the floor from the bed, no injuries were observed. The resident stated she was trying to go to the bathroom. While staff assisted the resident back to bed, her knees began to buckle under her when placed in a standing position. The bedpan was offered due to the resident's instability on her feet. The IDT follow-up note, dated 1/10/22 at 11:14 a.m., indicated the root cause of the fall was a slick surface. The new intervention was to add skid strips to the left side of the bed, and the care plan was updated. The nurse's note, dated 1/12/22 at 1:34 a.m., indicated the resident was very needy and turned on her call light frequently for numerous wants and needs, " ... like can you hand me a glass of water when bedside table is right there within reach, can you move my leg in bed, but resident gets up to go to the bathroom and can move extremities just fine..." The resident was continent of bowel and bladder, alert and oriented. The post-fall evaluation, dated 1/12/22 at 3:00 a.m., indicated the resident had an unwitnessed fall with a head injury and a nosebleed. The resident had impaired walking with difficulty rising from the chair. Her ability to transfer was identified as a sit to stand lift for transfers and she was non-ambulatory. She was unable to stand alone. She fell attempting to get to the bathroom, in her wheelchair. The suspected root cause			

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	02/21/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	indicated, "n/a" (not applicable). The nurse's note, dated 1/12/22 at 4:22 a.m., indicated the resident's roommate came out into the hallway and reported the resident had fallen. The resident was found sitting in the floor with a laceration to the bridge of her nose. She indicated she was getting up to go the bathroom. The resident's family requested staff to put a brief on her so she wouldn't get up in the middle of the night to use the restroom and the resident agreed. The nurse's note, dated 1/12/22 at 10:45 a.m., indicated the resident's family was requesting the resident to be sent to the hospital because they believed she had a urinary tract infection and wanted her sent out. Staff explained labs could be obtained in the facility, but her family insisted the resident be sent out. The resident was sent to the hospital. The nurse's note, dated 1/12/22 at 6:14 p.m., indicated the resident was admitted to the hospital with a left radial fracture and hypoglycemia. The resident did not return to the facility. During an interview, on 2/18/22 at 5:52 p.m., the RDCO indicated skid-strips would not have been an appropriate intervention if the resident's knees were buckling, and it would not have been appropriate to document afterwards that the resident could move her extremities just fine. The root cause should have been identified and addressed, with her complaints of not being able to move her legs, there should have been an assessment, notification to the nurse practitioner for further guidance, and interventions to assist the resident with her needs.			

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	02/21/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	3. The clinical record for Resident D was reviewed on 2/16/22 at 2:42 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, cognitive communication deficit, muscle weakness, difficulty walking, abnormalities of gait and mobility, lack of coordination, dementia, spondylosis, and spinal stenosis. The Quarterly MDS assessment, dated 12/28/21, indicated the resident was moderately cognitively impaired, required extensive assistance with bed mobility, transfers, toileting and personal hygiene, and had one fall with injury since her last quarterly assessment. The care plan, dated 10/6/20, indicated the resident was at risk for falls related to diminished safety awareness with schizophrenia and dementia, use of walker with mobility, and daily use of psychotropic medications which added to fall risk. Interventions included, but were not limited to, one-quarter side rails to bed for mobility, anticipate and meet the resident's needs, call light within reach, encourage gripper socks at all times, encourage resident to lie in the middle of the bed, encourage resident to wear new full cam boot with gripper at all times, encourage resident to use assistive devices when ambulating, follow facility fall protocol, keep adjustable bed in low position for safe transfers, and lock bed brakes. The nurse's note, dated 11/11/21 at 8:30 a.m., indicated the resident was found next to her bed by a housekeeper. She indicated she slipped on a blanket which was wrapped around her feet. Staff educated the resident on importance of ensuring area around feet and walker were clear.			

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	02/21/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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

The nurse's note, dated 11/11/21 at 12:00 p.m., indicated the resident was showing signs of increased confusion and lethargy. The Nurse Practitioner was in the building and ordered stat labs including a CBC (complete blood count), BMP (basic metabolic panel), and a U/A (urinalysis), as well as a onetime dose of Lopressor 25 mg, Tylenol 650 mg q 6 hours for fever, and covid-19 testing.

The SBAR (situation background assessment recommendation) note, dated 11/11/21 at 12:45 p.m., indicated the resident had an altered mental status and abnormal vital signs. Orders were given to send the resident to the hospital.

The nurse's note, dated 11/11/21 at 3:12 p.m., indicated the resident was transported to the hospital.

The nurse's note, dated 11/11/21 at 11:46 p.m., indicated the resident returned to the facility alert and oriented.

The IDT follow-up note, dated 11/12/21 at 12:14 p.m., indicated the root cause of the resident's fall was an unsteady gait. New interventions included a medical workup and occupational therapy to evaluate.

The nurse's note, dated 11/19/21 at 2:09 p.m., indicated the resident had a witnessed fall. She was attempting to get up from her chair and grab her walker, lost her balance, and fell forward rolling onto her side. She had no injury and did not hit her head. She indicated she didn't know why she kept falling.

The IDT follow-up note, dated 11/19/21 at 2:23

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	02/21/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	p.m., indicated the root cause of the fall was the resident holding her pants up with one hand. A new intervention to have family bring in new pants for the resident was put into place. The physician's note, dated 12/4/21 at 10:03 a.m., indicated the resident was assessed for falling twice that morning. She seemed to be more confused but had tried to get up twice and slid to the floor. She was fairly oriented and following commands. Orders were given to obtain a urinalysis. The nurse's note, dated 12/4/21 at 10:10 a.m. indicated the resident had fallen twice that morning within 5 minutes. She could not walk on her own, was incontinent, had increased confusion. New orders were given to hold her pain medication, obtain U/A, and obtain vitals every 4 hours. The IDT follow-up note, dated 12/6/21 at 11:18 a.m. indicated the root cause was identified as confusion, new interventions included a medical workup and U/A. The nurse's note, dated 12/8/21 at 11:30 a.m., indicated the resident had increased lethargy and was altered. The NP (Nurse Practitioner) ordered a onetime dose of intramuscular Rocephin due to pending U/A culture. The nurse's note, dated 12/8/21 at 2:55 p.m., indicated the resident was found on the floor next to her bed. She continued with lethargy and was unable to form words. The NP ordered to send the resident to the hospital. The nurse's note, dated 12/8/21 at 11:33 p.m., indicated the resident returned to the facility.			

