| 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 _____ | **03/10/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| **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.

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| F 0550<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | **Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, record review and interview, the facility failed to maintain the resident's dignity related to dining, a personal toileting device and personal hygiene for 4 of 27 residents reviewed for dignity. (Residents 10, 19, 39, and 20) Findings include: 1. During an observation on 3/4/20 at 12:15 p.m., Resident 10 was observed in the dining room to be in her pajamas, her hair was uncombed and looked disheveled. The resident did not have any shoes or socks on. During an observation on 3/5/20 at 3:00 p.m., Resident 10 was observed to have the same clothes on as she did on 3/4/20. The resident's hair was not combed, and her appearance was disheveled. The clinical record was reviewed on 3/6/20 at 6:31 p.m. The resident's [DIAGNOSES REDACTED]. A care plan, dated 1/2/20 and revised on 1/8/20, indicated the resident had an ADL (Activities of Daily Living) self-care performance deficit related to confusion, dementia, medications that contribute to functional decline, and psychoactive medications. Interventions included, but were not limited to, all needs will be anticipated and met, will improve current level of function in bed mobility, transfers, eating, dressing, toilet use, personal hygiene, and required set up and supervision of staff participation to eat. The Admission MDS (Minimum Data Set) assessment, dated 1/7/20, indicated the resident's cognition was moderately intact. The resident required extensive assistance with one staff member's physical assistance with all ADLs including eating. 2. During an observation on 3/4/20 at 12:20 p.m., Resident 19 was observed sitting at the dining room table with one sock on and no shoes. The resident's lunch tray was delivered, and set up, but the staff did not push the resident up to the table. The resident could not reach the food, and was unable to eat. The staff continued to serve several lunch trays, and no one attempted to push the resident to the table. The resident tried several times during this 10 minute observation to reach her food, but was unable to do so. The clinical record was reviewed on 3/6/20 at 10:22 a.m. The resident's [DIAGNOSES REDACTED]. A care plan dated 6/1/18 and revised on 1/2/20, indicated the resident was at risk for nutritional decline related to; body weight below desired range, [DIAGNOSES REDACTED]. The interventions included, but were not limited to, the resident would consume adequate energy to minimize nutrition risk, would consume foods/fluids as desired. Monitor and evaluate meal percentage intake via meal intake records and observation, notify hospice with any changes, provide meals per physician diet orders, provide snacks between meals prn (as needed) as requested. Provide medical food supplement between and with meals. The Quarterly MDS assessment, dated 1/8/20, indicated the resident's cognition was severely impaired. The resident required extensive assistance with one staff member's physical assistance with all ADLs. Eating required limited assistance with one staff member's physical assistance. 3. During an observation on 3/4/20 at 12:20 p.m., Resident 20 was observed in the assisted dining room eating lunch (non-finger foods) with her fingers. Staff members passed the resident several times and did not assist the resident or offer silverware. During an observation on 3/9/20 at 8:29 a.m., Resident 20 was observed in the dining room eating breakfast with her fingers. Staff members passed the resident several times and did not assist the resident or offer silverware. The clinical record was reviewed on 3/9/20 at 9:38 a.m. The resident's [DIAGNOSES REDACTED]. A care plan dated 5/30/18 and revised on 10/23/19, indicated the resident was at risk for nutritional decline. The interventions included, but were not limited to, monitor and evaluate energy intake and food and beverage intake via meal intake records and observations. Allow the resident sufficient time to eat and provide feeding and dining assistance as needed. The resident was not care planned for finger foods. The Quarterly MDS assessment, dated 1/22/20, indicated the resident's cognition was severely impaired. The resident required extensive assistance of one staff member for eating. 