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	01/23/2018

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00249661 and IN00251002. This visit resulted in a Partially Extended Survey-Substandard Quality of Care - Immediate Jeopardy. Complaint IN00249661 - Substantiated. Federal/State deficiencies related to the allegation are cited at F659 and F849. Complaint IN00251002 - Substantiated. Federal/State deficiencies related to the allegation are cited at F659 and F686. An unrelated deficiency is cited. Survey dates: January 18, 19, 20, 21, 22, and 23, 2018 Facility number: 000526 Provider number: 155488 AIM number: 100266970 Census Bed Type: SNF/NF: 109 Total: 109 Census Payor Type: Medicare: 11 Medicaid: 85 Other: 13 Total: 109 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	Preparation and submission of this Plan of Correction does not constitute the admission or agreement by the Provider to the truth of the “findings” alleged or conclusion set forth in the Statement of Deficiencies (CMS 2567). The Plan of Correction is prepared, executed and submitted solely because it is require by the provisions of federal and state law.	

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

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

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	Quality review completed on January 24, 2018.			
F 0659 SS=E Bldg. 00	483.21(b)(3)(ii) Qualified Persons §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. Based on interview and record review, the facility failed to ensure residents plan of care was followed for 4 of 7 residents reviewed for care plans. (Resident B, C, E, and H) Findings include: 1. The clinical record for Resident B was reviewed on 1/18/18 at 12:28 p.m. Diagnoses included, but were not limited to, dementia and left knee contracture. The care plan, dated 8/10/17, indicated a potential for pressure ulcer development due to decreased mobility, dementia, incontinence, and the need for hands on staff assist with activities of daily living. The interventions included administer treatments as ordered and weekly full body skin assessments.	F 0659	**F 659 Comprehensive Care Plans** 1.The facility is committed to providing quality care for all of its residents, as well as substantial compliance with all regulatory requirements for a licensed certified skilled nursing facility. Resident B was discharged from facility on 12/19/17. The other three residents identified had thorough care plan review and updates made to reflect current physician orders. 2.Any resident with altered skin integrity or hospice services have to possibility to be effected. On 1/18/18, all residents had a skin assessment completed to identify any skin impairment. Any resident	02/12/2018

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	The September 2017 treatment administration record lacked documentation of a weekly skin assessment on 9/22/17 and 9/29/17; no wound treatments were ordered. The physician order, dated 10/18/17 at 6:14 p.m., indicated to cleanse the left heel wound with wound cleanser, apply opticell (treatment for wounds), and wrap with kerlix daily and as needed. The October 2017 treatment administration record indicated the treatment was not completed to the wound on the left heel on 10/19/17, 10/22/17, 10/23/17, and 10/30/17. The record lacked documentation of a weekly skin assessment on 10/13/17 and 10/27/17. The progress noted, dated 11/18/17 at 6:31 a.m., indicated a full head to toe skin assessment was completed on 11/17/17 and the resident was noted with an unstageable pressure area to the left heel and inner bony prominence. A new treatment order for Santyl (wound debridement agent), cover with dry dressing, and wrap with kerlix daily was received. The care plan, initiated 11/18/17, indicated the resident had unstageable pressure ulcers to the left heel and inner left bony prominence related to decreased mobility, to complete treatments as ordered, and to apply heel protectors to bilateral feet. The November 2017 treatment administration record indicated on 11/17/17 to discontinue the current treatment to the left heel and start Santyl, apply to left heel and left inner bony prominence after cleansing with normal saline then cover with		identified with impaired skin integrity had notification to MD and Family and a skin grid pressure or skin grid non pressure was completed. Treatment orders received and care plan revised. On 1/21/18 all residents receiving hospice services received a 100% audit with care profile updated, orders update, and care plan updated. 3.All C.N.As have been in-serviced on the process for completing an “ALERT” in POC when identifying a skin impairment. The “ALERT” documentation will flow to the PCC dashboard for IDT notification and review Q day in the IDT clinical morning meeting. Education provided to all nurses, CNAs and the IDT on Pressure Ulcer Prevention with emphasis on identifying, and reporting impaired skin to the physician for change of condition and implementation of physician orders, Turning and repositioning, application of barrier creams, incontinent care, and moisture over bony prominences, support devices and refusal of care. Education was provided to nurses on completing the Braden to identify residents at risk for the development of pressure ulcers. Education was provided to all licensed nurses on completing the non-pressure skid grid, pressure ulcer skin grid on identification of impaired skin integrity and weekly.	