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	02/21/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	She was pleasant, but still very confused. The nurse's note, dated 12/9/21 at 11:35 a.m., indicated the resident was still increasingly confused and disoriented. The resident's family requested she be seen in the hospital again, due to decline. She was requiring 4 lpm (liters per minute) of oxygen, was incontinent of bowel and bladder, and unable to walk with walker. The NP ordered to send the resident to the hospital. The admission note, dated 12/10/21 at 5:00 p.m., indicated the resident returned to facility with an admitting chief complaint of sepsis due to UTI. The IDT follow-up, indicated on 12/9/21 a review of the resident's fall was conducted. The root cause was identified as increased confusion and weakness. The intervention was the resident sent to the hospital for evaluation related to increased confusion and weakness. The nurse's note, dated 12/25/21 at 1:50 a.m., indicated a QMA (Qualified Medication Aide) found the resident on the floor. She fell trying to get up to the restroom and hit her head. There was a baseball size hematoma to back of her head, and she was sent to the hospital for evaluation. The nurse's note, dated 12/25/21 at 10:10 a.m., indicated the resident's radiology results were negative and she was being sent back to the facility. The IDT follow-up note, dated 12/28/21 at 12:04 p.m., indicated the root cause of the resident's fall was slick flooring. A new intervention of skid strips to the bed was put into place.			

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	02/21/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	The nurse's note, dated 1/6/22 at 6:18 p.m., indicated a CNA was alerted by the resident's roommate, the resident was on the floor. The resident slid out of bed trying to get something. Her bed was at a high level, and she had regular socks on. The nurse's note, dated 1/6/22 at 8:30 p.m., indicated the resident had another fall at 8:00 p.m. She was unable to follow directions or answer questions about the situation, or correctly answer when asked about the date and time. The physician was notified and ordered to send to the hospital. The nurse's note, dated 1/7/22 at 6:40 a.m., indicated the resident was admitted for a urinary tract infection and altered mental status. The nurse's note, dated 1/8/22 at 3:04 p.m., indicated the resident was readmitted to the facility alert and oriented times two. The nurse's note, dated 1/8/22 at 7:15 p.m., indicated the nurse heard a loud noise from the resident's room followed by a yell for help. The resident was found lying across the floor in the direction of the bathroom with her right arm under her body and legs extended out. She stated she was going to the bathroom and forgot to ask for help. The nurse and QMA mechanically lifted the resident back to bed, as she was unable to assist with getting up. The IDT follow-up note, dated 1/10/22 at 2:29 p.m., indicated the root cause of the resident fall, was the bed at a height where her feet were not on the floor, and she couldn't balance herself. The new intervention indicated the resident was educated on proper bed height.			

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	02/21/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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

The IDT follow-up note, dated 1/10/22 at 2:32 p.m., indicated the root cause of the resident fall, was the resident was being treated for a UTI, forgetting to ask for help, and not using her wheelchair to get to the bathroom. The new intervention indicated the resident was placed back in bed and educated on asking for assistance with toileting.

During an interview, on 2/18/22 at 5:52 p.m., the RDCO indicated if a resident was not able to comprehend direction, education would not be appropriate. If a resident was confused and falling when trying to get to the restroom, she would consider interventions such as toileting plans.

During an interview, on 2/21/22 at 1:55 p.m., the SDC (Staffing Development Coordinator) indicated she was a part of the IDT team, and she did participate in fall reviews. The IDT team tried to do the review by the day after the fall, for instance if the fall was on a Saturday, they would review it on Monday. Interventions were supposed to be put into place immediately. Skid strips should be put into place by maintenance the same day. For an intervention of bed against the wall, they would place the long part, or side of the bed against the resident's wall as soon as possible. If a resident was confused educational approaches would not be appropriate, they would consider interventions such two hour toileting, therapy consult for a reaching device, it really just depended on what they were doing when they fell. They could do a medical workup to see where the confusion is coming from. If the fall was due to weakness, they would look at therapy case load, put an assist with them with transferring, if they're buckling they would

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	02/21/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	recommend skid strips, but if staff were having to assist the resident and their legs were still buckling it would probably not be appropriate to do that as an intervention. During an interview, on 2/21/22 at 2:55 p.m., Unit Manager 10 indicated prior to November, Resident 73 had been alert and oriented on a regular basis, but between November and January she'd had a change from her baseline and was very hit and miss. They sent her out, but she never bounced back. She was talking out of her head, mumbling, and had slurred speech. She would bounce back momentarily and then decline again; it wouldn't take but a week for her to decline. She did not feel when the resident was confused, she would have been able to be educated. She was requiring more assistance, normally she would get to the chair by herself, but towards the end she was an assist of 1, sometimes even an assist of 2, it depended on her mental state that day. The Fall Prevention and Management Policy, dated 5/25/21, provided on 2/17/22 at 3:30 p.m., by the RDCO, included, but was not limited to, "... Post Fall Intervention: Attempt to put an intervention in place that could prevent further falls such as: if the resident was going to the bathroom, assist them to toilet... Attempt to identify why the resident fell and put an immediate intervention in place... The IDT team should review all information for all falls at the next Daily Clinical Meeting... A deep root cause investigation should be discussed. The care plan should be reviewed to identify if interventions are appropriate or if the new interventions should be added..." This Federal tag relates to Complaint			

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	02/21/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	IN00372056. 3.1-45(a)(1) 3.1-45(a)(2)			
F 0732 SS=E Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.			

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	02/21/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation and interview, the facility failed to post the daily staff schedule for visitor and resident notification for 5 of 6 days reviewed for nurse posting. (2/14,/2/15, 2/16, 2/17 and 2/18) Findings include: Observations of the Staff Posting on 2/14/22, 2/15/22, 2/16/22, 2/17/22, and 2/18/22 lacked documentation of the scheduled staff on the staffing board at the entrance into the Main Dining Room hall. During an interview, on 2/18/22 at 2:58 p.m., the Executive Director indicated the posting should be on the staffing board. The Scheduler was supposed to be posting it, but had only been doing it for a few weeks. She may not have known that she was supposed to be doing it. During an interview, on 2/18/22 at 3:04 p.m., the Scheduler indicated she was new to the position and was trying to get her duties together. The Executive Director was supposed to be taking care of it in the mean time. The review of the Nurse Staffing Information policy, dated on 5/29/19, and provided by the Regional Clinical Nurse on 2/18/22 at 5:15 p.m., included, but was not limited to, "...Staffing Information: the total number and the actual hours worked by nurse staffing employees that are directly responsible for resident care per shift...The facility will post the daily nurse	F 0732	1) Facility will ensure daily staffing is posted for resident and visitor notification. There was no negative outcome as a result of the missing staffing posts for 5 of the 6 days 2) The daily staffing was posted when this observation was noted and each day thereafter. 3) The ED or designee will educate the facility staff that will be responsible to ensure the staffing is posted daily by 3/23/2022. 4) The ED or designee will audit the daily staffing posting 5 days per week for 4 weeks and 3 days per week for 2 months. The results of these audits will be reviewed in the monthly QAPI meeting and the QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	03/23/2022

