STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155551	A. Building B. Wing	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rolling Meadows Health Care Center	604 Rennaker St LA Fontaine, IN 46940

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45122 Based on record review and interview, the facility failed to ensure a Preadmission Screening and Resident Review (PASRR) was submitted for a resident with a newly diagnosed mental health condition requiring psychotropic medication for 2 of 3 residents reviewed for PASRR (Resident 76 and 90). Findings include: 1. Resident 76's clinical record was reviewed on 10/28/24 at 10:41 a.m. Diagnoses included unspecified dementia, severe, with anxiety (9/9/23), major depressive disorder (9/9/23), generalized anxiety disorder (9/9/23), and psychotic disorder with delusions due to known physiological condition (9/15/23). Current orders included olanzapine (antipsychotic) 2.5 milligrams (mg) daily (started 9/17/24), risperidone (antipsychotic) 1 mg twice a day (started 7/26/24), clonazepam (antianxiety)1 mg daily (started 8/14/24), and fluoxetine (antidepressant) 20 mg daily (started 7/27/24). An annual Minimum Data Set (MDS) assessment, completed 9/12/24, indicated the resident's diagnoses included depression, anxiety, and psychotic disorder. The resident's medications included an antipsychotic and antidepressant. The resident received the antipsychotic on a routine basis. A current care plan for behavioral symptoms such as throwing things, pacing, slapping, cursing, repetitive verbalization, spitting, rummaging, yelling/screaming, having delusions and hallucinations, and having an anxiety disorder and a cognitive deficit was initiated on 9/12/23 and last revised on 5/10/24. Interventions included the following: When the resident's behavior disrupts a social setting, remove her if she is not able to be redirected (initiated 9/12/23). The resident has delusions that cause her distress. She needs reassurance, validation, and understanding from the staff (initiated 8/9/24). Do not argue or confront the resident regarding her behavior (initiated 10/11/24). A progress note, dated 7/12/24 at 11:46 a.m., indicated the resident had increased confusion and new or worsened delusions or hallucinations. The resident became physically violent with staff and spit on staff when staff attempted to redirect her from other residents' rooms. The provider was notified. A new order was received to send the resident to the emergency room for evaluation and then to a behavioral facility from the emergency room if appropriate. (continued on next page)

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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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note, dated 7/26/24 at 3:40 p.m., indicated the resident returned from her stay at a psychiatric facility. Resident 76's current PASRR, dated 9/9/23, provided by the Assistant Director of Nursing (ADON) on 10/28/24 at 9:25 a.m., indicated the resident's current suspected or diagnosed mental health conditions included anxiety disorder and depression/depressive disorder. Psychotic disorder was not listed. The behavior and symptoms section of the PASRR indicated there were no known mental health behaviors which affected interpersonal interactions. There were no known recent or current mental health symptoms. Bupropion (antianxiety) 300 mg daily was listed under mental health medications and lacked listing other psychotropic medications. 2. Resident 90's clinical record was reviewed on 10/28/24 at 9:56 a.m. Diagnoses included unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (4/1/24), anxiety disorder (4/1/24), delusional disorders (4/1/24), and major depressive disorder, recurrent, moderate (4/1/24). Current orders included escitalopram (antidepressant) 20 mg daily (started 9/17/24), risperidone (antipsychotic) 0.25 mg daily (from 4/2/24 through 8/13/24), and risperidone 0.25 mg every other day (from 8/14/24 through 8/28/24). A quarterly MDS assessment, completed 8/2/24, indicated the resident's diagnoses included anxiety disorder, depression, and psychotic disorder. The resident's medications included an antipsychotic, antianxiety, and antidepressant. The antipsychotic was received on a routine basis. A care plan for behavioral symptoms such as false beliefs, seeing and hearing things that are not there, repetitive verbalization/questions, hitting/kicking, slapping, grabbing, throwing, yell/scream, cursing, rummaging, and having an anxiety disorder, a cognitive deficit, delusions, hallucinations, and major depression was initiated on 4/22/24 and revised on 8/9/24. Interventions included the following: The resident has hallucinations that cause her distress. She needs reassurance, validation, and understanding from the staff (initiated 4/22/24). The staff should participate in the resident's reality when indicated (initiated 4/22/24). If the resident is agitated, the staff is to not begin care, give her space, and return later initiated (10/11/24). Resident 90's current PASRR, dated 3/12/24, provided by the Assistant Director of Nursing (ADON) on 10/28/24 at 9:25 a.m., indicated the resident's current suspected or diagnosed mental health conditions included anxiety disorder, depression/depressive disorder, and major depressive disorder, recurrent, moderate. Psychotic disorder was not listed. The behavior and symptoms section of the PASRR indicated there were no known mental health behaviors which affected interpersonal interactions. There were no known recent or current mental health symptoms. Buspirone (antianxiety) 5 mg daily and escitalopram (antidepressant) 20 mg daily were listed under mental health medications and lacked listing of other psychotropic medications. During an interview, on 10/29/24 at 9:36 a.m., the Social Services Director indicated she would submit a new PASRR when a resident had a new psychotropic medication or psychiatric diagnoses or if dementia was added. She indicated she had submitted several new applications for PASRR when a new medication was added, and the application was rejected saying it was not necessary. She had not submitted a new PASRR application for Resident 76 nor 90 because both had significant dementia. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to Indiana PASRR FAQs for providers [frequently asked questions], revised 2022, accessed on 10/31/24 at 11:48 a.m. at maximusclincalservices.com, .If a significant change in mental health status has occurred since the last approval, a new Level I screening is required When is Status Change review required? Whenever there is a change in the mental status of an individual, since the prior Level 1 review According to the Indiana PASRR Level I & Level of Care Screening Procedures for Long Term Care Services Provider Manual, last revised 4/20/20, If a NF [nursing facility] resident's behavioral or mental status significantly changes, the NF must submit a new Level I to report the change through the PASRR process. This applies to people who have a known Level II condition and to people with a previous negative Level I . Examples of a mental status change event include: A new mental health diagnosis that is not listed on previous [NAME] or Level II. A new psychotropic medication for mental illness A current policy, dated 2024, provided by the Nurse Consultant, titled Resident Assessment-Coordination with PASARR Program, indicated Any resident who exhibits a newly evident or possible serious mental disorder, intellectual disability, or a related condition will be referred promptly to the state mental health or intellectual disability authority for a level II resident review. Examples include: . b. A resident whose intellectual disability or related condition was not previously identified and evaluated through PASARR. c. A resident transferred, admitted , or readmitted to the facility following an inpatient psychiatric stay or equally intensive treatment