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	a dry dressing and wrap with kerlix daily. The treatment record also indicated, on 11/18/17, the resident was to have heel protectors to bilateral feet. The November 2017 treatment administration record lacked documentation of a weekly skin assessment on 11/29/17, heel protectors in place on 11/22/17 and 11/27/17, and wound treatment completed on 11/18/17, 11/22/17, and 11/27/17. The December 2017 treatment administration record indicated the heel protectors to bilateral feet, wound treatment to the left heel, and left medial foot were discontinued on 12/2/17. The December 2017 MAR (medication administration record) indicated, between 12/9/17 and 12/11/17, to apply Santyl to the left heel topically every day shift, at which time the treatment was discontinued. The physician order, dated 12/11/17 at 11:25 a.m., indicated to apply Santyl to the left heel and left foot bony prominence (medial) topically every day shift for wound care. The December 2017 MAR lacked documentation of a wound treatment to the left heel on 12/3/17, 12/4/17, 12/5/17, 12/6/17, 12/7/17, 12/8/17, and 12/12/17 and to the left bony prominence (medial) between 12/3/17 - 12/12/17. There was also no documentation of weekly skin assessments. During an interview on 1/19/18 at 12:47 p.m., RN 2 indicated skin checks are completed weekly and nursing staff initial the treatment administration record when they are done. During an interview on 1/23/18 at 12:28 p.m., LPN		Education was completed with all licensed nurses on completing the weekly skin assessment on residents and documenting in PCC. Education on Abuse and Neglect provided to all departments. Education provided to both social services directors on any newly admitted patient to hospice services will have care profile and care plan updated. All licensed nurse educated on physician and hospice notification of change. 4. 1.The IDT will complete Q 2hour rounds for validation of turning and repositioning and implementation of support surfaces for 24 hours x 2 weeks, then Q 2 hours x 12 hours for 2 weeks, then Q 2 hours x 8 hours for 2 weeks, then Q 2 hours x 8 hours for 5 days a week x 2 weeks, then rounds will be twice daily for 30days, then IDT rounds once daily for 30 days. The facility will implement weekly wound rounds with the IDT and assigned nursing staff. 2.The DNS/Designee will validate completion of treatments for all wounds x 7 days a week for 2 weeks, then daily for 5 days a week for 2 weeks, then 3 days a week for 2 weeks. Then the IDT will continue making weekly wound rounds with the assigned C.N.A. and licensed nurse as part of the resident at risk weekly meeting.	

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	(Licensed Practical Nurse) 8 indicated once a treatment is completed, it is initialed by the nurse on the treatment administration record to verify it was completed. 2. The clinical record for Resident C was reviewed on 1/19/18 at 2:15 p.m. Diagnoses included, but were not limited to, dementia and heart disease. The end of life plan of care, dated 10/18/16, indicated to notify hospice of any changes. The progress note, dated 12/17/17 at 2:36 a.m., indicated the resident was vomiting up coffee ground material LPN 9 notified the Nurse Practitioner and a new order was received to sent the resident to the hospital for evaluation. The progress note, dated 12/17/17 at 7:30 p.m., indicated a call was made to the hospital to check on the resident's status and LPN 9 was told she was admitted at 4:11 a.m. The clinical record lacked documentation of hospice notification prior to sending the resident to the hospital. On 1/21/18 at 7:40 a.m. during an interview, LPN 4 indicated prior to sending a hospice resident to the hospital, the hospice nurse was notified. On 1/22/18 at 1:45 p.m. during an interview, Resident C's hospice nurse indicated he was unaware the resident was sent to the hospital until the following Monday (12/18/17) when he came in to see the resident for a routine visit. 3. The clinical record for Resident E was reviewed on 1/19/18 at 2:48 p.m. Diagnoses included, but were not limited to, dementia and anxiety.		3.The weekly resident at risk meeting will validate completion of the weekly skin assessments, skid grids, care plan implementation, RD recommendations and assessments, weights, support surfaces and MD and RP notification when appropriate. 4.All residents with a pressure ulcer and residents identified on the Braden scale as High Risk (10-12) and Very High Risk (9 or below) will have a Turning and repositioning schedule documented on the MAR/TAR and on the C.N.A. Kardex. 5. The ED/DNS/designee will audit PCC dashboard for “Alerts”, 24hr progress notes, and new orders to monitor for change in condition to include notifications to MD, and resident responsible party daily five times a week in clinical meeting. 6. Daily rounding by ED/DNS to monitor for abuse and neglect and initiate an investigation. These rounds will include observation and interviews with residents, staff, visitors and families. The facility will complete 5 random resident/family interviews weekly as an ongoing practice of the QAPI related to identifying concerns/grievances and abuse and neglect. 7.The IDT will have a Weekly resident risk meeting to include rounding with all residents that	