4. During an observation on 3/9/20 at 8:29 a.m., Resident 39 was observed in the dining room eating breakfast oatmeal with her fingers. Staff passed the resident several times and did not assist the resident, or offer silverware. The clinical record was reviewed on 3/9/20 at 9:38 a.m. The resident's [DIAGNOSES REDACTED]. A care plan, dated 12/12/18 and revised on 10/23/19, indicated the resident was at risk for nutritional decline. The interventions included, but were not limited to, provide feeding and dining assistance as needed. The resident was not care planned for finger foods. The Quarterly MDS assessment, dated 2/04/20, indicated the resident's cognition was severely impaired. The resident required extensive assistance of one staff member for eating. During an interview on 3/10/20 at 9:46 a.m., LPN (Licensed Practical Nurse) 9 indicated to protect the resident's dignity, staff should have knocked on the resident's door before entering. Staff needed to dress the resident's properly in their own clothes with shoes or nonskid socks on. If a resident needed assistance with eating in the dining room, staff would set up the resident's tray and let them get started if they were able. After the trays were served to the residents, staff would sit down and provide assistance to the residents that needed assistance. During an interview on 3/10/20 at 10:20 a.m., CNA (Certified Nursing Aide) 5 indicated staff should knock on the resident's door before entering. In the dining room if a resident needed assistance, staff would set up the food tray, like open the milk and give the resident silverware. On 3/10/20 at 12:59 p.m., the Administrator provided a current copy of the document titled, Resident Rights, dated 5/1916 which included, but was not limited to, .A state of worthy of honor or respect; includes but not limited to speaking respectfully to resident, providing privacy for care and treatment, providing safe and secure housing, sanitary food and hydration, respecting resident choice and attending to needs in a timely fashion . 3.1-3(a) |
| F 0642<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | **Ensure a qualified health professional conducts resident assessments.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record review and interview, the facility failed to ensure accurate information was in the MDS (Minimum Data Set) assessments for 2 of 23 residents reviewed for MDS assessments. (Residents 72 and 29) Findings include: 1. The clinical record for Resident 72 was reviewed on 3/10/20 at 1:13 p.m. The annual MDS (minimum data set) assessment, dated 3/13/20, indicated the resident was not receiving hospice services. The resident's [DIAGNOSES REDACTED]. The physician's orders [REDACTED]. The care plan, dated 5/2/17, indicated the resident was receiving end of life and palliative care related to advancing dementia and physical decline. During an interview on 3/10/20 at 1:34 p.m., the MDS Coordinator indicated the resident had switched to hospice on 5/2/17. She had been on hospice for a very long time. The annual MDS should have indicated the resident was receiving hospice services. 2. During the review on 3/10/20 at 1:31 p.m., Resident 29's Admission MDS assessment, dated 1/31/20, indicated the resident had pneumonia, however was not receiving any antibiotics. The resident's [DIAGNOSES REDACTED]. The clinical record lacked documentation of the resident being treated for [REDACTED]. During an interview on 3/10/20 at 1:36 p.m., the MDS Coordinator indicated if the resident was not being treated for [REDACTED]. The resident was not getting antibiotics when she came to the facility. She had probably been treated at the hospital, but finished before she came to the facility. The pneumonia should not have been on the admission MDS assessment, because she did not have active pneumonia, just a history of pneumonia. The MDS Responsibilities policy, dated 11/1/12, last revised 11/15/19, provided on 3/10/20 at 3:00 p.m., by the DON (Director of Nursing), included, but was not limited |

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

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| F 0642<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | (continued... from page 1)<br>to, . Each individual who completes a portion of the assessment . must certify the accuracy of that portion . 3.1-31(i) |
