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	01/27/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	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. Complaint IN00370994 - Substantiated. Federal/State deficiencies related to the allegations are cited at F686, F690, F691, and F755. Survey dates: January 26 and 27, 2022 Facility number: 000526 Provider number: 155488 AIM number: 100266970 Census Bed Type: SNF/NF: 107 Total: 107 Census Payor Type: Medicare: 13 Medicaid: 85 Other: 9 Total: 107 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on February 2, 2022.	F 0000	**A complaint surveyor from ISDH completed a Complaint Survey at Rolling Hills Healthcare. Enclosedplease find the stated list of deficiencieswith the facility's plan of correction forthese alleged deficiencies. Please considerthis letter and plan of correction to be thefacility's credible allegation ofcompliance. This letter is ourrequest for a desk review/ papercompliance to verify the facilityhas achieved substantialcompliance with the applicablerequirements as of the date setforth in the plan of correction.**	
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers.			

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

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	Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on interview and record review, the facility failed to ensure wound treatments were completed for 2 of 3 residents reviewed for pressure ulcers. (Residents F and G) Findings include: 1. The clinical record for Resident F was reviewed on 1/26/22 at 2:13 p.m. Diagnoses included, but were not limited to, unstageable pressure ulcer (an ulcer that has full thickness tissue loss but was either covered by extensive necrotic tissue or by an eschar) to the left plantar and left heel. The care plan, dated 10/7/21, indicated the resident had impaired skin integrity and to provide wound care per treatment orders. The resident's wound evaluation sheet, dated 1/6/22, indicated the following: - Unstageable to the left heel measured 5.22 cm (centimeters) in length with a width of 3.15 cm The resident's wound evaluation sheet, dated 1/20/22, indicated the following:	F 0686	**1. Residents F and G were not harmed by the alleged deficient practice. Resident F and G had their wound(s) assessed and treatment orders were reviewed and updated accordingly. The plan of care for residents F and G were reviewed and revised accordingly.** 2. Any resident residing in the facility requiring wound care could be affected by this alleged deficient practice. An audit was conducted of the last 7 days of TARS of residents that required wound care. Any resident identified as not having wound care, had their wound assessed, physician and family notified, and any new orders were addressed immediately. 3. DON/Designee will complete in service training with all licensed staff on the facilities policy identified as, “Skin Care and Wound Management Overview” with emphasis on	02/25/2022

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	- Unstageable to the left heel measured 4.11 cm in length with a width of 3.43 cm The physician's order, dated 1/6/22, indicated staff were to cleanse the resident's left heel with normal saline, pat dry, apply medihoney, and cover with a dry dressing daily. The January 2022 TAR (treatment administration record) lacked documentation that the treatment was completed on 1/10/22, 1/11/22, or 1/12/22. The physician's order, dated 1/13/22, indicated staff were to cleanse the resident's left heel with normal saline, pat dry, apply Santyl (debriding agent) to the area, and cover with a dry dressing daily. The January 2022 TAR lacked documentation that the treatment was completed on 1/17/22, 1/19/22, 1/20/22, and 1/23/22. The resident's wound evaluation sheet, dated 1/6/22, indicated the following: - Unstageable to the left plantar measured 7.24 cm in length with a width of 7.49 cm The resident's wound evaluation sheet, dated 1/20/22, indicated the following: -Unstageable to the left plantar measured 5.19 in length with a width of 8.6 cm The physician's order, dated 1/6/22, indicated staff were to cleanse the resident's left plantar with normal saline, pat dry, apply medihoney to the area, and cover with a dry dressing daily. The January 2022 TAR lacked documentation that		completing wound care per the physician order. **4. DON/Designee will conduct audits of residents with wound treatments to ensure compliance weekly x 8 weeks, monthly x 1 month and quarterly x 1 quarter. The DON/Designee will bring the results of the audits to the monthly QAPI meeting. The results of the audit will be reported, reviewed, and trended for a minimum of 6 months, then randomly thereafter for further recommendations.**	

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	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			

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	treatments as ordered. This Federal tag relates to Complaint IN00370994 3.1-40(a)(2)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of			