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	02/21/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	staffing information for public viewing and maintain the data for a minimum of 18 months or as required by State law, whichever is greater... 1. The facility will post the nurse staffing data daily at the beginning for each shift... 3. The daily nurse staffing data will be posted in a prominent place readily accessible for residents and visitors..."			
F 0741 SS=E Bldg. 00	483.40(a)(1)(2) Sufficient/Competent Staff-Behav Health Needs §483.40(a) The facility must have sufficient staff who provide direct services to residents with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with §483.70(e). These competencies and skills sets include, but are not limited to, knowledge of and appropriate training and supervision for: §483.40(a)(1) Caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/or post-traumatic stress disorder, that have been identified in the facility assessment conducted pursuant to §483.70(e), and [as linked to history of trauma and/or post-traumatic stress disorder, will be implemented beginning November 28, 2019 (Phase 3)]. §483.40(a)(2) Implementing			

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	02/21/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	non-pharmacological interventions. Based on observation, record review, and interview the facility failed to ensure adequate staffing which contributed to the lack of resident care, supervision, adequate ADL (activities of daily living) care, and the distribution of fluids for 42 of 99 residents residing in the facility. Findings include: During observations on 2/14/22 and 2/15/22, only one of the dementia unit residents had water at the bedside, or any other fluids. During observations from 2/14/22, 2/15/22, and 2/18/22, no activities were observed with the residents. The activity calendar listed the same activities everyday. Residents observed in the dining room were sitting in their wheelchairs with no staff present and the television was on. The residents were not engaged in watching television. No equipment or supplies were available for activities. A resident was observed with his head and shoulder leaning over the side of his laid back recliner and another resident was trying to get help. No staff were observed to be in the dining room with the residents during activity times. During an observation, on 2/16/22 at 9:18 a.m., Resident 206 was observed lying at the foot of his bed. He had a bloody abrasion on his forehead at the hairline. The resident had a large amount of dried blood on the right sleeve of his sweat shirt. The bloody area was approximately the size of a quarter, on the resident's sheet. A large blood smear was observed on the resident's floor. The QMA (Qualified Medication Aide) came in the room and indicated she was going to get the resident's weight. She did not acknowledge the	F 0741	**1. Residents that was identified in survey had staffing needs reviewed and updated to meet the resident's needs.** **2. All residents could be affected by this alleged deficient practice. Staffing for the facility was reviewed and updated accordingly to meet the residents physical and psychosocial needs.** **3. The facility will staff at or above the minimum staffing requirement for daily census to meet resident needs and determined by the facility assessment. The scheduler was in-serviced on the staffing requirements identified for the building. DON/Designee will complete in service training with nurse managers and scheduler on the facilities policy identified as, "Facility Assessment Policy and Procedure".** **4. The staffing schedule will be reviewed daily Monday-Friday and the weekend will be reviewed on Friday with the Administrator, DON/Designee, Human Resources manager, and staffing coordinator to validate appropriate staffing numbers and identify the distribution of staff based on resident needs.**	03/23/2022

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	02/21/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	blood on the resident or the blood smear on the floor. During an observation, on 2/17/22 at 2:49 p.m., Resident 50 was in Resident 206's room holding a water pitcher. Resident 206 was observed at his roommate's dresser. He was going through the dresser and then drank from his water pitcher. Resident 206's soiled brief was laying on the floor. He did not have a shirt on. His bed was observed to be soiled with a red substance. The resident's blue shirt was also soiled with a red substance. The PCA (Personal Care Aide) was informed that Resident 50 was in Resident 206's room. The PCA then came into the room and removed Resident 50. The PCA watched Resident 206 drink from his roommates water pitcher and she did not remove or replace it from the resident's room. During an observation on 2/18/22 at 10:11 a.m., Resident 59 was sitting on the left side of her bed with a blanket over her shoulders. She was trying to change her own brief with the entry door open. During an interview, on 2/14/22 at 10:30 a.m., with Resident 65 indicated there needed to be more staff. He was always getting his medications late or not getting them at all. During a confidential interview, between 2/14/22 and 2/21/22, Staff B indicated the unit was shorthanded for 42 residents. There was one nurse, one CNA, 1 PCA, and 1 orientee today. During a confidential interview, between 2/14/22 and 2/21/22, Staff C indicated she felt tired and burned out when they were short staffed. There was was only 1 nurse, 2 CNAs and a PCA on the		**This is an on-going facility practice.** **The Administrator will be responsible for the compliance of the audits. The results of these audits will be reviewed in Quality Assurance Committee monthly meeting for 6 months or until 100% compliance is achieved x 3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	

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	02/21/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	hall, but one CNA was going to leave at 2:00 p.m., when their schedule ended. During a confidential interview, between 2/14/22 and 2/21/22, Staff G indicated her hall was not short staffed typically. She had one CNA that day. Call-ins caused them to have only one CNA on the hall today. She normally had 3 CNAs. She was lucky to have a good CNA on her hall. During a confidential interview, between 2/14/22 and 2/21/22, Staff E indicated she was helping a staff member on the 400 Hall because she needed help. During a confidential interview, between 2/14/22 and 2/21/22, Staff B indicated there had been falls on the unit, but none that day. She did not know how to look at the care plans in the computer, but often spoke with the unit manager concerning safety of the residents due to them walked up and down the hallway and wondered in and out of other resident's rooms. She often redirected the residents by talking with them. "They were trying to include scheduled activities." During a confidential interview, between 2/14/22 and 2/21/22, Staff H indicated the Staffing Coordinator was responsible for the schedule, but she was new to the position. The facility did not use agency staff. They wanted the same staff scheduled for each hall for continuity of care and for accountability. The call-in staff had a 2 hour window to report to the scheduler. If they needed to report an absence for the following day, the night supervisor would be notified. The DON would be told and would fill the spot. It was not a hard thing to do, but challenging to find someone to fill the position. The bad effects of a staff			

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	02/21/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	shortage would be resident care and the negative impact on the team, who depended on them to be there. Two nurses and one to four CNAs would be ideal on a hall. The review of the Nurse Staffing Information policy, dated 5/29/19, and provided on 2/18/22 at 5:15 p.m., by the Regional Clinical Nurse, included, but was not limited to, "...The facility will provide the sufficient number of staff to care for the resident population. Daily nurse staffing requirements will vary based on upon resident census, acuity and safety needs..." This Federal tag relates to Complaint IN00372056.			
F 0744 SS=E Bldg. 00	483.40(b)(3) Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on observation, record review, and interview, the facility failed to ensure adequate supervision and the implementing of care planned interventions for residents with dementia related to wandering, aggressive behaviors, and falls for 4 of 6 residents (Residents 206, 51, 50, 2) reviewed for dementia care. Findings include: 1. During an observation, on 2/14/22 at 1:19 p.m., Resident 206 was observed wandering into other resident rooms. During observations, on 2/14/22, 2/15/22, and	F 0744	**1. Resident 206, 51, 50, and 2 were not harmed by the alleged deficient practice. Resident 206, 51, 50, and 2 had their plan of care reviewed and updated accordingly to reflect an accurate plan of care that meets the residents needs. Staffing needs were reviewed and updated accordingly to meet the needs of the residents.** **2. All residents with dementia have the potential to be affected by the alleged**	03/23/2022

