STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155488	A. Building B. Wing	01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 34231 Based on observation, interview and record review, the facility failed to ensure Indwelling catheter care orders were implemented for 1 of 3 residents reviewed for Indwelling catheters. (Resident M) Findings include: On 1/28/25 at 11:29 a.m., the resident was observed sitting in a chair in her room with an Indwelling catheter in place. The clinical record for Resident M was reviewed on 1/28/25 at 11:04 a.m. The resident's diagnosis included, but was not limited to, stage 4 sacral pressure ulcer (wound that extends through all layers of the skin, reaching the underlying muscle, tendon or bone). The care plan, dated 1/13/25, indicated the resident had an Indwelling catheter and to provide catheter care every shift. The clinical record lacked documentation of any Indwelling catheter care for Resident M. During an interview on 1/28/25 at 9:55 a.m., Staff Member 11 indicated Indwelling catheter care orders should be implemented upon admission. On 1/28/25 at 2:44 p.m., the Regional Director of Clinical Operations provided a current, undated copy of the document titled Catheter Care. It included, but was not limited to, Policy .It is the policy of this facility to provide resident centered care .Catheter care is performed twice daily on residents that have indwelling catheters, for as long as the catheter is in place 3.1-41(a)(2)

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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 34231 Based on observation, interview and record review, the facility failed to ensure narcotic medications were not signed out prior to administration times for 7 of 11 residents reviewed for medication storage. (Resident E, Resident M, Resident N, Resident R, Resident S, Resident T and Resident U) Findings include: On 1/27/25 at 11:24 a.m., during an observation of the 400 hall controlled drug administration records with LPN (Licensed Practical Nurse) 6, the following narcotic medications had been signed out but not administered: -Resident E - Hydrocodone-APAP 5-325 mg (milligrams) signed out on 1/27/25 at 1:00 p.m. -Resident M - Oxycodone IR 5 mg (2 tabs to equal 10 mg) signed out on 1/27/25 at 2:00 p.m. -Resident N - Oxycodone IR 10 mg signed out on 1/27/25 at 2:00 p.m. -Resident R - Oxycodone IR 10 mg signed out on 1/27/25 at 1:00 p.m. -Resident S - Hydrocodone-APAP 5-325 mg signed out on 1/27/25 at 1:00 p.m. -Resident T - Oxycodone-APAP 5-325 mg signed out on 1/27/25 at 1:00 p.m. -Resident U - Hydrocodone-APAP 10-325 mg signed out on 1/27/25 at 1:00 p.m. During an interview on 1/27/25 at 11:24 p.m., LPN 6 indicated she had already signed out her 1:00 p.m. and 2:00 p.m. medications but had not given them yet. She was aware that she should not sign the medications out ahead of time. 1. The clinical record for Resident E was reviewed on 1/27/25 at 12:09 p.m. The diagnoses included, but were not limited to, major depressive disorder, right above the knee amputation and left hand contracture. The physician's order, dated 1/7/25, indicated the resident was to receive Hydrocodone-Acetaminophen 5-325 mg three times a day for pain. During an interview on 1/28/25 at 9:55 a.m., Staff Member 11 indicated the controlled drug administration record should be signed when pulled from the card to administer. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/28/25 at 12:30 p.m., the Regional Director of Clinical Operations provided a current, undated copy of the document titled Chain of Custody for Controlled Substances. It included, but was not limited to, Policy .It is the policy of this facility to provide resident centered care .Safety of residents .is a top priority .Nurses will sign both the MAR (medication administration record) and the Drug Count sheet when administering a controlled substance to a resident On 1/28/25 at 12:30 p.m., the Regional Director of Clinical Operations provided a current, undated copy of the document titled Medication Administration. It included, but was not limited to, MAR: Medication Administration Record - the legal documentation for medication administration .Policy .It is the policy of this facility to provide resident centered care .Procedure .Narcotic will be signed out when given 2. The clinical record for Resident M was reviewed on 1/28/25 at 11:04 a.m. The diagnosis included, but was not limited to, stage 4 sacral pressure ulcer (wound that extends through all layers of the skin, reaching the underlying muscle, tendon or bone). The physician's order, dated 1/14/25 indicated the resident was to receive Oxycodone HCl 10 mg every 4 hours as needed for pain. 3. The clinical record for Resident N was reviewed on 1/28/25 at 11:24 a.m. The diagnoses included, but were not limited to, diabetes with neuropathy and rheumatoid arthritis. The physician's order, dated 1/22/25, indicated the resident was to receive Oxycodone HCl 10 mg every 8 hours as needed for pain. 4. The clinical record for Resident R was reviewed on 1/28/25 at 2:01 p.m. The diagnoses included, but were not limited to, malignant neoplasm of the laryngeal cartilage and recurrent depressive disorder. The physician's order, dated 1/2/25, indicated the resident was to receive Oxycodone HCl 10 mg three times a day for pain. 5. The clinical record for Resident S was reviewed on 1/28/25 at 1:40 p.m. The diagnosis included, but was not limited to, depression. The physician's order, dated 1/15/25, indicated the resident was to receive Hydrocodone-Acetaminophen 5-325 mg three times a day for pain. 6. The clinical record for Resident T was reviewed on 1/28/25 at 2:10 p.m. The diagnoses included, but were not limited to, depression, anxiety and congestive heart failure. The physician's order, dated 12/30/24, indicated the resident was to receive Oxycodone-Acetaminophen 7. 