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	bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on interview and record review, the facility failed to ensure Foley catheter care was completed and urine output measured, as ordered by the physician, for 2 of 2 residents reviewed for Indwelling catheters. (Residents F and H) Findings include: 1. The clinical record for Resident F was reviewed on 1/26/22 at 2:13 p.m. Diagnoses included, but were not limited to neuromuscular dysfunction of the bladder and stage 4 chronic kidney disease. The care plan, dated 10/14/21, indicated the resident had an Indwelling Foley catheter and staff were to provide catheter care every shift. The physician's order, dated 11/23/21 indicated staff were to cleanse the Indwelling Foley catheter with soap and water every shift and to measure/record urine output every shift. Review of the December 2021 treatment administration record lacked documentation of catheter care and the measurement of urine output on 12/9/21 (night shift) or 12/15/21 (day shift). Review of the January 2022 treatment administration record lacked documentation of the following: -Catheter care for day shift on 1/10, 1/17, 1/19, and 1/20/22 -Measurement of urine output on 1/8/22 (night shift), 1/10/22 through 1/12/22 (day shift), 1/17/22 (day shift), 1/19/22 (day shift), 1/20/22 and 1/21/22 (both shifts).	F 0690	**1. Residents F and G were not harmed by the alleged deficient practice. Resident F and H had their physician and family notified of missing documentation as it relates to catheter care and output.** 2. All residents residing in the facility with physician orders for catheter care and output monitoring have the potential to be affected by the alleged deficient practice. An audit was conducted on residents that had the potential to be affected to ensure catheter care and output monitoring had been conducted in the last 7 days. Any resident identified needing correction was immediately addressed. 3. DON/Designee will complete in service training with all licensed staff on the facilities policies identified as, “Catheter Care” and “Measuring Intake and Output” with emphasis on following physician orders, completing orders, and documenting in the EMAR/ETAR. **4. DON/Designee will conduct audits of residents with a catheter ensure compliance weekly x 8 weeks, monthly x 1 month and quarterly x 1 quarter. The DON/Designee will bring the results of the audits to**	02/25/2022

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	During an interview on 1/27/22 at 12:05 p.m., LPN (Licensed Practical Nurse) 4 indicated the physician orders should always be followed. 2. The clinical record for Resident H was reviewed on 1/26/22 at 2:47 p.m. Diagnosis included, but was not limited to, kidney failure. The care plan, dated 6/10/21, indicated the resident had an Indwelling Foley catheter and to provide catheter care every shift. The physician's order, dated 6/22/21, indicated staff were to cleanse the Indwelling Foley catheter with soap and water every shift and to measure/record urine output every shift. Review of the January 2022 treatment administration record lacked documentation of the following: -Catheter care for day shift on 1/5/22, 1/11/22, and 1/15/22 -Measurement of urine output for day shift on 1/5/22, 1/11/22, 1/15/22, 1/17/22, 1/18/22, 1/21/22 and night shift on 1/13/22. On 1/27/22 at 2:32 p.m., the Executive Director provided a current copy of the document titled "Catheter Care" dated 10/13/13. It included, but was not limited to, "Policy...It is the policy of this facility to provide resident care that meets the...needs...of the residents. Catheter care is performed at least twice daily on residents that have indwelling catheters, for as long as the catheter is in place...." This Federal tag relates to Complaint IN00370994		**the monthly QAPI meeting. The results of the audit will be reported, reviewed, and trended for a minimum of 6 months, then randomly thereafter for further recommendations.**	

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F 0691 SS=D Bldg. 00	483.25(f) Colostomy, Urostomy, or Ileostomy Care §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. Based on interview and record review, the facility failed to ensure colostomy care was provided, as ordered by the physician, for 1 of 1 resident reviewed for special needs devices. (Resident H) Findings include: The clinical record for Resident H was reviewed on 1/26/22 at 2:47 p.m. diagnosis included, but was not limited to, colostomy status (surgically diverted bowel). The care plan, dated 6/24/21, indicated the resident had an alteration in bowel elimination and staff were to provide assistance with ostomy care as needed. The clinical record lacked documentation of any care provided related to the colostomy. On 1/27/22 at 2:45 p.m., the Director of Nursing indicated a resident's colostomy should be changed every 3 days. The colostomy site and the colostomy bag should be cleaned every time the bag was emptied. On 1/27/22 at 2:32 p.m., the Executive Director provided a current copy of the document titled "Colostomy Appliance Bag Change" dated 4/8/2016. It included, but was not limited,	F 0691	**1. Resident H was not harmed by the alleged deficient practice. Upon identification of this alleged deficient practice resident H had his orders reviewed and updated accordingly to include orders for colostomy care.** 2. Any resident residing in the facility with a colostomy has the potential to be affected. An audit was conducted on all residents that had the potential to be affected to ensure colostomy orders for care and changing of colostomy were in place. Any resident identified to be out of compliance was immediately addressed. 3. DON/Designee will complete in service training with all licensed staff on the facilities policy identified as, “Colostomy Appliance Change” with emphasis on ensuring residents with colostomy’s have appropriate physician orders for maintenance. **4. DON/Designee will conduct audits of residents with**	02/25/2022

