STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155488	A. BUILDING _____ B. WING _____	**07/15/2020**

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure resident to resident (Resident E and Resident F) abuse did not occur and prevent a second encounter from occurring (Resident E and Resident G) for 2 of 3 residents reviewed for abuse. Findings include: 1. The clinical record for Resident E was reviewed on 7/15/20 at 1:10 p.m. [DIAGNOSES REDACTED]. The care plan for Resident E, dated 7/1/20, indicated the resident had the potential to demonstrate physical behaviors, such as hitting, and the potential to harm others. The nurse's note, dated 6/27/20 at 9:05 p.m., indicated the resident had no recollection of the altercation, the residents were separated, and Resident E was placed one on one. The nurse's note, dated 6/28/20 at 4:14 a.m., indicated Resident E was walking down the hallway and suddenly grabbed a chair in the hallway. It required 2 staff members to redirect the resident and he was agitated. The resident was redirected to sit on his bed and offered a snack. After the resident finished his snack, he pushed the table very hard towards a staff member. The social services note, dated 6/29/20 at 4:23 p.m., indicated the resident's behavior increased when overstimulated with noise. The social services note dated 6/29/20 at 5:21 p.m., indicated the resident was seen by the psychiatric nurse practitioner via video and discontinued the one on one. The social services note, dated 7/1/20 at 7:19 p.m., indicated the resident wandered intrusively and was triggered and reacted defensively to resident's negative reactions while in other resident rooms. The resident has a history of agitation and the potential to get very angry per his family. The nurse's note, dated 7/7/20 at 3:15 a.m., indicated Resident E entered another resident's room (Resident G) and hit the resident in the head with a shoe. Resident G attempted to get away and Resident E chased her and attempted to put his hands on her in a choking manner. Staff intervened and separated the residents. When staff attempted to remove Resident E from Resident G's room, Resident E began to throw himself into the wall, hitting his head on the wall and said the voices were telling him to hit women. Resident E was placed one on one. During an interview on 7/15/20 at 1:20 p.m., the Director of Nursing indicated she was not working at the facility when the first incident occurred. When the second incident occurred, she had staff send Resident E out for evaluation. During an interview on 7/15/20 at 3:19 p.m., the RDCO (Regional Director of Clinical Operations) indicated, per the psychiatric visit on 7/1/20, the resident was no a danger to self/others. 2. The incident report, dated 6/27/20, indicated Resident F approached the nurse's station and reported Resident E had struck him. The clinical record for Resident F was reviewed on 7/15/20 at 2:46 p.m. [DIAGNOSES REDACTED]. The nurse's note, dated 6/27/20 at 9:05 p.m., indicated Resident F approached the nurse's station and told LPN (Licensed Practical Nurse) 4 that his roommate (Resident E) was crazy and just hit him. Resident F had a small skin tear to the right outer forearm which was cleaned and a bandaid applied. Resident F and Resident E were separated. 3. The clinical record for Resident G was reviewed on 7/15/20 at 2:54 p.m. [DIAGNOSES REDACTED]. The incident report, dated 7/7/20, indicated Resident E entered Resident G's room and made contact with her head with a shoe. Resident G attempted to move away and Resident E followed her, attempting to put his hands on her neck. The nurse's note, dated 7/7/20 at 3:15 a.m., indicated Resident G was in bed when a male resident (Resident E) entered her room. Resident E hit her in the head with her shoe. Resident G attempted to get away from Resident E, chased Resident G out of her room, and attempted to put his hands on her in a choking manner. The residents were separated. On 7/14/20 at 12:40 p.m., the AIT (Administrator In Training) provided a current copy of the document titled INDIANA Abuse & Neglect & Misappropriation of Property dated 5/14/20. It included, but was not limited to, Policy .It is the policy of the facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of residents .It is the intent of this facility to prevent abuse This Federal tag relates to Complaint IN 122 3.1-27(a)(1)
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure staff followed a residents (Resident D) plan of care for hoyer lift transfers for 1 of 3 residents reviewed for Quality of Care. Findings include: The incident report, dated 7/7/20, indicated Resident D had requested a shower and was transferred to the shower chair. The resident began to slide out of the shower chair and was assisted to the floor. The clinical record for Resident D was reviewed on 7/14/20 at 2:24 p.m. [DIAGNOSES REDACTED]. The activities of daily living care plan, dated 5/9/17, indicated the resident required a hoyer lift, using 2 staff members, with transfers. The written statement, dated 7/7/20 and untimed, from LPN (Licensed Practical Nurse) 7, indicated staff went to assist the resident to the shower chair. Staff assisted the resident down to the floor and she landed on LPN 5's legs, at which time the staff assisted her into the shower chair. The hoyer lift was not used. During an interview on 7/14/20 at 3:46 p.m., the Director of Nursing indicated the one staff member had the resident under her arms while the other had her legs and transferred the resident to the shower chair. Staff did not follow the resident's care plan to use a hoyer lift with transfers. On 7/15/20 at 12:58 p.m., the AIT (Administrator In Training) provided a current copy of the document titled Plan of Care Overview, dated 7/26/18. It included, but was not limited to, Definitions: PoC: for the purpose of this policy the Plan of Care, also Care Plan is the written treatment provided for a resident that is resident-focused and provides for optimal personalized care .Policy .It is the policy of this facility to provide resident centered care .Safety is a primary concerns for our residents This Federal tag relates to Complaint IN 242 3.1-45(a)(2)

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.