STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155488		(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			(X3) DATE SURVEY COMPLETED 01/27/2022		
NAME OF I	NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP COD 3625 ST JOSEPH RD		
ROLLING	G HILLS HEALTHO	CARE CENTER		NEW A	LBANY, IN 47150		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE
0000							
Bldg. 00	This visit was for Investigation of Complaints IN00370924, IN00370994, and a COVID-19 Focused Infection Control Survey. Complaint IN00370924 - Unsubstantiated due to lack of sufficient evidence.		F 00	00	A complaint surveyor from ISDH completed a Complaint Sur at Rolling Hills Healthcare. Enclosedplease	-	
	Federal/State defic allegations are cite	20994 - Substantiated. viencies related to the ed at F686, F690, F691, and F755. ary 26 and 27, 2022			find the stated list of deficiencieswith the facility plan of correction forthese alleged deficiencies. Please considerthis letter and plan correction to be thefacility's credible allegation	e I of	
	Facility number: 0 Provider number: AIM number: 100 Census Bed Type: SNF/NF: 107 Total: 107	155488 1266970	526ofcompliance. This I5488ourrequest for a des6970papercompliance tofacilityhas achievedsubstantialcomplianapplicablerequirementthe date setforth in the		ofcompliance. This letter is ourrequest for a desk revier papercompliance to verify the facility has achieved substantial compliance with applicable requirements as the date setforth in the plan correction.	w/ :he : the of	
	Census Payor Typ Medicare: 13 Medicaid: 85 Other: 9 Total: 107	e:					
	These deficiencies accordance with 4	reflect State Findings cited in 10 IAC 16.2-3.1.					
	Quality review con	npleted on February 2, 2022.					
⁵ 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs t Ulcer §483.25(b) Skin	o Prevent/Heal Pressure					

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

TITLE

(X6) DATE

PRINTED: 03/07/2022

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 01/27/2022 155488 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 3625 ST JOSEPH RD ROLLING HILLS HEALTHCARE CENTER NEW ALBANY, IN 47150 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Based on the comprehensive assessment of a resident, the facility must ensure that-(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. F 0686 02/25/2022 Based on interview and record review, the facility 1. **Residents F and G were** failed to ensure wound treatments were completed not harmed by the alleged for 2 of 3 residents reviewed for pressure ulcers. deficient practice. Resident F (Residents F and G) and G had their wound(s) assessed and treatment orders Findings include: were reviewed and updated accordingly. The plan of care 1. The clinical record for Resident F was reviewed for residents F and G were on 1/26/22 at 2:13 p.m. Diagnoses included, but reviewed and revised were not limited to, unstageable pressure ulcer (an accordingly. 2. Any ulcer that has full thickness tissue loss but was resident residing in the facility either covered by extensive necrotic tissue or by requiring wound care could be an eschar) to the left plantar and left heel. affected by this alleged deficient practice. An audit was conducted The care plan, dated 10/7/21, indicated the of the last 7 days of TARS of resident had impaired skin integrity and to provide residents that required wound wound care per treatment orders. care. Any resident identified as not having wound care, had their The resident's wound evaluation sheet, dated wound assessed, physician and 1/6/22, indicated the following: family notified, and any new orders were addressed immediately. - Unstageable to the left heel measured 5.22 cm DON/Designee will 3. (centimeters) in length with a width of 3.15 cm complete in service training with all licensed staff on the facilities The resident's wound evaluation sheet, dated policy identified as, "Skin Care 1/20/22, indicated the following: and Wound Management Overview" with emphasis on IV3X11 Event ID: Facility ID: 000526 If continuation sheet Page 2 of 11 FORM CMS-2567(02-99) Previous Versions Obsolete

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155488		(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 01/27/2022			