| F 0684<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Provide appropriate treatment and care according to orders, resident's preferences and goals.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record review and interview, the facility failed to ensure daily weights were obtained per the physician's order for a resident with a [DIAGNOSES REDACTED]. (Resident 65) Findings include: The clinical record for Resident 65 was reviewed on 3/9/20 at 9:33 a.m. The resident's [DIAGNOSES REDACTED]. The care plan, dated 1/6/20, indicated the resident had [MEDICAL CONDITION]. Goals included the resident's body weight would remain within normal limits through the review date. The interventions included, but was not limited to, weight monitoring as ordered. The physician's order, dated 1/8/20, indicated to weigh the resident daily, every shift, related to heart failure. The Treatment Administration Records lacked documentation of weights being obtained on the following dates: January 10, 12, 15, 16, 23, 29, 30, and 31, 2020, and February 4, 5, 6, 12, 14, 16, 17, 18, 19, 20, 24, 25, 26, and 29, 2020. During an interview on 3/9/20 at 10:28 a.m., the DON (Director of Nursing) indicated he did not have any explanation for the missing weights. During a second interview on 3/10/20 at 2:55 p.m., the DON indicated he did not have a policy regarding the weights, but they should have been obtained per physician's order. 3.1-37(a) |
| F 0686<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Provide appropriate pressure ulcer care and prevent new ulcers from developing.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record review and interview, the facility failed to ensure treatments were completed as ordered for 1 of 4 residents reviewed for pressure ulcers. (Resident 65) Findings include: During the clinical record review on 3/6/20 at 2:08 p.m., Resident 65's [DIAGNOSES REDACTED]. The skin assessment, dated 1/29/20, indicated the resident had a community acquired stage III pressure ulcer to the left great toe. The wound measured 2.0 cm (centimeters) in length x (by) 1.0 cm in width x 0 cm in depth, which was first observed on 1/4/20. The skin assessment, dated 3/2/20, indicated the resident's pressure ulcer to the left great toe measured 0.3 cm in length x 0.3 cm in width x 0 cm in depth, which was first observed on 1/4/20. The care plan, dated 1/6/20, indicated the resident had a pressure ulcer to the left great toe. Interventions included, but were not limited to, monitor and document location, size and treatment of [REDACTED]. The TAR (Treatment Administration Record) lacked documentation of the treatment to the left great toe being completed on the following dates: January 10, 18, and 28, 2020, February 5, 10, 12, 14, 17, and 26, 2020, and March 6 and 7, 2020. The clinical record lacked documentation of any reason why the wound treatments were not completed, or documented as completed on these dates. During an interview on 3/10/20 at 11:07 a.m., the DON (Director of Nursing) indicated the treatments should have been documented on the administration record and there was no reason why they were not documented. During an interview on 3/10/20 at 2:19 p.m., Unit Manager 4 indicated the resident had chronic wounds on his toes and the nurses were supposed to complete the treatments every day. The treatments should have been signed off every day. During an interview on 3/10/20 at 2:55 p.m., the DON indicated he did not have a policy regarding the treatments, however he expected them to be completed per physician's orders [REDACTED]. |
| F 0698<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Past noncompliance - remedy proposed**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observations and record review, the facility failed to ensure [MEDICAL TREATMENT] site monitoring and assessments were completed for 1 of 2 residents reviewed for [MEDICAL TREATMENT]. (Resident 65) Findings include: The clinical record for Resident 65 was reviewed on 3/9/20 at 9:33 a.m. The resident's [DIAGNOSES REDACTED]. The care plan, dated 1/6/20, indicated the resident had [MEDICAL CONDITION] related to [MEDICAL CONDITION] with routine [MEDICAL TREATMENT]. The interventions included, but were not limited to, monitor and report changes in mental status, signs of hypovolemia, lab reports and electrolytes, [MEDICAL CONDITION], weight changes, and signs of [MEDICAL CONDITION]. The care plan did not address monitoring of the [MEDICAL TREATMENT] site. The physician's orders [REDACTED]. The review of the TAR (Treatment Administration Record) lacked documentation of the monitoring of the site being completed on 2/26/20. The