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	The care plan, dated 7/7/6 and revised on 1/19/18, indicated the resident had a pressure ulcer due to often sitting for extended periods of time and was admitted with a stage 2 pressure ulcer which was healed and had reopened as a stage 3 pressure ulcer. The interventions included to administer treatments as ordered, assess/record/monitor wound healing weekly, measure weekly, and weekly skin assessments. The September 2017 TAR (treatment administration record) indicated to cleanse the coccyx with wound cleanser, pat dry, apply Opti-foam AG to the wound bed, and cover with a dry dressing every day shift. The TAR for September 2017 indicated the weekly skin assessments were discontinued on 9/18/17 and lacked documentation of a treatment completed on 9/1/17, 9/2/17, 9/4/17, 9/5/17, and 9/12/17. The October 2017 treatment administration record lacked documentation of weekly skin assessments. Review of the pressure grid sheets indicated no weekly wound measurements between 8/23/17 - 9/22/17 and 10/11/17 - 1/18/18. 4. The clinical record for Resident H was reviewed on 1/22/18 at 1:40 p.m. Diagnoses included, but were not limited to, dementia and depression. The care plan, dated 3/27/17, indicated the resident had the potential for pressure ulcer development due to decreased mobility, sits for extended periods of time, incontinence, and need for staff assist with activities of daily living. The		have a wound and assigned C.N.A. and nurse. 8.Daily review of progress notes will be completed in morning meeting to validate notification of change has been made to hospice. 9.The results of these observations will be reported, reviewed, or trended for compliance through the facilities' quality assurance performance improvement (QAPI) for a minimum of 6 months for further compliance. V. Systematic changes will be completed on or before 2/12/18.	

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	interventions included to administer treatments as ordered, remind/assist to turn/reposition at least every 2 hours, and weekly full body skin assessments. The December 2017 treatment administration record indicated a weekly skin assessment on 12/26/17 was not completed. The physician order, dated 1/3/18, indicated to cleanse the right buttock with wound cleanser/normal saline, apply triple antibiotic ointment, and cover with a dry dressing daily. The order was discontinued on 1/13/18. The physician order, dated 1/13/18, indicated to cleanse the right buttock with wound cleanser/normal saline, apply betadine, and cover with borderfoam every day shift. The January 2018 treatment administration record lacked documentation of a skin assessment on 1/2/18 and wound treatments on 1/5/18, 1/8/18, 1/14/18, 1/15/18, and 1/16/18. 3.1-35(g)(2)			
F 0686 SS=J 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. 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			

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	(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 observation, interview, and record review, the facility failed to ensure interventions and treatments were in place for one resident who was at an increased risk for developing pressure ulcers and developed, in house, one unstageable pressure ulcer to the left heel and one stage four pressure ulcer to the left medial foot which resulted in an above knee amputation of the left leg (Resident B); one resident with a healed pressure ulcer that reopened to a stage 3 pressure ulcer on the coccyx (Resident E); and one resident who developed a stage 3 pressure ulcer in the right gluteal fold acquired in the facility (Resident H) for 3 of 3 resident reviewed for pressure ulcers. The Immediate Jeopardy began on 9/17/17 at 6:48 p.m. when an area to the left heel was identified by staff and the facility failed to ensure interventions and treatments were in place. The Administrator and Regional Nurse Consultant were notified of the Immediate Jeopardy on 1/19/18 at 3:15 p.m. Findings include: 1. The clinical record for Resident B was reviewed on 1/18/18 at 12:28 p.m. Diagnoses included, but were not limited to, dementia and left knee contracture. The five day Admission MDS (Minimum Data Set) assessment, dated 8/16/17, indicated the resident had intact skin, was at risk for pressure ulcers, required an extensive two person assistance with bed mobility, and had functional range of motion	F 0686	**F 686 Treatment/Svcs to Prevent/heal pressure Ulcer** 1.Resident A developed two in house pressure areas. One unstageable pressure ulcer to the posterior aspect of the left heel on 9-17-2017 and a stage 4 pressure ulcer to the medial aspect of the left foot on 11-1-2017. On 9-17-2017 when an area of impaired skin integrity was observed by resident's daughter the nurse placed heel protectors to feet. The physician was notified on 10-18-2017 and treatment orders obtained. Resident A required dependent assist for all ADL's and transfers. Bilateral lower extremities exhibited high tonicity and adduction at bilateral hips and knees. He had significant flexion contractures affecting bilateral lower extremities. Resident A was evaluated at Baptist Health Floyd wound center on 12-13-2017 and treatment orders updated and plan of care. On 12-20-2017 he had an ABI performed and interpretation demonstrated distal disease right side below the ankle mild. On the left side there is a mild superficial femoral artery obstruction digit waveform is decreased in	02/12/2018