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	02/21/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	2/18/22, of the dementia unit 41 of 42 residents did not have water or any other beverages available at the bedside. During an interview, on 2/14/22 at 12:00 p.m., Resident 206's family member indicated when he came to visit the resident, the resident would ask him for water. During an observation 2/15/22 at 11:38 a.m., the resident was observed in room 118 in another resident bed. CNA 17 said she did not know where he was but, that's what he does. He goes in and out of rooms. During an observation, on 2/16/22 at 09:18 a.m., Resident 206 was observed laying at the foot of his bed. He had a bloody abrasion on his forehead at the hairline. The resident had a large amount of dried blood on the right sleeve of his sweat shirt. Blood the size of a quarter was on the resident's sheet. A large blood smear was observed on the residents floor. The QMA (Qualified Medication Aide) 15 came in the room and indicated she was going to get the resident's weight. She did not acknowledge the blood on the resident or the blood smear on the floor. During an observation, on 2/17/22 at 3:39 p.m., Resident 50 was in resident 206's room holding a water pitcher. Resident 206 was observed at his roommates dresser. He was going through the dresser, and then drank from the roommates water pitcher. Resident 206 soiled depends was laying in the floor. He did not have a shirt on. His bed and blue shirt was observed to be soiled with red food substance. He had taken off his shirt,and was lying in his soiled bed. PCA (Patient Care Aide) 14 was informed that resident 50 was in resident 206's room and she came and removed		**deficient practice. All current residents with a dementia diagnosis will have care plans reviewed and updated as needed. Staffing needs were reviewed and updated accordingly to meet the needs of the residents.** **3. DON/Designee will complete in service training with all staff on the facilities policy identified as, "Dementia Care Residents Rights and Privileges" with emphasis on supervision and implementation of interventions as identified on the plan of care.** **4. DON/Designee will conduct an audit via observation of residents with dementia diagnosis to ensure the plan of care interventions are implemented and supervision is appropriate based on the following schedule: 5 residents weekly x 4 weeks, then 3 residents weekly x 4 weeks, then 5 residents monthly x 1 month.** **DON/Designee is responsible for the compliance. The results of these audits will be reviewed**	

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	02/21/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	her. The PCA did not attempt to assist resident 206. PCA 14 watched resident 206 drink from his room mates water pitcher and she did not remove it from the resident's room. She did not assist resident 206 at this time. During an observation 2/18/22 at 1:40 p.m., the resident was observed without nonskid footware on. He walking around in his room with an unsteady gait. During an observation, on 2/18/22 at 3:01 p.m., Resident 206 was observed in another resident's room laying in the bed. When CNA (Certified Nursing Aide) 12 asked him what he was doing, the resident stated he was waiting on water. During an observation, on 2/18/22 at 5:40 p.m., Resident 206 was observed in Resident 94's room getting into the bed. Resident 94 became upset, and started yelling at resident 206. He yelled "Get out of my room. You better stop touching my things. I am going to knock your head off." Resident 94 was trying to get the resident out of his room. There were no staff in sight of the back half of the dementia Unit. Nursing staff was called to intervene. Resident 206 was removed from the situation and assisted back to his room. Resident 94 was angry and stood in his doorway for several minutes and watched resident 206. At the time of the incident no staff was observed on the back half of the unit. The clinical record for Resident 206 was reviewed on 2/17/21 at 6:41 p.m. The diagnoses included, but were not limited to, fracture of one rib on the left side, laceration without foreign body to the right lower leg and dementia without behavioral disturbance.		**in Quality Assurance Committee monthly meeting for 6 months or until 100% compliance is achieved x 3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	

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	02/21/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	The care plan, dated 12/28/21, indicated the resident was at risk for falls related to a history of falls. Interventions included, assess blood pressure lying, sitting, and standing to rule out orthostatic hypotension. Physical and occupational therapy to evaluate and treat as needed. The nurse's note, dated 1/28/22, indicated the resident had a fall in his bathroom. Upon doing rounds the CNA found the resident on the floor beside his bed. A blanket was wrapped around his legs. The resident had an open area to his left hand due to the fall. During an interview, on 2/16/22 at 9:18 a.m., QMA 15 indicated Resident 206 fell sometime this morning. She wasn't sure what time he fell. During an interview, on 2/16/21 at 9:25 a.m., RN 9 indicated the resident 206 had an unwitnessed fall at 7:30 am. He also had a fall yesterday and was sent to the hospital for evaluation because he was on blood thinners. During an interview, on 2/21/22 at 9:30 a.m., the Memory Care Unit Director indicated she did not know about the resident to resident altercation involving Resident 206. 2. The clinical record for Resident 51 was reviewed on 2/17/21 at 2:23 p.m. The diagnoses included, but were not limited to, abnormalities of gait and mobility and dementia with behavioral disturbance. The care plan, dated 10/6/20 and revised on 7/8/21, indicated the resident had potential for wandering, going into other resident's rooms and thought a specific resident was his wife and			

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	02/21/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	would let her in his room to nap or sit at the edge of the bed. He wanted her with him when he saw her. Interventions included but were not limited to, anticipate and meet residents needs, caregivers to provide opportunity for positive interaction and attention. Stop and talk with him as passing by. Intervene as necessary to protect the rights and safety of others. The nurse's notes, dated 12/16/21 at 11:19 p.m., indicated Resident 51 was alert with confusion (baseline). He was wandering in halls and in and out of other resident's rooms. He was verbally disruptive. The resident yelling out profanity. The nurse's note, dated 12/8/21 at 5:09 p.m., indicated Resident 51 has been wandering the unit, going into peers rooms, requiring multiple redirections. The resident became irritated with the redirection and started cursing at staff. Calling them "b----h's". Resident 51's behaviors continued throughout the shift. The nurse's note, dated 11/1/21 at 4:22 a.m., indicated Resident 51 had been awake, wandering up and down hallways, and in and out of other residents rooms the entire shift. He took off his brief and tried to walk around naked. The nurse's note, dated 10/28/21 at 5:30 p.m., indicated Resident 51 had been wandering up and down the hallways and going into peers rooms. He was taking other's belongings and pulling his brief out of his pants. The nurse's note, dated 9/2/21 indicated Resident 51 was in a peer to peer incident. The resident went into another resident's room and was hit in the left side of his face several times. He was removed from the room. He had a 1 cm			