clinical record lacked documentation of any routine monitoring of the [MEDICAL TREATMENT] prior to 2/7/20. The [MEDICAL TREATMENT] Treatment report, dated 3/5/20, indicated the resident received [MEDICAL TREATMENT] treatments on the following dates. January 14, 16, 18, 21, 23, 25, 28, and 30, 2020, February 1, 4, 6, 8, 11, 13, 15, 18, 20, 22, 25, 27, and 29, 2020, and March 3, 2020. The clinical record lacked documentation of pre-[MEDICAL TREATMENT] assessments on the following dates: January 16, 18, 21, 23, 25, and 30, 2020, February 1, 4, 6, 8, 13, 15, 18, 20, 22, 27, and 29, 2020, and March 3, 2020. The clinical record lacked documentation of any post [MEDICAL TREATMENT] assessments. During an interview on 3/9/20 at 10:28 a.m., the DON (Director of Nursing) indicated the resident was on [MEDICAL TREATMENT] during his entire stay at the facility. Staff were supposed to do a pre and post [MEDICAL TREATMENT] assessment on every [MEDICAL TREATMENT] day, which included an assessment of the [MEDICAL TREATMENT]. He did not see any monitoring of the site in January and did not see any additional pre and post [MEDICAL TREATMENT] assessments. The [MEDICAL TREATMENT] Care and Monitoring policy, dated 11/1/13, last revised 3/23/18, provided on 3/10/20 at 3:00 p.m., by the DON, included, but was not limited to, . VII. General VAD (venous access device) care and Precautions a. Monitor for infection i. Pain, swelling, tenderness or redness around access area ii. Fever b. Thrill: normal sensation felt at site . c. Bruit: normal sensation heard with stethoscope as swishing sound at site . iii. Check pulses in access limb . e. Bleeding . VIII. Pre-[MEDICAL TREATMENT] a. Evaluation completed within four (4) hours of transportation to [MEDICAL TREATMENT] to include but not limited to . Accurate weight . Blood Pressure, Pulse, Respirations and Temperature . Medications administered or medication(s) withheld prior to [MEDICAL TREATMENT] . Provide meal or snack prior to leaving facility . Send copy of nursing evaluation . Include MAR (medication administration record) . Emergency contact and facility contact information . IX. Post-[MEDICAL TREATMENT] . b. Nurse to complete the post-[MEDICAL TREATMENT] evaluation upon return from [MEDICAL TREATMENT] center to include but not limited to: i. Thrill absence or presence ii. Bruit absence or presence iii. Pulse in access limb . iv. Blood pressure, pulse, respirations and temperature . v. visual inspection of site for bleeding, swelling, or other abnormalities . vi. any abnormal or unusual occurrence resident reports while at [MEDICAL TREATMENT] center . 3.1-37(a) |
| F 0759<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Ensure medication error rates are not 5 percent or greater.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, record review, and interview, the facility failed to ensure the accurate dose and timely administration of medication for 2 of 38 residents during medication administration. (Residents 63 and 98) Findings include: 1. During a medication administration observation, on 3/6/20 at 8:18 a.m., LPN (Licensed Practical Nurse) 6 dispensed one tablet of [MEDICATION NAME] 25 mg (milligrams) into a cup for Resident 63. She then proceeded to the resident's room to administer the medication. During the clinical record review on 3/6/20 at 10:00 a.m., the physician's orders [REDACTED]. During an interview on 3/06/20 at 8:29 a.m., LPN 6 indicated, after reviewing the MAR (medication administration record) the resident was supposed to receive two tablets of [MEDICATION NAME] and she had only pulled one. 2. During a medication administration observation, on 3/10/20 at 10:28 a.m., QMA (Qualified Medication Aide) 8 administered one tablet each of [MEDICATION NAME] 1 mg, [MEDICATION NAME] 1 mg, topiragen 100 mg, and [MEDICATION NAME] 5 mg to Resident 98. The medications were scheduled to be given at 8:00 a.m. and highlighted on the e-mar (electronic medication administration record) as late. During the clinical record review, on 3/10/20 at 11:15 a.m., the physician's orders [REDACTED]. During an interview on 3/10/20 at 10:36 a.m., QMA 8 indicated there was no particular reason for why she was running behind on medication administrations. It did happen pretty regularly, the hall she was on had a lot of residents whom received multiple prescriptions. During an interview on 3/10/20 at 10:55 a.m., the DON (Director of Nursing) indicated medications should be given within the range of one hour before or after the administration time, and nurses should utilize the five rights of administration, which included checking the order with the label to administer the dose that was on the resident's MAR. The review of the current Medication Administration policy last reviewed on 12/14/17 and provided by the DON on 3/10/20 at 3:00 p.m., included, but was not limited to, .a. Administer medication only as prescribed by the provider .f. Observed the 'five rights' in giving each medication .ii. the right time .iv. the right dose .ff. Medications will be administered within the time frame of one hour before up to one hour after time ordered . 3.1-48(c)(1) |