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	impairment to both upper and lower extremities. The Braden Scale for Predicting Pressure Sore Risk, dated 8/17/17 at 2:08 a.m., indicated Resident B was bedfast with very limited mobility which signified the inability to make frequent or significant changes in body position without assistance. The care plan, dated 8/10/17, indicated a potential for pressure ulcer development due to decreased mobility, dementia, incontinence, and the need for hands on staff assist with activities of daily living. The interventions included administer treatments as ordered, follow the facility policies/protocols, remind/assist to turn/reposition at least ever 2 hours, use of pressure reducing mattress on bed, cushion in wheel chair, and weekly full body skin assessments. The progress note, dated 9/17/17 at 6:48 p.m., indicated the family notified staff of a wound on the resident's left heel, which was discolored, intact, and very mushy to touch. Notification was placed in the physician's binder for further evaluation, and a heel protector boot was placed on the left foot to aid in protection. The September 2017 treatment administration record lacked documentation of a weekly skin assessment on 9/22/17 and 9/29/17 or any new treatment orders for the identified area on the heel. The September 2017 shower sheets indicated the resident had no skin areas of concern. The progress note, dated 10/18/17 at 5:52 p.m., indicated the resident had an open area on the left heel which measured 5 cm (centimeters) in diameter with a moderate amount of drainage and		amplitude showing small vessel disease below the ankle. On 12-20-2017 resident A was admitted to Baptist Health Floyd for worsening of the left heel ulcer. The ulcer on the left posterior heel presented with extension to the level of the bone, purulence, necrotic tissue, and malodor. The medial aspect presented with ulceration to the medial aspect of the first metatarsal head. Deep extension without obvious infection. 2.Others at risk: All other residents have potential to be effected. 1. On 1-18-2018 all residents had a skin assessment completed to identify any skin impairment. Any resident identified with impaired skin integrity have notification to MD and family a skin grid for pressure or non-pressure completed and care plan revised. 2.Daily wound monitoring implemented that will completed daily and documented in PCC. 3. All residents have a weekly skin assessments assigned weekly to identify any areas of skin impairment. 4. All residents have a Braden assessment completed on 1-19-2018 to identify residents at risk and individualized	

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	a foul smelling odor. The physician order, dated 10/18/17 at 6:14 p.m., indicated to cleanse the left heel wound with wound cleanser, apply opticell (treatment for wounds), and wrap with kerlix daily and as needed. The October 2017 treatment administration record indicated the treatment was not completed to the wound on the left heel on 10/19/17, 10/22/17, 10/23/17, and 10/30/17. The record lacked documentation of a weekly skin assessment on 10/13/17 and 10/27/17. The October 2017 shower sheets indicated the resident had no skin areas of concern. The Nurse Practitioner note, dated 11/6/17, indicated to send the resident for an evaluation at the wound care center. The progress note, dated 11/10/17 at 1:14 p.m., indicated the wound on the inner aspect of the foot was 3 cm x 2.5 cm with red/black/slough. The left heel was approximately 5 cm x 3.6 cm, which was all black. The progress note, dated 11/13/17 at 1:53 p.m., indicated the left heel had yellow drainage with an odor and a new order was received to obtain an x-ray and wound culture during the next dressing change. The progress note, dated 11/15/17 at 3:53 p.m., indicated the wound culture was obtained. The radiology report, dated 11/13/17 at 6:59 p.m., indicated no evidence of osteomylitis but an MRI (magnetic resonance imaging) was more sensitive.		interventions are implemented. 5.All residents' Kardex has been updated with any care plan revisions to communicate to the C.N.A.s interventions for prevention of pressure ulcers and individualized interventions. 6. The Dietician has completed an assessment of any identified wounds and any recommendations reviewed with the physician and RP for implementation. 7. An audit was completed of supportive surfaces for all residents. 8.The DNS/Designee will consult with the residents' physician for a referral to the wound center for consultation on all wounds. 1.Education: 1.All C.N.As have been in-serviced on the process for completing an "ALERT" in POC when identifying a skin impairment. The "ALERT" documentation will flow to the PCC dashboard for IDT notification and review Q day in the IDT clinical morning meeting. 2. Education provided to all nurses, CNAs and the IDT on Pressure Ulcer Prevention with emphasis on identifying, and reporting impaired skin to the physician for change of condition	

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	The left heel wound culture, dated 11/18/17 at 1:35 p.m., indicated MRSA (methicillin resistant staphyloccoccus aureus) with heavy growth. The progress noted, dated 11/18/17 at 6:31 a.m., indicated a full head to toe skin assessment was completed on 11/17/17 and the resident was noted with an unstageable pressure area to the left heel and inner bony prominence. A new treatment order for Santyl (wound debridement agent), cover with dry dressing, and wrap with kerlix daily was received. The progress note, dated 11/18/17 7:23 p.m., indicated the the Nurse Practitioner was notified and to start Cipro, 500 mg (milligrams) twice daily. The care plan, initiated 11/18/17, indicated the resident had unstageable pressure ulcers to the left heel and inner left bony prominence related to decreased mobility, to complete treatments as ordered, and to apply heel protectors to bilateral feet. The skin grid pressure sheet, dated 11/18/17 at 3:54 p.m., indicated the resident had an unstageable area to the left heel, first observed on 10/19/17, house acquired, with risk factors of impaired/decreased mobility and contracture of the left knee. The area measured 5 cm x 3 cm. The skin grid pressure sheet, dated 11/18/17 at 7:05 p.m., indicated the resident had an area to the left foot, first observed on 10/19/17, was house acquired, with risk factors of impaired/decreased mobility and contracture of the left knee. The area measured 2.5 cm x 2 cm and the area was not staged.		and implementation of physician orders, Turning and repositioning, application of barrier creams, incontinent care, and moisture over bony prominences, support devices and refusal of care. 3.Education was provided to nurses on completing the Braden to identify residents at risk for the development of pressure ulcers. 4.Education was provided to all licensed nurses on completing the non-pressure skid grid, pressure ulcer skin grid on identification of impaired skin integrity and weekly. 5.Education was completed with all licensed nurses on completing the weekly skin assessment on residents and documenting in PCC. 6. Education on Abuse and Neglect provided to all departments. 1.Monitoring: PREVENTION: 1. The IDT will complete Q 2hour rounds for validation of turning and repositioning and implementation of support surfaces for 24 hours x 2 weeks, then Q 2 hours x 12 hours for 2 weeks, then Q 2 hours x 8 hours for 2 weeks, then Q 2 hours x 8 hours for 5 days a week x 2 weeks, then rounds will be twice daily for 30days, then IDT	