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	02/21/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	(centimeter) abrasion by his left eye. 3. During an observation, on 2/14/22 at 1:44 p.m., Resident 2 was lying in bed in her room, covered with a sheet, her tray table in front of her across bed. Resident 51 was sitting on the end of the bed, facing the door. Resident 2 was pushing at him with her feet and her face was scrunched up. During an observation, on 2/14/22 at 1:46 p.m., PCA 14 was walking with a resident down the hall, walked past room 120, called for Resident 51 to come out of the room. Resident 51 got up off the bed, walked out into the hallway, turned around and walked back into room 120 and sat down on the bed. During an observation, on 2/14/22 at 1:52 p.m., observed PCA 14 in the hallway near the dining area. Surveyor ask if it was appropriate for a male resident to be in a female resident room. PCA indicated she did not know as it was her first day. During an interview, on 2/14/22 at 2:08 p.m., the RSD was notified of Resident 51 being in Resident 2's room, on the bed. The RSD indicated she would take care of it immediately. The Clinical Record for Resident 2 was reviewed on 2/16/22 at 9:30 a.m. The resident's diagnoses included, but were not limited to, dementia with behavior, Alzheimer's, psychotic disorder with delusions, depression, and muscle weakness. 4. During an observation, on 2/14/22 at 11:37 a.m., Resident 50 was in another room 104, standing between the beds, PCA 14 and CNA 17 were in the room but did not attempt to redirect the resident.			

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	02/21/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	During an observation, on 2/14/22 at 1:42 p.m., Resident 50 was walking up and down the hallway. During an observation, on 2/14/22 at 1:48 p.m., Resident 50 entered room 120, pick up the trash can, walk around the room with it, removed the liner containing a soiled adult brief, dropped one unused liner in the hallway, stopped, picked it up, placed it on the hand rail, proceeded to walk down the hallway with the liner containing the soiled brief. During an observation on 2/16/22 at 10:49 a.m., Resident 50 was standing at a medication cart next to the nurses station, removing tissues. There was no staff in vicinity. The Clinical Record for Resident 50 was reviewed on 2/16/22 at 2:07 p.m. The Quarterly MDS indicated she was severely cognitively impaired. She had adequate hearing and vision, clear speech, was usually understood, and usually understands. She was a one person extensive assistance for mobility, transfer, and ADLs. She was always incontinent of bladder and bowel. She had one fall since admission with a minor injury. Resident 50's diagnoses included but was not limited to, fracture of neck of right femur, nondisplaced fracture of distal phalanx of right ring finger, Alzheimer's, dementia with behavior, and insomnia. A Progress Note, dated 1/27/22 at 3:08 p.m. indicated, Resident 50 was up wandering in the hallway. Going in and out of peers rooms. Taking others belongings. Resident difficult to redirect this shift. When assisting her out of peers rooms, resident has been getting agitated. Resident has			

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	02/21/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	been hitting staff, attempting to bite them. Staff has attempted to redirect with food and fluids. Resident continues with behaviors. Combative with care. A Progress Note, dated 1/20/2022 at 9:27 p.m. indicated, Resident 50 was found sitting on the floor on her bottom. She had a small 0.3 cm by 0.5 cm skin tear, no signs of injury to head. Good range of motion of all extremities. At her baseline, neuro checks initiated given it was an unwitnessed fall. A Progress Note, dated 1/13/22 at 10:20 p.m. indicated, Resident 50 had an unwitnessed fall hit her head and had a laceration, so was sent to the ER and obtained 6 stitches to right upper eye and had scratches on her left jaw bone. A Progress Note, dated 12/31/2021 at 11:45 a.m. indicated, Resident 50 was found on the flood at the foot of the bed sitting on her buttock. The foot board of her bed had broken off and was on the floor. Resident had a laceration above her right eye and a scratch to her left jawline. Pressure applied to laceration. Bleeding stopped. EMS called and resident taken to ER. A Progress Note, dated 10/14/21 at 11:00 a.m. indicated, Resident 50 was found sitting on buttock in peers' room. Appears Resident 50 fell over the peers bedside table. Resident had a nosebleed, small skin tears to her right hand, a small cut to left lower lip, a cut to bride of nose, and facial abrasions to both cheeks. A Care Plan, with a revision date of 10/6/20, indicated Resident 50 was at risk for falls related to confusion and diminished safety awareness with a dementia diagnosis. Need for hands on			

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	02/21/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	staff assist with ADLS and psychotropic medication use adds to fall risk. History of falls. Interventions included but were not limited to, 1/13/22 - Offer to toilet upon awakening and before and after each meal. 10/18/21 Lock bed brakes. 5/3/21 Physical Therapy to evaluate and treat as indicated. 10/30/20 Staff to provide resident with activities after meals for safety. 10/6/20 Anticipate and meet needs. Ensure that resident has nonskid soles on footwear at all times. Remove current slippers from room and have family take home with them. Follow facility fall protocol. Resident needs a safe environment with: even floors free from spills and/or clutter, and adequate glare-free light. Monitor medication for side effects that may increase risk for falls. PT to evaluate and treat as indicted. Resident to be in eye site from staff while up in wheelchair. During an interview on 2/18/22 at 4:23 p.m., RN 9 indicated there had been falls on the unit but none today. Just this week Resident 18 had fallen and had two staples in the back of her head. Resident 206 had fallen on the same day and had an abrasion on his head. She did not know how to look at the care plans in the computer but often spoke with the unit manager concerning safety of the residents due to, they walked up and down the hallway and wondered in and out of other resident rooms. She often redirected the residents by talking with them. During an interview on 2/18/22 at 4:41 p.m., the 100 hall Unit Manager was working on the 300 Hall as a CNA. She indicated to ensure staff compliance with care interventions, she did frequent rounds and checked. She thought there had been four falls recently. Some of the most common interventions were gripper socks,			

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	02/21/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	redirect, and to keep them busy with activities. If no activity observed while rounding, she would tell them to start the activity. On 2/17/22 at 3:30 p.m., the DON (Director of Nursing) presented a copy of the facility's current policy titled Dementia Care Residents Rights and Privileges." Review of this policy included, but was not limited to, "It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. Safety is a primary concern for our residents, staff and visitors." 3.1-37(a)			
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. §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-			