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| F 0849<br><br>**Level of harm -** Actual harm<br><br>**Residents Affected -** Few | **Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.** |

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| F 0849<br><br>**Level of harm -** Actual harm<br><br>**Residents Affected -** Few | (continued... from page 2)<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record review and interview, the facility failed to ensure comfort medication orders were obtained in a timely manner for a hospice patient who was displaying signs of anxiety and pain for 1 of 5 residents reviewed for hospice services. (Resident 107) Findings include: The clinical record for Resident 107 was reviewed on 3/9/20 at 1:10 p.m. The resident's [DIAGNOSES REDACTED]. The care plan, dated 12/16/19, indicated the resident was on palliative and end of life care due to a [DIAGNOSES REDACTED]. The goal included, the resident would be cared for with respect and dignity and would be comfortable during end of life process. The Social Services note, dated 12/11/19 at 8:27 a.m., indicated the resident signed a Do Not Resuscitate (DNR) and wished to be on hospice services. The nurse's note, dated 12/16/19 at 3:29 p.m., indicated the resident was complaining of pain, 7 out of 10, involving her bilateral lower extremities and back. She was having difficulty sleeping at night and performing her normal every day activities. The nurse reminded the resident she had PRN (as needed) Tylenol and the resident indicated the Tylenol did not help her pain. A look back over the past 7 days indicated the resident had not taken any Tylenol. The DON (Director of Nursing) was made aware. The clinical record lacked documentation of any notification to the physician at that time of the resident's pain or the lack of pain relief from the Tylenol. The nurse's note, dated 12/16/2019 at 3:57 p.m., indicated hospice had given new orders to discontinue some of the resident's medications. No new orders were given for pain or anxiety medications. A nurse's note, dated 12/18/19 at 11:38 p.m., indicated the resident was very restless and was twitching from side to side in the bed. The hospice nurse indicated she would try to get orders for medications to address pain and anxiety. No medications were ordered at that time. A nurse's note, dated 12/19/19 at 1:10 a.m., indicated the resident was thrashing and continued to be very restless. The hospice nurse was notified and said she would come in to visit the resident. No new orders were given at that time. A nurse's note, dated 12/19/19 at 3:19 a.m., indicated the hospice nurse had left messages for the hospice physician, however no return call had been received. No new prescriptions had been received. A nurse's note, dated 12/19/2019 at 3:44 a.m., indicated the hospice nurse had left the facility and would call when she received new orders from the physician. A nurse's note, dated 12/19/19 at 12:30 p.m., indicated the resident's family members were present and requested medications for the resident's pain and anxiety for the resident's comfort. No new orders were written at that time. The MAR (medication administration record) indicated the resident did not receive a dose of [MEDICATION NAME] sulfate 100 mg/5 mL (milligrams per milliliter) until 12/19/19 at 2:04 p.m. A nurse's note, dated 12/19/19 at 3:30 p.m., indicated hospice was in the facility and had written orders for [MEDICATION NAME] 0.25 mL (milliliters) every two hours as needed for shortness of breath or pain, and Tylenol 650 mg (milligrams) rectal suppository every four hours as needed for fever or pain. No orders to address anxiety were written at that time. A nurse's note, dated 12/20/19 at 5:49 a.m., indicated the resident had been placed on concentrated [MEDICATION NAME] every four hours as needed for anxiety or shortness of