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	The clinical record lacked documentation of any other skin grid pressure sheets prior to 11/18/17 and thereafter. On 1/19/18 at 9:48 a.m., LPN (Licensed Practical Nurse) 3 indicated wounds were measured weekly and the information was put on the skin grid pressure sheets. The November 2017 treatment administration record indicated on 11/17/17 to discontinue the current treatment to the left heel and start Santyl, apply to left heel and left inner bony prominence after cleansing with normal saline then cover with a dry dressing and wrap with kerlix daily. The treatment record also indicated, on 11/18/17, the resident was to have heel protectors to bilateral feet. The November 2017 treatment administration record lacked documentation of a weekly skin assessment on 11/29/17, heel protectors in place on 11/22/17 and 11/27/17, and wound treatment completed on 11/18/17, 11/22/17, and 11/27/17. The November 2017 shower sheets indicated no skin areas noted. The progress note, dated 11/30/17 at 2:26 p.m., indicated the resident had a wound consult at the wound care center on 12/13/17. The wound care center assessment report, dated 12/13/17 at 9:00 a.m., indicated the left heel measured 4 cm x 2 cm x 0.3 cm and was classified as an unstageable area. The left medial foot measured 2.5 cm x 2.5 cm x 0.2 cm and was classified as a stage 4. The wound center progress note, dated 12/13/17		rounds once daily for 30 days. The facility will implement weekly wound rounds with the IDT and assigned nursing staff. 2.The DNS/Designee will validate completion of treatments for all wounds x 7 days a week for 2 weeks, then daily for 5 days a week for 2 weeks, then 3 days a week for 2 weeks. Then the IDT will continue making weekly wound rounds with the assigned C.N.A. and licensed nurse as part of the resident at risk weekly meeting. 3.The weekly resident at risk meeting will validate completion of the weekly skin assessments, skid grids, care plan implementation, RD recommendations and assessments, weights, support surfaces and MD and RP notification when appropriate. 4.All residents with a pressure ulcer and residents identified on the Braden scale as High Risk (10-12) and Very High Risk (9 or below) will have a Turning and repositioning schedule documented on the MAR/TAR and on the C.N.A. Kardex. 5. The ED/DNS/designee will audit PCC dashboard for “Alerts”, 24hr progress notes, and new orders to monitor for change in condition to include notifications to MD, and resident responsible party daily five times a week in clinical meeting.	

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	at 9:00 a.m., indicated the left heel was an unstageable pressure injury, the base was soft black necrotic tissue, and the lateral aspect had an area open with surrounding ecchymosis. The area needed to be offloaded. The progress note, dated 12/19/17, indicated the resident had an appointment at the wound center and was directly admitted to the hospital from the wound center. The wound center progress note, dated 12/19/17 at 3:30 p.m., indicated the left heel measured 4.5 cm x 4.5 cm x 0.3 cm and was classified as an unstageable area. The left medial foot measured 2.5 cm x 2.5 cm x 0.2 cm and was classified as a stage 4. The December 2017 treatment administration record indicated the heel protectors to bilateral feet, wound treatment to the left heel, and left medial foot were discontinued on 12/2/17. The December 2017 MAR (medication administration record) indicated, between 12/9/17 and 12/11/17, to apply Santyl to the left heel topically every day shift, at which time the treatment was discontinued. The physician order, dated 12/11/17 at 11:25 a.m., indicated to apply Santyl to the left heel and left foot bony prominence (medial) topically every day shift for wound care. The December 2017 MAR lacked documentation of a wound treatment to the left heel on 12/3/17, 12/4/17, 12/5/17, 12/6/17, 12/7/17, 12/8/17, and 12/12/17, and to the left bony prominence (medial) between 12/3/17 - 12/12/17. There was also no documentation of weekly skin assessments.		6. Daily rounding by ED/DNS to monitor for abuse and neglect and initiate an investigation. These rounds will include observation and interviews with residents, staff, visitors and families. The facility will complete 5 random resident/family interviews weekly as an ongoing practice of the QAPI related to identifying concerns/grievances and abuse and neglect. 7.The IDT will have a Weekly resident risk meeting to include rounding with all residents that have a wound and assigned C.N.A. and nurse. 8. The DNS/Designee will validate completion of treatments for all wounds x7 days a week for 2 weeks. Validate completion of treatments for all wounds x5 days a week for 2 weeks. Validation completion of treatments for all wounds x3 days a week for 2 weeks. Continued weekly validation of treatment for all wounds. 9.The results of these observations will be reported, reviewed, or trended for compliance through the facilities' quality assurance performance improvement (QAPI) for a minimum of 6 months for further compliance 1.Systematic changes will be in place on or by 2/12/18.	