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	"Policy...It is the policy of this facility to promote resident centered care by providing care to maintain the proper function of the colostomy and provide a comfortable and hygienic environment...." This Federal tag relates to Complaint IN00370994 3.1-47(a)(3)		**a colostomy to ensure compliance weekly x 8 weeks, monthly x 1 month and quarterly x 1 quarter. The DON/Designee will bring the results of the audits to the monthly QAPI meeting. The results of the audit will be reported, reviewed, and trended for a minimum of 6 months, then randomly thereafter for further recommendations.**	
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- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.			

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	§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on interview and record review, the facility failed to ensure medications were administered, as ordered by the physician for 2 of 4 residents reviewed for pharmaceutical services. (Residents B and C) Findings include: 1. The clinical record for Resident B was reviewed on 1/26/22 at 11:53 a.m. Diagnoses included, but were not limited to, sacral fracture, atrial fibrillation, hypertension, and constipation. The admission medication orders, dated 12/30/21, indicated the resident was to receive the following: - Apixaban (blood thinner) 2.5 mg (milligrams) two times a day - Docusate Sodium (stool softener) 100 mg two times a day - Metoprolol Succinate Extended Release 24 hour (hypertensive medication) 50 mg two times a day The January 2022 medication administration record indicated the evening dose of the Apixaban, Docusate Sodium, and Metoprolol were not administered on January 1, 2, 3, 4, 5, 8, 9, 11, 12, 13, 17, or 18	F 0755	**1. Residents F and G were not harmed by the alleged deficient practice. Resident F and G had their wound(s) assessed and treatment orders were reviewed and updated accordingly. The plan of care for residents F and G were reviewed and revised accordingly.** 2. Any resident residing in the facility requiring wound care could be affected by this alleged deficient practice. An audit was conducted of the last 7 days of TARS of residents that required wound care. Any resident identified as not having wound care, had their wound assessed, physician and family notified, and any new orders were addressed immediately. 3. DON/Designee will complete in service training with all licensed staff on the facilities policy identified as, “Skin Care and Wound Management Overview” with emphasis on completing wound care per the physician order.	02/25/2022

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	During an interview on 1/27/22 at 10:31 a.m., LPN (Licensed Practical Nurse) 2 indicated once a medication was administered, the nurse initials the medication administration record to show the medication was given. 2. The clinical record for Resident C was reviewed on 1/26/22 at 12:58 p.m. Diagnoses included, but were not limited to, anxiety, depression, and borderline personality disorder. The January 2022 medication administration record indicated the resident was to received Risperidone 0.5 (antipsychotic medication) mg twice daily in the morning and evening and Lorazepam (antianxiety medication) 0.5 ml (milliliters) in the morning, afternoon, and bedtime. The clinical record lacked documentation of the administration of the evening dose of Risperidone on January 3, 4, 5, 8, and 9, 2022 and the bedtime dose of the Lorazepam on January 4, 5, and 8. On 1/27/22 at 11:30 a.m., the Executive Director provided a current copy of the document titled "Medication Administration" dated 12/14/17. It included, but was not limited to, "Definitions...MAR: Medication Administration Record...the legal documentation of medication administration...Medications will be charted when given...." This Federal tag relates to Complaint IN00370994 3.1-25(a)(3)		**4. DON/Designee will conduct audits of residents with wound treatments to ensure compliance weekly x 8 weeks, monthly x 1 month and quarterly x 1 quarter. The DON/Designee will bring the results of the audits to the monthly QAPI meeting. The results of the audit will be reported, reviewed, and trended for a minimum of 6 months, then randomly thereafter for further recommendations.**	