5-325 mg three times a day for pain. 7. The clinical record for Resident U was reviewed on 1/28/25 at 2:17 p.m. The diagnoses included, but were not limited to, peripheral vascular disease, diabetes and depression. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The physician's order, dated 1/1/25, indicated the resident was to receive Hydrocodone-Acetaminophen 10-325 mg three times a day for pain. This Citation relates to Complaint IN00450462 3.1-25(a)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 34231 Based on interview and record review, the facility failed to ensure medication administration records reflected the administration of narcotic medications for 4 of 11 residents reviewed for medical records. (Resident M, Resident N, Resident O and Resident V) Findings include: 1. The clinical record for Resident M was reviewed on 1/28/25 at 11:04 a.m. The diagnosis included, but was not limited to, stage 4 sacral pressure ulcer (wound that extends through all layers of the skin, reaching the underlying muscle, tendon or bone). The physician's order, dated 1/14/25, indicated the resident was to receive Oxycodone (narcotic pain medication) HCl (hydrochloride) 10 mg (milligrams) every 4 hours as needed for pain. The January 2025 controlled drug administration record indicated the resident received the medication on the following dates and times: - 1/20/25 at 6:00 a.m., 10:00 a.m. and 2:00 p.m. - 1/21/25 at 6:00 a.m., 10:00 a.m., 2:00 p.m. and 8:00 p.m. - 1/22/25 at 6:00 a.m., 10:00 a.m., 3:00 p.m. and 8:00 p.m. - 1/23/25 at 1:00 a.m., 6:00 a.m., 10:00 a.m. and 2:00 p.m. - 1/24/25 at 8:00 a.m. and 5:00 p.m. The January 2025 medication administration record (MAR) lacked documentation of the administration of the medication. During an interview on 1/28/25 at 9:55 a.m., Staff Member 11 indicated when as needed medications are administered, the MAR should be signed to show the medication was administered. 2. The clinical record Resident N was reviewed on 1/28/25 at 11:24 a.m. The diagnoses included, but were not limited to, diabetes with neuropathy, osteoarthritis and rheumatoid arthritis. The physician's order, dated 1/22/25, indicated the resident was to receive Oxycodone HCl 10 mg every 8 hours as needed for pain. The January 2025 controlled drug administration record indicated the resident received the medication on the following dates and times: - 1/22/25 at 9:00 p.m. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 1/23/25 at 6:00 a.m. and 2:00 p.m. - 1/25/25 at 8:00 a.m. The January 2025 MAR lacked documentation of the administration of the medication. 3. The clinical record for Resident O was reviewed on 1/28/25 at 11:44 a.m. The diagnosis included, but was not limited to, depression. The physician's order, dated 1/20/25, indicated the resident was to receive Morphine Sulfate (narcotic pain medication) 0.25 ml (milliliters) every 4 hours as needed for pain or shortness of air. The January 2025 controlled drug administration record indicated the resident received the medication on the following dates and times: - 1/22/25 at 8:45 a.m. and 12:45 p.m. - 1/23/25 at 6:00 a.m., 11:00 a.m. and 3:00 p.m. - 1/26/25 at 12:00 p.m. The January 2025 MAR lacked documentation of the administration of the medication. 4. The clinical record for Resident V was reviewed on 1/28/25 at 2:28 p.m. The diagnoses included, but were not limited to, left femur fracture, diabetes and depression. The physician's order, dated 12/19/24, indicated the resident was to receive Norco (narcotic pain medication) 7.5-325 mg every 6 hours as needed for pain. The January 2025 controlled drug administration record indicated the resident received the medication on the following dates and times: - 1/20/25 at 7:00 a.m., 1:00 p.m. and 8:00 p.m. - 1/21/25 at 7:00 a.m., 1:00 p.m. and 8:00 p.m. - 1/22/25 at 7:00 a.m., 1:00 p.m. and 8:00 p.m. - 1/23/25 at 7:00 a.m., 1:00 p.m. and 8:00 p.m. - 1/26/25 at 5:00 p.m. The January 2025 MAR lacked documentation of the administration of the medication. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/28/25 at 12:30 p.m., the Regional Director of Clinical Operations provided a current, undated copy of the document titled Medication Administration. It included, but was not limited to, MAR: Medication Administration Record - the legal documentation for medication administration .Policy .It is the policy of this facility to provide resident centered care .Procedure .Medications will be charted when given This Citation relates to Complaint IN00450462 3.1-50(a)(2)