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	02/21/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	§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 record review and interview, the facility failed to ensure residents received medications as ordered in a timely manner for administration during 3 of 4 record reviews for pharmacy review. (Residents 8, 16, and 55) Findings include: 1. During an interview, on 2/15/22 at 11:08 a.m., Resident 8 indicated she had to wait 9 days for the Fentanyl patch to be provided. During an interview, on 2/16/22 at 9:25 a.m., the resident indicated she had a pain level of 8-9. Her pain medication brings her level down. She had broken bones in the C2-T3 are and they were fused. She had a compression fracture of the L2-L7 area of her spine. She had bilateral knee replacement surgery and a rod had been placed in her left thigh. She also had osteoarthritis. The clinical record for Resident 8 was reviewed on 2/16/22 at 2:15 p.m. The diagnoses included, but was not limited to heart failure, chronic obstructive pulmonary disease, conversion disorder with seizures or convulsions, chronic	F 0755	**1. Resident 8, 16, and 55 were not harmed by the alleged deficient practice. Residents 8, 16, and 55 had their medications reviewed to ensure that all physician ordered medications were available and administered timely.** **2. All residents have the potential to be affected by the alleged deficient practice. An audit was conducted on all residents residing in the facility to ensure all physician ordered medications were available and administered timely. Any resident found to be without available medication had the pharmacy notified for reorder, physician notified, and family notified.** **3. DON/Designee will complete in-service training**	03/23/2022

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	02/21/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	pain, obesity, and major depressive disorder. The MDS (Minimum Data Set) Quarterly assessment 1/25/22 at 9:34 a.m., indicated the resident was cognitively intact and makes needs known daily. The care plan, dated 10/6/20, indicated the resident had chronic pain related to myofascia pain, chronic back pain and immobility. Interventions indicated to administer medications as ordered. Monitor for effectiveness and side effects. Anticipate need for pain relief and respond immediately to any complaint of pain. Monitor/document for side effects of pain medication. Notify physician if interventions are unsuccessful or if current complaint is a significant change from residents past experience of pain. The nurse practitioner note, dated 2/3/22 at 2:07 p.m., indicated the patient complained of knee pain but denied myalgias. Diagnosis of chronic pain. The nurse's note, dated 2/11/22 at 4:34 p.m., indicated the resident was prescribed a Fentanyl patch 72 hour 50 micrograms per hour, apply every 72 hours for pain, rotate site and remove per schedule. Unavailable and not in the EDK (Emergency Drug Kit). Reordered from pharmacy, awaiting delivery. The nurse's note, dated 1/3/22 at 3:24 p.m., indicated the resident was prescribed a Fentanyl patch 50 micrograms per hour. Staff were to rotate the site and remove per schedule, need hard script. The nurse's note, dated 1/3/22 at 3:25 p.m.,		**with all licensed staff and Qualified Medication Aides on the facilities policy identified as, "Medication Administration" with emphasis on reordering medications and timeliness of administration per physician orders.** **4. DON/Designee will conduct an audit of residents medication orders to ensure medication availability and timely administration based on the following schedule: 10 residents weekly x 4 weeks, 5 residents weekly x 4 weeks, and 10 resident monthly x 1 month.** **DON/Designee is responsible for the compliance. The results of these audits will be reviewed in Quality Assurance Committee monthly meeting for 6 months or until 100% compliance is achieved x 3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	

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	02/21/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	indicated the resident was prescribed a Fentanyl patch 50 micrograms per hour. Rotate site and remove per schedule, awaiting delivery. The nurse practitioner note, dated 12/31/21 at 2:19 p.m., indicated the resident had a history of seizure, chronic pain, and obesity. The patient indicated she had decreased mobility. She presented with chronic pain to the left lower leg and knee. It is described as aching pain. The symptom was ongoing. Pertinent findings included decreased range of motion and pain with movement. The nurse's note dated, 12/13/21 at 5:04 a.m., indicated the resident inquired about her Fentanyl patch. The nurse called the pharmacy to see if a new script was needed; they stated that they needed a prior authorization. The nurse's note, dated 11/17/21 at 1:58 a.m., indicated the resident was prescribed a Vimpat 50 milligrams at bedtime for seizures. The medication was not available and had been ordered. The physician's order, started on 2/14/21 at 3:45 p.m., indicated the resident was prescribed a Fentanyl patch 72 Hour 50 micrograms per hour. Staff were to apply one patch transdermally every 72 hours for pain. Staff were to rotate the site and remove per schedule. The physician's order, started on 5/20/19 at 6:00 p.m., indicated staff were to monitor the resident for pain every shift with monitoring level of comfort. The documentation for the resident's pain levels indicated the resident's pain averaged a level of 2.			

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	02/21/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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

The resident's pain levels on the following dates were documented:

- On 2/11/22 at 9:36 p.m. pain level 9
- On 2/8/22 at 9:17 p.m. pain level 10
- On 2/8/22 at 9:17 p.m. pain level 10
- On 2/7/22 at 8:51 p.m. pain level 7
- On 12/24/21 at 12:36 a.m. pain level 7
- On 12/21/21 at 2:30 a.m. pain level 8
- On 12/20/21 at 8:35 p.m. pain level 7
- On 12/13/21 at 10:37 p.m. pain level 6

The pharmacy order history indicated orders for Fentanyl were sent on the following dates:

- On 11/29/21 (3 patches) indicating 3 missed dose days after administration.
- On 12/13/21 (3 patches)
- On 12/21/21 (3 patches) indicating 1 missed dose day after administration.
- On 1/3/22 (2 patches) indicating 3 missed dose days after administration.
- On 1/18/22 (3 patches) indicating 1 missed dose day after administration.
- On 1/30/22 (3 patches) indicating 1 missed dose day after administration.
- On 2/13/22 (3 patches) indicating 1 missed dose day after administration.

An observation,on 2/18/22, indicated the resident's Fentanyl patch was dated 2/17/22 and located on her right chest area.