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 45122 Based on record review and interview, the facility failed to ensure procedures were in place to ensure pending physician's orders were followed up on and medications administered in a timely manner for 1 of 5 residents reviewed for unnecessary medications (Resident 70). Finding includes: Resident 70's clinical record was reviewed on 10/29/24 at 2:12 p.m. Diagnoses included atherosclerotic heart disease of native coronary artery without angina pectoris and type 2 diabetes mellitus without complications. Current physician's orders included insulin glargine (for diabetes), inject 15 units daily (started 10/25/24), dulaglutide (for diabetes), inject 1.5 milligrams (mg) every Saturday (started 10/26/24), metformin (for diabetes)1000 mg twice a day (started 2/11/24), and obtain blood sugars at meals and at bedtime. Notify physician for blood sugars less than 60 or greater than 400 mg/dl (deciliters) (started 9/18/24). The pharmacist recommended an increase in semaglutide to 1 mg from 0.5 mg every week and a decrease in insulin glargine from 24 units to 15 units daily to augment glucose insulin dependent secretion, slow gastric emptying, provide cardioprotective benefits, and aid in weight loss. The nurse practitioner (NP) signed the order on 10/24/24. The resident's medication administration record (MAR) lacked initials indicating administration of the dulaglutide on 10/26/24. The record lacked documentation of the medication being held or physician notification about the medication. During an interview, on 10/29/24 at 4:36 p.m., the Director of Nursing (DON) was uncertain if the dulaglutide had been given on 10/26/24 and she would check into it. During an interview, on 10/29/24 at 4:41 p.m., the Assistant Director of Nursing (ADON) indicated the physician had been notified on 10/28/24 about a pharmacy interchange. During an interview, on 10/30/24 at 9:35 a.m., the DON indicated the dulaglutide was ordered on 10/24/24 and delivered on 10/25/24. The pharmacy had made an interchange for the originally ordered semaglutide to dulaglutide. Because of the substitution, the order became pending and needed confirmation. The order would not have shown up on the MAR and was not have been given. Pending orders showed up on the resident's orders but not on the MAR. The dulaglutide order was changed and given on 10/29/24 and set up for every week on Tuesdays. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 10/30/24 at 2:27 p.m., LPN 7 indicated the nurse practitioner (NP) had agreed to the pharmacy recommendation. Semaglutide was ordered. The pharmacy changed the order from the semaglutide to dulaglutide as a pharmacy interchange. The pharmacy was able to change the order on the electronic software and would have caused the order to be pending until the new order was confirmed by the provider. The order was placed on the provider's notification board for the NP to review. She reviewed it on 10/28/24. When the order was confirmed, the order date would have been the date the pharmacy had changed the order and sent the medication. The next date to give the medication would have been the next Saturday, 11/2/24. During an interview, on 10/30/24 at 2:49 p.m., the ADON indicated when the order was confirmed, the order date did not change from the original date on 10/25/24. Providers understood and signed an agreement that an interchange for certain medications will be done unless they specifically write dispense as written. The order for the semaglutide was not written dispense as ordered. A current facility policy, dated 11/1/2023, provided by the Nurse Consultant on 10/30/24 at 3:30 p.m., titled Medication Orders, indicated .Documentation of Medication Orders: .b. Clarify the order .ensure the new order is in the MAR 3.1-25(a)