NAME OF PROVIDER OR SUPPLIER ROLLING HILLS HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 3625 ST JOSEPH RD NEW ALBANY, IN 47150				
ROLLIN (X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE REGULATORY C - Unstageable to th length with a widt The physician's or were to cleanse the saline, pat dry, app dry dressing daily. The January 2022 record) lacked doc was completed on The physician's or staff were to clean normal saline, pat agent) to the area, daily. The January 2022 the treatment was 1/20/22, and 1/23/ The resident's wou 1/6/22, indicated to in length with a with	A STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION the left heel measured 4.11 cm in th of 3.43 cm der, dated 1/6/22, indicated staff the resident's left heel with normal oly medihoney, and cover with a TAR (treatment administration umentation that the treatment 1/10/22, 1/11/22, or 1/12/22. der, dated 1/13/22, indicated se the resident's left heel with dry, apply Santyl (debriding and cover with a dry dressing TAR lacked documentation that completed on 1/17/22, 1/19/22, 22. and evaluation sheet, dated the following: the left plantar measured 7.24 cm and evaluation sheet, dated	ID PREFIX TAG	ALBANY, IN 47150 PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE AF DEFICIENCY) Completing wound care physician order. 4. DON/Designee w conduct audits of resid wound treatments to e compliance weekly x 8 monthly x 1 month and quarterly x 1 quarter. T DON/Designee will brin results of the audits to monthly QAPI meeting results of the audit will reported, reviewed, an trended for a minimum months, then randomly thereafter for further recommendations.	per the per the fill dents with nsure sweeks, d The ng the the b the l. The l be d n of 6	(X5) COMPLETIO DATE	
	length with a widt The physician's or were to cleanse the normal saline, pat area, and cover wi	e left plantar measured 5.19 in h of 8.6 cm der, dated 1/6/22, indicated staff e resident's left plantar with dry, apply medihoney to the th a dry dressing daily. TAR lacked documentation that					

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 01/27/2022 155488 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 3625 ST JOSEPH RD ROLLING HILLS HEALTHCARE CENTER NEW ALBANY, IN 47150 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE the treatment was completed on 1/10/22, 1/11/22, and 1/12/22. During an interview on 1/27/22 at 10:31 a.m., LPN (Licensed Practical Nurse) 2 indicated when a treatment was completed, the nurse would initial the TAR. 2. The clinical record for Resident G was reviewed on 1/26/22 at 2:38 p.m. Diagnosis included, but was not limited to, Stage 2 pressure ulcer (partial thickness skin loss). The care plan, dated 1/10/22, indicated the resident had a Stage 2 pressure ulcer to the coccyx and staff were to provide wound care as ordered. The resident's wound evaluation sheet, dated 1/11/22, indicated the wound measured 1.29 cm in length with a width of 3.75 cm. The resident's wound evaluation sheet, dated 1/20/22, indicated the wound measured .81 cm in length with a width of .72 cm. The physician's order, dated 1/11/22, indicated staff were to cleanse the resident's coccyx wound with normal saline, pat dry, apply medihoney, then cover with a dry dressing daily. The January 2022 TAR lacked documentation that the treatment was completed on 1/16/22, 1/18/22, and 1/22/22. A current copy of the document titled "Monitoring A Wound" dated 7/1/16, included, but was not limited to, "Policy...Each resident/patient is evaluated upon admission...Procedure...Implement wound IV3X11 Facility ID: 000526 Event ID: Page 4 of 11 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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PRINTED:

PRINTED: 03/07/2022 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 155488	(X2) MULTIPLE CO A. BUILDING B. WING	<u>00</u>	(X3) DATE SURVEY COMPLETED 01/27/2022
	PROVIDER OR SUPPLI		3625 ST	ADDRESS, CITY, STATE, ZIP COD I JOSEPH RD LBANY, IN 47150	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (ROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	treatments as orde	ered.			