During a interview on 2/18/22 at 12:30 p.m., LPN (Licensed Practical Nurse) 13 indicated the order for the Fentanyl patch had been changed several times. The pharmacy wouldn't send the patches. They would give excuses the insurance was submitted wrong or wasn't available. It was

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	02/21/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	this way for all resident's medications. She tried to order the medications ahead of time and stay ahead of it, but when it came time to administer the medication, it wasn't there. She just marked it to be held because the EDK (Emergency Drug Kit) didn't have the medication available. The usual wait time was 2 to 3 days and the residents would go without the medication. During an interview on 2/18/22 at 4:57 p.m., the pharmacy representative indicated the cut off date for narcotic medication was at 30 days. Resident 8 would need a prescription order from the physician before they could fill it. The nurse would have to call the pharmacy or have the doctor call in an order to fill the medication. The delivery time would depend on the order call time. If the nurse contacted the doctor and the order was placed by 5:00 p.m., the medication could be delivered by 9:00 p.m. Otherwise the medication would be delivered the next morning. 2. During an interview on 2/18/22 at 4:33 p.m., Resident 16 indicated she had to go 8 days without her sleeping medication. The nurse told her the pharmacy needed a script. The nurse told the resident it came in, but the resident still didn't receive the medication. The resident indicated the medication was a narcotic that started with the letter "R". She had to go through symptoms of withdrawal when she didn't receive the medication. The clinical record for Resident 16 was reviewed on 2/18/22 at 4:46 p.m. The diagnosis included, but was not limited to, insomnia. The care plan, dated 11/26/21 indicated the resident used, hypnotic sedative medication related to insomnia. The interventions included,			

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	02/21/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	but was not limited to, Provide hypnotic/sedative medication per medical provider's orders. The care plan, dated 11/18/21 included, but were not related to, the resident had a mood problem related to the diagnosis of depression and insomnia. Potential for impaired sleep pattern. Reports trouble sleeping. Interventions included, but was not limited to, Administer medications as ordered. The current physician orders indicated the resident was prescribed (Restoril) Temazepam Capsule 15 milligrams at bedtime for insomnia and Trazadone HCl 50 milligrams at bedtime for insomnia. The Social Services note, dated 2/9/22 at 9:06 a.m., indicated the resident reported feeling down, tired, and having trouble sleeping and concentrating. The nurse's note, dated 2/12/22 at 2:20 a.m., indicated the resident had requested to see the nurse around 8:00 p.m. The resident was crying and shaking and stated she was very anxious. The nurse informed the resident it was too soon to receive her PRN (as needed) Ativan. The resident was given her PRN Ativan at 11:45 p.m. The nurse's note, dated 2/13/22 at 9:10 p.m., indicated the resident had an order for Temazepam 15 milligrams at bedtime for insomnia, not available. The nurse's note, dated 2/14/22 at 9:10 p.m., indicated the resident had an order for Temazepam 15 milligrams at bedtime for insomnia.			

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	02/21/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	The nurse's note, dated 2/16/22 at 8:34 p.m., indicated the resident had an order for Temazepam 15 milligrams at bedtime for insomnia, pending arrival. The nurse's note, dated 2/16/22 at 9:10 p.m., indicated the resident had an order for Temazepam 15 milligrams at bedtime for insomnia, pending arrival from pharmacy. The nurse practitioner note, dated 2/17/22 at 2:49 p.m., indicated the resident reported she was having trouble sleeping and had increased crying. the nurse practitioner was the resident in hours and increased her Trazadone to 100 milligrams every night. Her Bursar was increased to 7.5 milligrams three times daily for anxiety. The patient complained of insomnia but denied chills, fever and fatigue. The November and December 2021 Medication Administration Record indicated the resident received Temazepam 15 mg at bedtime for insomnia. The January 2022 Medication Administration Record indicated the resident received Temazepam 15 milligrams at bedtime for insomnia from 1/1/22 through 1/31/22. 3. During an interview on 2/18/22 at 4:29 p.m., Resident 55 indicated her medications were missed once in a while. Her heart pill, folic acid and potassium were missed because the facility didn't have the medication. She would miss the day's dose, but would get it the next morning when they received it. The clinical record for Resident 55 was reviewed on 2/18/22 at 4:50 p.m. The diagnoses included,			

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	02/21/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	atherosclerotic heart disease, left and right bundle-branch block, anxiety disorder, and insomnia. The care plan, dated 2/8/22, indicated the resident was at risk for nutritional decline related to dementia and osteoarthritis. She received a regular diet with risks for weight changes related to diuretic therapy. Interventions included, but was not limited to, administer vitamin/mineral supplement per physician order. The care plan, dated 10/6/20, indicated the resident had hypertension and was at risk for complications. The resident's interventions included, but were not limited to, give anti hypertensive medications as ordered. Observe for side effects. The nurse's note, dated 1/31/21 at 8:21 p.m., indicated the resident was prescribed ropinirole 1 milligram at bedtime for restless leg syndrome. The medication was not available for administration. The nurse's note, dated 2/3/22 at 9:48 a.m., indicated the resident was prescribed escitalopram 5 milligrams in the morning for depression. She was waiting for delivery for administration. The nurse's note, dated 2/5/22 at 8:31 a.m., indicated the resident was prescribed Lasix 40 milligrams one time daily for hypertension. She was waiting for delivery for administration. The January 2022 Medication Administration Record indicated the resident's escitalopram 5 milligrams to be administered in the morning for depression was administered between 1/1/22 and			

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	02/21/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	1/31/22. The ropinirole 1 milligram to be administered at bedtime for restless leg syndrome was administered between 1/1/22 through 1/31/22. The potassium 20 milli-equivalents to be administered in the morning for low potassium was administered between 1/1/22 through 1/31/22. The folic acid 1 milligrams to be administered in the morning for anemia was administered between 1/1/22 and 1/31/22. The Lasix 40 milligrams to be administered one time daily for hypertension was administered between 1/1/22 through 1/31/22. The February 2022 Medication Administration Record indicated the resident's escitalopram 5 milligrams to be administered in the morning for depression was administered between 2/1/22 and 2/8/22 when it was discontinued. The potassium 20 milli-equivalents to be administered in the morning for low potassium was administered between 2/1/22 thru 2/18/22. The folic acid 1 milligrams to be administered in the morning for anemia was administered between 2/1/22 and 2/18/22. The Lasix 40 milligrams to be administered one time daily for hypertension was administered between 2/1/22 thru 2/18/22. During an interview on 2/18/22 at 4:16 p.m., the Regional Director of Clinical Operations indicated medication should not be missed. It should be available in the EDK. If not, the physician should be contacted the notify the pharmacy to get a STAT order sent. The review of the Ordering and Receiving Non-controlled Medications policy, dated September 2018, provided by the Regional Director of Clinical Operations on 2/18/22 at 5:15 p.m., included, but was not limited to, "... b. The refill order is called in, faxed, sent			

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	02/21/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	electronically, or otherwise transmitted to the pharmacy. When available and legible, the pharmacy label... is pull and transmitted to the pharmacy. 3. "STAT" and emergency medication are ordered as follows. a. During regular pharmacy hours, the pharmacy is notified of the emergency or STAT order... The nurse must call the pharmacy to request a STAT delivery. If available, the initial dose is obtained from the emergency kit, when necessary..." This Federal tag relates to Complaint IN00372056. 3.1-25(g)(3)			
F 0804 SS=D 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 foods were served at appropriate and safe temperatures for 2 of 3 observations of nutritive value and appearance of meal service. During an observation of meal service, on 2/17/22 at 12:21 p.m. Two trays, including the test tray had to be put on top of the cart due to being out of room in the cart. Cook 11 tempted the food on the test tray. The tomato soup was	F 0804	1) Facility will ensure all food served to residents is palatable, attractive and at a safe and appetizing temperature. The identified residents were assessed, there was no negative outcome as a result of this noted deficient practice. ThThe Culinary Director or designee will interview all	03/23/2022