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The December 2017 shower sheets indicated there were no skin areas noted.

During an interview on 1/19/18 at 12:47 p.m., RN (Registered Nurse) 2 and LPN 3 indicated they did not have an answer as to why there were no wound measurements documented prior to 11/18/17 and thereafter, when the medial left foot wound was first identified; why it took so long to set up a wound evaluation at the wound care center; or why it took so long for a treatment to be started on the identified wounds.

The hospital history and physical, dated 12/20/17 at 12:18 p.m., indicated the following: "Plan of Care...Assessment...infected decubitus left heel/foot."

The hospital infectious disease consultation report, dated 12/20/17, indicated the resident was admitted due to a worsening left heel ulcer which was necrotic, very deep and had a foul odor.

The hospital operation report, dated 1/2/18, included, but was not limited to, the following: "Date of Procedure...1/2/18...Preoperative Diagnoses: Gangrene of the left foot...Postoperative Diagnoses...Gangrene of the left foot involving heel and lateral side of foot with contracture of knee...Procedure Performed...Above Knee Amputation..."

During an interview on 1/19/18 at 1:55 p.m., Resident B's primary care physician at the facility indicated he was unaware of the resident's wounds until he was admitted to the hospital on 12/19/17 and had the wounds been identified and properly treated, the resident likely would not have lost his leg and the clinical course would

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	have been different. On 1/19/18 at 10:10 a.m., the Unit Manager provided a copy of the document titled "Skin Care & Wound Management", dated 7/2016. It included, but was not limited to, the following: "Policy...The facility staff strives to prevent resident/patient skin impairment and to promote the healing of existing wounds...Treatment...1. Select and complete the appropriate form...a. Pressure Ulcer Documentation. Complete for all pressure ulcers...2. Review and select the appropriate treatment for the identified skin impairment...3. Obtain a physician's order...5. Document treatment on the Treatment Administration Record...6. Monitor and document progress...7. Evaluate effectiveness of interventions during the clinical meeting..." 2. The clinical record for Resident E was reviewed on 1/19/18 at 2:48 p.m. Diagnoses included, but were not limited to, dementia and anxiety. The care plan, dated 7/7/6 and revised on 1/19/18, indicated the resident had a pressure ulcer due to often sitting for extended periods of time, was admitted with a stage 2 pressure ulcer which was healed, and had reopened as a stage 3 pressure ulcer. The interventions, included but were not limited to, administer treatments as ordered, assess/record/monitor wound healing weekly, measure weekly, and weekly skin assessments. On 11/23/18 at 11:35 a.m. Resident E's wound was observed to be approximately 2.5 cm (centimeters) in length, 1.5 cm in width, and 0.1 cm in depth. The wound bed was white/yellowish in color. The September 2017 TAR (treatment administration record) indicated to cleanse the			

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	coccyx with wound cleanser, pat dry, apply Opti-foam treatment to the wound bed, and cover with a dry dressing every day shift. The TAR for September 2017 indicated the weekly skin assessments were discontinued on 9/18/17 and lacked documentation of a treatment completed on 9/1/17, 9/2/17, 9/4/17, 9/5/17, and 9/12/17. The October 2017 treatment administration record lacked documentation of weekly skin assessments. Review of the pressure grid sheets indicated the wound was assessed and measured on 8/23/17 and not again until 9/22/17, and on 10/11/17 and not again until 1/18/18. During an interview on 1/19/18 at 12:47 p.m., RN 2 indicated skin checks are completed weekly and nursing staff initial the treatment administration record when they are done. During an interview on 1/23/18 at 12:28 p.m., LPN 8 indicated once a treatment was completed, it was initialed by the nurse on the treatment administration record to verify it was completed. 3. The clinical record for Resident H was reviewed on 1/22/18 at 1:40 p.m. Diagnoses included, but were not limited to, dementia and depression. The annual MDS assessment, dated 1/2/18, indicated the resident had impaired cognition and required extensive two person physical assistance with bed mobility. On 1/23/18 at 11:13 a.m., Resident H's wound to the right gluteal fold was observed to be approximately 3 cm length by 3 cm width and 0.3			