	This Federal tag r	elates to Complaint IN00370994			
	3.1-40(a)(2)				
F 0690 SS=D Bldg. 00	§483.25(e) Incol §483.25(e)(1) The resident who is a bowel on admiss assistance to may or her clinical contract of that continence, bat comprehensive a ensure that- (i) A resident wh an indwelling cat unless the resided demonstrates the necessary; (ii) A resident wh indwelling cather one is assessed as soon as poss clinical condition catheterization is (iii) A resident w receives approp- to prevent urinar	ncontinence, Catheter, UTI ntinence. ne facility must ensure that continent of bladder and sion receives services and aintain continence unless his ndition is or becomes such s not possible to maintain. r a resident with urinary sed on the resident's assessment, the facility must o enters the facility without theter is not catheterized ent's clinical condition at catheterization was no enters the facility with an ter or subsequently receives for removal of the catheter ible unless the resident's demonstrates that s necessary; and ho is incontinent of bladder riate treatment and services y tract infections and to ce to the extent possible.			
	incontinence, ba comprehensive	or a resident with fecal sed on the resident's assessment, the facility must sident who is incontinent of			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 455 400 455 400		(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			(X3) DATE SURVEY COMPLETED			
	155488			NG		01/27	7/2022	
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD			
ROLLIN	G HILLS HEALTHO	CARE CENTER			ALBANY, IN 47150			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE	IATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		ppropriate treatment and re as much normal bowel						
	function as possi							
		v and record review, the facility	F 06	500	1. Residents F and G w	oro	02/25/2022	
		ley catheter care was completed	1.00	590	not harmed by the alleged		02/23/2022	
		neasured, as ordered by the			deficient practice. Resident	F		
	-	2 residents reviewed for			and H had their physician a			
		rs. (Residents F and H)			family notified of missing			
		````			documentation as it relates	to		
	Findings include:				catheter care and output.			
	-				2. All residents residing i	n the		
	1. The clinical rec			facility with physician orders	for			
	on 1/26/22 at 2:13 p.m. Diagnoses included, but				catheter care and output			
	were not limited to neuromuscular dysfunction of				monitoring have the potentia	l to be		
	the bladder and stage 4 chronic kidney disease.				affected by the alleged defic	ent		
					practice. An audit was condu	icted		
	-	ed 10/14/21, indicated the			on residents that had the por	ential		
		dent had an Indwelling Foley catheter and			to be affected to ensure catheter			
	staff were to provide catheter care every shift.				care and output monitoring h			
				been conducted in the last 7	-			
		ne physician's order, dated 11/23/21 indicated			Any resident identified needi	ng		
		se the Indwelling Foley catheter			correction was immediately			
	· ·	er every shift and to			addressed.			
	measure/record ur	ine output every shift.			3. DON/Designee will			
	Denti Cil D				complete in service training			
		Review of the December 2021 treatment			all licensed staff on the facili			
	administration record lacked documentation of catheter care and the measurement of urine output				policies identified as, "Cathe			
		shift) or 12/15/21 (day shift).			Care" and "Measuring Intake	and		
		(uay siiiit).			Output" with emphasis on following physician orders,			
	Review of the Jan	uary 2022 treatment			completing orders, and			
		ord lacked documentation of the			documenting in the EMAR/E	TAR		
	following:	and accord accumentation of the				i / u X.		
					4. DON/Designee will			
	-Catheter care for	day shift on 1/10, 1/17, 1/19, and			conduct audits of residents	s with		
	1/20/22				a catheter ensure complian	се		
		arine output on 1/8/22 (night			weekly x 8 weeks, monthly	x 1		
		ough 1/12/22 (day shift), 1/17/22			month and quarterly x 1			
	(day shift), 1/19/22	2 (day shift), 1/20/22 and 1/21/22			quarter. The DON/Designee	will		
	(both shifts).		1		bring the results of the aud	ito to	1	

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Event ID:

IV3X11 Facility

Facility ID: 000526

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155488			(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			(X3) DATE SURVEY COMPLETED 01/27/2022	
NAME OF PROVIDER OR SUPPLIER ROLLING HILLS HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 3625 ST JOSEPH RD NEW ALBANY, IN 47150				
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE)	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COD (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	RECTION HOULD BE APPROPRIATE	(X5) COMPLETION DATE	
	During an intervie (Licensed Practica physician orders sl 2. The clinical reco	w on 1/27/22 at 12:05 p.m., LPN l Nurse) 4 indicated the hould always be followed. ord for Resident H was reviewed p.m. Diagnosis included, but		the monthly QAPI me results of the audit w reported, reviewed, a trended for a minimu months, then random thereafter for further recommendations.	ill be nd m of 6		
	· ·	ed 6/10/21, indicated the dwelling Foley catheter and to are every shift.					