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	02/21/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	tempted at 115.7 degrees, the banana cream pie was tempted at 54.1 degrees, the macaroni salad was tempted at 68.5 degrees, the cole slaw was tempted at 53.2 degrees, the chicken salad sandwich was tempted at 57.9 degrees. The soup was luke-warm and a thin liquid consistency. During an observation, on 2/21/22 at 12:12 p.m., a test tray was placed on top of the meal cart with another resident tray. When all trays were passed, Cook 11 tested the food temps. The ravioli tempted at 53.7 degrees. The ravioli had irregular temperature. One piece was very hot to taste, another piece was barely luke warm. During an interview, on 2/15/22 at 10:36 a.m., Resident 23 indicated most of the time his food was cold by the time he got it. During an interview, on 2/21/22 at 12:05 p.m., Cook 11 indicated there was not enough room in the cart for all the trays on 400 Hall or the 200 Hall when they were fully occupied. She indicated she did not temp the ravioli when she pulled it from the oven. The Food: Preparation policy statement, last revised 9/17, provided on 2/21/22 at 2:15 p.m., by the MDS (Minimum Data Set) Coordinator, included, but was not limited to, "... 13. All foods will be held at appropriate temperatures, greater than 135 (or as state regulation requires) for hot holding, and less than 41 degrees for cold food holding..." 3.1-21(a)(2)		residents to ensure drinks and food are palatable, attractive and at a safe and appetizing temperature for them to consume. The interviews will be completed by 03/23/2022. 2) The Administrator or designee will provide education to the culinary/nursing teams to ensure food temperatures are obtained at the start of tray line and all meal trays served, stored and delivered safely and securely in order for all foods to maintain appropriate temperatures. The education will be completed by 3/23/2022. 3) The Administrator or designee will audit 3 meals 5 days per week for two months and 3 days per week for one month. The Culinary Director or designee will attend the resident monthly Food Committee meeting to review results of audits and ensure resident meal satisfaction. The results of these audits/reviews will be reviewed in the monthly QAPI meeting and the QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary			

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	02/21/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	§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 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, record review and interview, the facility failed to ensure the scheduled cleaning of kitchen equipment was conducted and failed to monitor food products for expiration dates for 3 of 3 kitchen observations with the potential to effect 99 of 99 residents that resided in the facility Findings include: During the tour of the kitchen on 2/14/22 at 9:28 a.m., the following was observed: -An open cabinet had rust on the top half of a shelf which had clean water pitchers, sitting on their tops, resting on the rusty areas. Cook 11 indicated the shelves needed to be painted again. -2 bags of iceberg lettuce with chopped carrots	F 0812	1) Facility will store, prepare, distribute and serve food in accordance with professional standards of food service safety. There was no negative outcome as a result of this observation. 2) All areas/equipment in the kitchen was cleaned on 3/23/2022. All areas noted to store kitchen equipment are cleaned and painted. *3)* The Culinary Director or designee will educate culinary staff on the daily cleaning of equipment/areas, routine observation of food storage to ensure first in first out inventory is observed and to ensure expiration	03/23/2022

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	02/21/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	and cabbage in the refrigerator, were observed with, use by dates of 2/11/22. -The stove top grates had a build up of black charcoal and grease around them. The back metal plate of the stove had a scattered, brown colored area to the right half of the back plate and a circular burn area to the left side of the back plate of the stove. There was also scattered food debris around the grates and 2 of the 3 drip pans under the cook top were lined with foil and were covered with black charcoal and grease. The right third drip pan could not be opened. -The convection oven to the right of the stove had a build up of black grease and the glass doors were covered with a brown substance and could not be seen through. An observation on 2/14/22 at 11:00 a.m., Dietary Aide 12 was opening a bag of chopped iceberg lettuce, carrots and cabbage and about the pour the bag into a large bowl to be served. When she was informed of the expiration date, she returned with another bag. An observation on 2/16/22 at 11:32 a.m., indicated the stove grill top still had grease build up and food particles on it and the back metal plate was still covered with the brown grease and burn area. During an interview on 2/16/22 at 11:30 a.m., the Assistant Dietary Manager indicated the cleaning schedule sheet was on the board, on the wall. The oven was cleaned on Saturdays, the stove's grill top was cleaned on Wednesdays, and the labels and dates on the refrigerator items were checked on Thursdays.		dates are checked on all food items prior to meal preparation. The education will be completed by 3/23/2022. 4) The Administrator or designee or designee will complete kitchen observations 5 days per week for 4 weeks, 3 days per week for 2 months to ensure equipment and food are stored and prepared in accordance with professional standards of food service safety. The results of these audits/reviews will be reviewed in the monthly QAPI meeting and the QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

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	02/21/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	During a tour of the kitchen on 2/17/22 at 8:35 a.m., Cook 11 indicated the stove's grill top was cleaned randomly by the kitchen staff a couple of times a week. The grill top had greasy black build up around the grates and on the back splash of the stove. The grease areas and burned area were still on the back splash. The Cook indicated the metal panel on the wall next to the left side of the wall was there because the grill flamed up. She indicated the grill top was looking bad. The hood above the stove was coated with a greasy substance. The cook felt of the underside of the hood and indicated it had a build up. The convection oven had a build up of grease on the bottom, under the elements. She personally had not cleaned the convection oven in a while. It was supposed to be cleaned weekly. She and the other kitchen staff conducted daily checks on the cold food labels in the refrigerator for expiration dates. During an interview on 2/17/22 at 8:40 a.m., the Executive Director, provided a copy of the Weekly Cleaning Schedule for the Cooks. The schedule indicated by staff initials the convection over had been cleaned Tuesday and the Grill top of the stove was cleaned on Wednesday. At 2:42 p.m., the Executive Director indicated the kitchen staff were responsible for monitoring the expired foods and discarding them. The review of the current Storage of Resident Food policy, provided by the Administrator on 2/17/22 at 2:42 p.m., included, but was not limited to, "... Unsafe foods... This may also include food that is expired, outdate or food that has been exposed to incorrect temperatures or other environmental contaminants..."			

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	02/21/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	The review of the Equipment policy, revised on September, 2017, provided by the Administrator on 2/17/22 at 3:06 p.m., included, but was not limited to, "..1. All equipment will be routinely cleaned and maintained in accordance with manufacturer's directions and training materials... 4. All non-food contact equipment will be clean and free of debris..." 3.1-21(a)(1) 3.1-21(i)(3)			