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	cm depth. The wound bed a dark grayish/black color. The care plan, dated 3/27/17, indicated the resident had the potential for pressure ulcer development due to decreased mobility, sitting for extended periods of time, incontinence, and need for staff assistance with activities of daily living. The interventions included to administer treatments as ordered, remind/assist to turn/reposition at least every 2 hours, and weekly full body skin assessments. The Braden Scale for Predicting Pressure Sore Risk, dated 9/24/17, indicated the resident was chairfast and at a low risk for pressure ulcers. The Braden Scale for Predicting Pressure Sore Risk, dated 1/19/18, indicated the resident was chairfast, very limited mobility, problem with friction/shearing, and at a moderate risk for pressure ulcers. The December 2017 treatment administration record indicated a weekly skin assessment on 12/26/17 was not completed. The progress note, dated 1/2/18 at 11:44 a.m., indicated RN 10 was alerted, during report at start of shift, that Resident H had a spot on his right buttock, and, upon assessment, there was an area which measured 2.8 cm in length by 2.5 cm in width and 0.1 cm in depth. The physician order, dated 1/3/18, indicated to cleanse the right buttock with wound cleanser/normal saline, apply triple antibiotic ointment and cover with a dry dressing daily. The order was discontinued on 1/13/18.			

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	The progress note, dated 1/4/18 at 10:36 a.m., indicated the area did not appear to be pressure related and was an abrasion. The Nurse Practitioner note, dated 1/4/18, indicated the resident has had no changes per the nurse. The weekly skin check note, dated 1/10/18 at 5:10 a.m., indicated the resident had an abrasion to the right buttock due to diaper rubbing the right fold of the buttock. The December 2017 treatment administration record indicated a weekly skin assessment on 12/26/17 was not completed. The physician order, dated 1/13/18, indicated to cleanse the right buttock with wound cleanser/normal saline, apply betadine and cover with borderfoam every day shift. The skilled documentation note, dated 1/15/18 at 12:14 p.m., indicated the resident had a stage 2 to the right buttock. The care plan, dated 1/19/18, indicated the resident had a stage 3 pressure ulcer to the right buttocks The January 2018 treatment administration record lacked documentation of a skin assessment on 1/2/18 and wound treatments on 1/5/18, 1/8/18, 1/14/18, 1/15/18, and 1/16/18. The Immediate Jeopardy that began on 9/17/17 at 6:48 p.m. was removed on 1/23/18 at 12:02 p.m. when the facility completed staff education/inservices on daily wound monitoring, identifying skin impairment, pressure ulcer			

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	prevention, at risk residents, weekly skin assessments, pressure and non pressure skid grid documentation, and abuse and neglect. The Immediate Jeopardy was removed on 1/23/18, but noncompliance remained at the lower scope and severity of isolated, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy because not all staff had been educated on daily wound monitoring, identifying skin impairment, pressure ulcer prevention, at risk residents, weekly skin assessments, pressure and non pressure skid grid documentation, and abuse and neglect. This Federal tag relates to Complaint IN00251002 3.1-40			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed			

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	compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on interview and record review, the facility failed to ensure staff followed policy and procedure on controlled substance storage which resulted in missing narcotics. (Resident J, K, and L) Findings include: The clinical record for Resident J was reviewed on 1/22/18 at 4:01 p.m. Diagnosis included, but was not limited to, left hip fracture. The 90 day MDS (Minimum Data Set) assessment, dated 1/13/18, indicated intact cognition. The clinical record for Resident K was reviewed on 1/22/18 at 4:10 p.m. Diagnosis included, but was not limited to, osteoarthritis. The quarterly MDS assessment, dated 12/14/17, indicated intact cognition. The clinical record for Resident L was reviewed on 1/22/18 at 4:18 p.m. Diagnosis included, but was not limited to, osteoarthritis. The resident was admitted to the facility on 1/12/18. The incident report, dated 1/15/18 at 1:20 p.m., indicated staff reported one pack of missing narcotics and, after an audit was completed, there were 3 packs of narcotics missing. The pharmacy delivery receipt, dated 1/12/18 at 8:19 p.m. and signed by LPN (Licensed Practical	F 0761	**F 761 Label/Store Drugs and Biologicals** 1.The facility is committed to providing quality care for all of its residents, as well as substantial compliance with all regulatory requirements for a licensed certified skilled nursing facility. There were no adverse effects from the missing narcotics. Residents effected had a full pain assessment complete with no noted increased pain. Pain medications reordered immediately from Omnicare. 2.All other residents currently prescribed narcotics have the possibility of being effected. 100% narcotic audit completed on all other medication carts with no further concerns noted. 100% pain assessment completed on effected hall. No other residents effected. 3.To ensure this practice does not recur, the Facility initiated in-servicing with licensed nurses and QMAs. All Licensed nurses and QMAs will be educated on Policy Title 5.1 deliver and receipt of routine deliveries and Policy	02/12/2018