breath. The pharmacy had been contacted several times, but could not provide the authorization codes to pull the medication. The pharmacy would send the medication after 7:00 a.m. The MAR indicated [REDACTED]. She had not initially been given any pain medication or anxiety medication due to her history of [MEDICAL CONDITION], however once she went on hospice, due to the restlessness she would have needed medications to address pain and anxiety. During an interview on 3/9/20 at 11:27 a.m., The hospice RN indicated the resident's order for pain and anxiety medications should have been written upon admission to hospice. The hospice physicians were available 24 hours a day, 7 days a week, and normally responded quickly. During an interview on 3/9/20 at 1:56 p.m., the DON (Director of Nursing) indicated the resident was observed with pain and restlessness on 12/16/19, when she went onto hospice and said her Tylenol did not work. He did not know why it took so long to get pain and anxiety medications for the resident. During an interview on 3/10/20 at 2:55 p.m., the DON indicated he did not have a policy regarding hospice services. |
| F 0867<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | **Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.**<br><br>Based on record review and interview, the facility failed to identify an unresolved quality deficiencies involving hospice, pressure ulcers, and medication administration. These deficiencies had the potential to affect 112 current residents residing in the facility. Findings include: The current facility QAPI (Quality Assurance Performance Improvement) Plan with a most recent revision date of May 30, 2019, was provided by the Administrator on 3/5/20. The policy indicated, .QAPI is data-driven. QAPI is a proactive approach to improving quality of life, care and services. The activities of QAPI involve members at all levels of the organization to: identify opportunities for improvement, address gaps in systems or processes; develop and implement an improvement or corrective plan; and continuously monitor effectiveness of interventions . The facility's Quality Assurance Committee did not identify, develop, and implement appropriate measures to correct identified issues or prevent the deficiency as follows: Pressure Ulcers: Based on record review and interview, the facility failed to ensure treatments were completed as ordered for 1 of 4 residents reviewed for pressure ulcers. (Resident 65) Cross Reference F686 During an interview with the Executive Director on 3/10/20 at 2:20 p.m., she indicated the Unit Managers documented weekly assessments for pressure ulcers. The Unit Manager had not been checking it daily. Hospice: Based on record review and interview, the facility failed to ensure comfort medications orders were obtained in a timely manner for a hospice patient who was displaying signs of anxiety and pain for 1 of 5 residents reviewed for hospice services. (Resident 107) Cross Reference F849 During an interview on 3/10/20 at 2:25 p.m., the DON (Director of Nursing) indicated he didn't think they had done anything differently with hospice since the last annual survey. They had used only one company last year and now they let the residents choose their hospice company. Last year the nurses had to exit with us and we asked for any changes which needed to be communicated. They didn't have exit conferences with the hospice staff, they would just come and go and they didn't know they were at the facility. Medication Administration Based on observation, record review, and interview, the facility failed to ensure accurate dose and timely administration for 2 of 38 residents during medication administration. (Residents 63 and 98) Cross Reference F759 During an interview on 3/10/20 at 2:28 p.m., the DON indicated they had monitored documentation for narcotics, but had not performed skills check offs for following orders on the Medication Administration Records. 3.1-52(b)(2) |