	staff were to clean with soap and wate	der, dated 6/22/21, indicated se the Indwelling Foley catheter er every shift and to ine output every shift.					
		uary 2022 treatment ord lacked documentation of the					
	1/15/22 -Measurement of u	day shift on 1/5/22, 1/11/22, and urine output for day shift on 15/22, 1/17/22, 1/18/22, 1/21/22 1/13/22.					
	provided a current "Catheter Care" da was not limited to, facility to provide theneedsof the performed at least	e p.m., the Executive Director copy of the document titled ted 10/13/13. It included, but "PolicyIt is the policy of this resident care that meets residents. Catheter care is twice daily on residents that theters, for as long as the "					
	This Federal tag re	elates to Complaint IN00370994					

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 01/27/2022 155488 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 3625 ST JOSEPH RD ROLLING HILLS HEALTHCARE CENTER NEW ALBANY, IN 47150 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE F 0691 483.25(f) SS=D Colostomy, Urostomy, or Ileostomy Care Bldg. 00 §483.25(f) Colostomy, urostomy,, or ileostomy care. The facility must ensure that residents who require colostomy, urostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. F 0691 Based on interview and record review, the facility 1. Resident H was not 02/25/2022 failed to ensure colostomy care was provided, as harmed by the alleged ordered by the physician, for 1 of 1 resident deficient practice. Upon reviewed for special needs devices. (Resident H) identification of this alleged deficient practice resident H Findings include: had his orders reviewed and updated accordingly to include The clinical record for Resident H was reviewed orders for colostomy care. on 1/26/22 at 2:47 p.m. diagnosis included, but 2. Any resident residing in the was not limited to, colostomy status (surgically facility with a colostomy has the diverted bowel). potential to be affected. An audit was conducted on all residents The care plan, dated 6/24/21, indicated the that had the potential to be resident had an alteration in bowel elimination and affected to ensure colostomy staff were to provide assistance with ostomy care orders for care and changing of as needed. colostomy were in place. Any resident identified to be out of The clinical record lacked documentation of any compliance was immediately care provided related to the colostomy. addressed. 3. DON/Designee will On 1/27/22 at 2:45 p.m., the Director of Nursing complete in service training with indicated a resident's colostomy should be all licensed staff on the facilities changed every 3 days. The colostomy site and the policy identified as, "Colostomy colostomy bag should be cleaned every time the Appliance Change" with emphasis bag was emptied. on ensuring residents with colostomy's have appropriate On 1/27/22 at 2:32 p.m., the Executive Director physician orders for maintenance. provided a current copy of the document titled "Colostomy Appliance Bag Change" dated **DON/Designee will** 4. 4/8/2016. It included, but was not limited, conduct audits of residents with IV3X11 Event ID: Facility ID: 000526 Page 8 of 11 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155488			(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 01/27/2022		
NAME OF PROVIDER OR SUPPLIER ROLLING HILLS HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 3625 ST JOSEPH RD NEW ALBANY, IN 47150				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY)	N BE PRIATE	(X5) COMPLETION DATE
	"PolicyIt is the p resident centered c maintain the prope provide a comforta environment"	olicy of this facility to promote are by providing care to r function of the colostomy and		TAU	a colostomy to ensure compliance weekly x 8 we monthly x 1 month and quarterly x 1 quarter. The DON/Designee will bring to results of the audits to the monthly QAPI meeting. The results of the audit will be reported, reviewed, and trended for a minimum of months, then randomly thereafter for further recommendations.	he 9 1e	DAIL
⁼ 0755 SS=D Bldg. 00	§483.45 Pharma The facility must emergency drugs residents, or obta described in §483 permit unlicensed drugs if State law general supervisi §483.45(a) Proce provide pharmac procedures that a acquiring, receivi administering of a meet the needs of §483.45(b) Servi must employ or of licensed pharmac §483.45(b)(1) Pro-	s/Pharmacist/Records cy Services provide routine and a and biologicals to its ain them under an agreement 3.70(g). The facility may d personnel to administer permits, but only under the on of a licensed nurse. edures. A facility must eutical services (including assure the accurate ng, dispensing, and all drugs and biologicals) to of each resident. ce Consultation. The facility abtain the services of a					