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	Nurse) 6 on 1/13/18 at 1:45 a.m., indicated the following was delivered: - Oxycodone - Acetaminophen (pain medication), 5/325 mg (milligrams), 30 tablets for Resident J. - Hydrocodone - Acetaminophen (pain medication), 5/325 mg, 30 tablets for Resident K. - Oxycodone (pain medication), 5 mg, 42 tablets for Resident L. During an interview on 1/22/18 at 2:50 p.m., the Administrator and Regional Nurse indicated LPN 6 told them she did sign for the narcotics but did not recall putting the medications away. After speaking with LPN 6 again, she indicated, after the delivery, staff called her to a resident room and she left the narcotics on the counter of the 400 hall nurses station. On 1/23/18 at 11:07 a.m., Medical Records provided a current copy of the document titled "Delivery and Receipt of Routine Deliveries", dated 1/1/2013. It included, but was not limited to, the following: "...Procedure...2. Upon delivery by Pharmacy, Facility nurse or other authorized designee on behalf of Facility should...Sign the delivery manifest...and take responsibility for the receipt, proper storage...3. After taking delivery, Facility should place medications in the appropriate location for use. Facility should...Immediately log controlled substances into Facility's controlled medication inventory system and should store such controlled substances in compliance with Applicable Law...." 3.1-25(m)		Title NS-1197-01-VA Chain of Custody for Controlled Substances. New licensed nurse and QMA hire will be educated in orientation. 4.The corrective action will be monitored by the DNS or designee by conducting random audits of 3 medication carts with narcotic drawers daily for 2 weeks. Thereafter, three medication carts with narcotic drawers a week for one month. Thereafter, three medication carts with narcotic drawers a month for 6 months. The results of these observations will be reported, reviewed, or trended for compliance through the facilities' quality assurance performance improvement (QAPI) for a minimum of 6 months for further compliance. 5.Systematic changes will be completed on or by 2/12/18.	
F 0849 SS=D	483.70(o)(1)-(4) Hospice Services			

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Bldg. 00	§483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice			

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	155488	A. BUILDING 00 B. WING	01/23/2018

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

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	provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the			

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	administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these			

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	services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing			

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	hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. Based on interview and record review, the facility failed to notify hospice prior to sending a resident (Resident C) to the hospital for 1 of 3 residents reviewed for hospice services. Findings include: The clinical record for Resident C was reviewed on 1/19/18 at 2:15 p.m. Diagnoses included, but were not limited to, dementia and heart disease. The physician orders indicated, on 10/18/16, the resident was admitted to hospice care. The end of life plan of care, dated 10/18/16, indicated to notify hospice of any changes. The progress note, dated 12/17/17 at 2:36 a.m., indicated the resident was vomiting up coffee ground material, LPN (Licensed Practical Nurse) 9 notified the Nurse Practitioner, and a new order was received to sent the resident to the hospital for evaluation. The progress note, dated 12/17/17 at 7:30 p.m., indicated a call was made to the hospital to check on the resident's status and the LPN 9 was told she was admitted at 4:11 a.m. The clinical record lacked documentation of hospice notification prior to sending the resident to the hospital.	F 0849	**F 849 Hospice Services** 1.The facility is committed to providing quality care for all of its residents, as well as substantial compliance with all regulatory requirements for a licensed certified skilled nursing facility. Hospice was notified of Resident C transfer to hospital. Care plan was held on 12/26/18 at 10am with hospice and responsible parties. Care plan review and updates made. Post form updated to reflect resident and responsible party wishes. 2.All other hospice residents have potential to be effected. On 1/21/18 all residents receiving hospice services received a 100% audit with care profile updated, orders update, and care plan updated 3.To ensure this practice does not recur, the facility initiated in-servicing with licensed nurses and QMAs. The facility provided education on proper notification of hospice before transfer to another care setting and change of condition. New licensed nurse and QMA hires will be educated in	02/12/2018

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	During an interview on 1/21/18 at 7:40 a.m., LPN 4 indicated prior to sending a hospice resident to the hospital, the hospice nurse was notified. During an interview on 1/22/18 at 1:45 p.m., Resident C's hospice nurse indicated he was unaware the resident was sent to the hospital until the following Monday (12/18/17) when he came in to see the resident on a routine visit. On 1/22/18 at 12:35 p.m., the Administer provided a copy of the document titled "Hospice-Nursing Facility Services Agreement". It included, but was not limited to, the following: "This Hospice Facility Services Agreement...is effective on the 1st day of January, 2015...by and between...[name of hospice service]...and...[facility name]...Agreements...In consideration of the Recitals and mutual agreements that follow, the parties agree to the following terms and conditions...Patient Transfer...Facility shall not transfer any Hospice Patient to another care setting without prior approval of Hospice..." This Federal tag relates to Complaint IN00249661		orientation. 4.The corrective action will be monitored by the DNS or designee by daily review of progress notes will be completed in morning meeting to validate notification of change has been made to hospice. The results of these observations will be reported, reviewed, or trended for compliance through the facilities' quality assurance performance improvement (QAPI) for a minimum of 6 months for further compliance. 5.Systematic changes will be completed on or by 2/12/18.	