| F 0880<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Many | **Provide and implement an infection prevention and control program.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, record review, and interview, the facility failed to follow appropriate infection control guidelines related to perineal care for 1 of 2 resident observed for perineal care, and ensure complete and accurate monthly infection monitoring logs were maintained for 12 of 12 months reviewed. This deficient practice had the potential to affect all 112 residents currently residing in the facility. (Resident 96) Findings include: 1. During an observation of perineal care for Resident 96, on 3/9/20 at 2:45 p.m., CNA 3 (Certified Nursing Aide) removed the resident's soiled brief. CNA 3 used a warm wash cloth with cleanser, and proceeded to wash the resident's perineal area. CNA 3 cleansed the left groin, pubic area, and labia, using 5 to 7 swipes and did not fold the wash cloth or use a different clean wash cloth. CNA 3 used another wash cloth, and rinsed in the same manner. She patted the area dry. While cleaning the rectal area, CNA 3 cleansed the rectum using 1 to 2 swipes at a time, before folding the cloth. CNA 3 rinsed in the same manner and patted dry. The clinical record was reviewed on 3/9/20 at 3:00 p.m. The resident's [DIAGNOSES REDACTED]. The Quarterly MDS (Minimum Data Set) assessment, dated 2/7/20, indicated the resident was rarely or never understood. Resident 96 required extensive assistance with 1 to 2 staff members assistance for all ADLs (Activities of Daily Living). During an interview on 3/10/20 at 1:50 p.m., CNA 5 indicated staff used 1 wet wipe and 1 swipe at a time when doing incontinent care. On 3/5/20 at 11:45 a.m., the Executive Director provided a current copy of the document titled, Perineal Care Male and Female, dated 4/20/17 which included, but was not limited to, .4. Apply soap to cloth layers directly . 6. Wring out first cloth and apply soap to first wash cloth in layers, if fold method is used . C.ii Wipe down each side of the urethral opening, turning the wipe to a clean area continuing to wipe down the other side, turn wipe to clean area then clean down the middle of the urethral opening . 2. During a review of the Infection Control/Antibiotic Stewardship binder on 3/4/20 at 9:29 a.m., the following concerns were identified: The month of July 2019 lacked documentation of any infection in the facility, including infection control logs, or infection surveillance of any kind. The months of April 2019 through March 2020 of the antibiotic stewardship log lacked documentation of the monitoring for signs and symptoms of infection, type of isolation and the duration of isolation, and radiology reports. During an interview on 3/10/20 at 3:31 p.m., the Infection Preventionist |

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|---|---|---|---|
| | **155488** | A. BUILDING _____ B. WING _____ | **03/10/2020** |

| 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 0880<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Many | (continued... from page 3)<br>indicated they started an infection symptom monitoring program, but it had not been implemented yet. Signs and symptoms were not monitored in the infection control log. She was not aware isolation and X-ray results needed to be specific on the infection control log. On 3/5/20 at 11:45 a.m., the Executive Director provided a current copy of the document titled, Infection Preventionist included, but was not limited to, .Performs on-going monitoring of healthcare associated infections . 3.1-18(a) 3.1-18(b)(1)(A) |
| F 0881<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | **Implement a program that monitors antibiotic use.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record review and interview, the facility failed to ensure the antibiotic stewardship policy and procedure was followed related to ongoing antibiotic stewardship monitoring for 1 of 12 months reviewed. This deficient practice had the potential to affect 112 residents currently residing in the facility. Findings include: During a review of the Infection Control/Antibiotic Stewardship binder on 3/4/20 at 9:29 a.m., the following concerns were identified: The month of July 2019 lacked documentation of any monthly antibiotic report for residents prescribed antibiotics, duration or indication for antibiotic use, or criteria for antibiotic use. During an interview on 3/10/20 at 3:39 p.m., the Executive Director indicated the former SDC (Staff Development Coordinator) left the facility in July and a new SCD took over in August. They missed a month in between there. On 3/5/20 at 11:45 a.m., the Executive Director provided a current copy of the document titled, Antibiotic Stewardship which included, but was not limited to, .The aim of this antibiotic stewardship program is to optimize the treatment of [REDACTED].The facility will provide surveillance, tracking, trending and reporting to the leadership team to optimize the use of antibiotics in this facility . |