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 01/27/2022 155488 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 3625 ST JOSEPH RD ROLLING HILLS HEALTHCARE CENTER NEW ALBANY, IN 47150 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation: and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on interview and record review, the facility F 0755 1. Residents F and G were 02/25/2022 failed to ensure medications were administered, as not harmed by the alleged ordered by the physician for 2 of 4 residents deficient practice. Resident F reviewed for pharmaceutical services. (Residents and G had their wound(s) B and C) assessed and treatment orders were reviewed and updated Findings include: accordingly. The plan of care for residents F and G were 1. The clinical record for Resident B was reviewed reviewed and revised on 1/26/22 at 11:53 a.m. Diagnoses included, but accordingly. were not limited to, sacral fracture, atrial 2. Any resident residing in fibrillation, hypertension, and constipation. the facility requiring wound care could be affected by this alleged The admission medication orders, dated 12/30/21, deficient practice. An audit was indicated the resident was to receive the conducted of the last 7 days of following: TARS of residents that required wound care. Any resident - Apixaban (blood thinner) 2.5 mg (milligrams) two identified as not having wound times a day care, had their wound assessed, - Docusate Sodium (stool softener) 100 mg two physician and family notified, and times a day any new orders were addressed - Metoprolol Succinate Extended Release 24 hour immediately. (hypertensive medication) 50 mg two times a day 3. DON/Designee will complete in service training with The January 2022 medication administration all licensed staff on the facilities record indicated the evening dose of the policy identified as, "Skin Care Apixaban, Docusate Sodium, and Metoprolol were and Wound Management not administered on January 1, 2, 3, 4, 5, 8, 9, 11, Overview" with emphasis on 12, 13, 17, or 18 completing wound care per the physician order. IV3X11

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FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES       X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER         155488		(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 01/27/2022		
NAME OF PROVIDER OR SUPPLIER			STREET 3625 S NEW A	•		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY O During an interview (Licensed Practical medication was add medication admini- medication was giv 2. The clinical reco on 1/26/22 at 12:58 were not limited to borderline personal The January 2022 frecord indicated th Risperidone 0.5 (and twice daily in the m Lorazepam (antian (milliliters) in the frecord administration of th on January 3, 4, 5, dose of the Lorazep On 1/27/22 at 11:3 provided a current "Medication Admini- included, but was frecordthe legal of administrationMag- given"	ord for Resident C was reviewed 8 p.m. Diagnoses included, but 9, anxiety, depression, and lity disorder. medication administration e resident was to received ntipsychotic medication) mg norning and evening and xiety medication) 0.5 ml morning, afternoon, and bedtime. lacked documentation of the he evening dose of Risperidone 8, and 9, 2022 and the bedtime pam on January 4, 5, and 8. 0 a.m., the Executive Director copy of the document titled nistration" dated 12/14/17. It	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE (FACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY) 4. DON/Designee will conduct audits of residen wound treatments to ensu compliance weekly x 8 we monthly x 1 month and quarterly x 1 quarter. The DON/Designee will bring to results of the audits to the monthly QAPI meeting. Th results of the audit will be reported, reviewed, and trended for a minimum of months, then randomly thereafter for further recommendations.	inte PRIATE ts with ure eeks, the e he	(X5) COMPLETION DATE

Facility ID: 000526

If continuation sheet

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