STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/20/2024
NAME OF PROVIDER OR SUPPLIER Rolling Hills Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. 34231 Based on interview and record review, the facility failed to ensure behaviors were care planned and monitored for 3 of 4 residents reviewed for behavior management. (Residents B, D, and G) Findings include: 1. The clinical record for Resident B was reviewed on 12/19/24 at 1:24 p.m. The resident's diagnoses included, but were not limited to, dementia with agitation and schizoaffective disorder. During an interview on 12/19/24 at 10:15 a.m., the Memory Care unit manager indicated Resident B would actively seek out Resident C and had done so for a couple of months. She did not know if the resident had been care planned for the behavior. During an interview on 12/19/24 at 10:24 a.m., the Director of Nursing indicated she and the Executive Director had went back to the unit. As they were going down the hallway, there were two females (Residents B and D) in Resident C's room. One was standing up and the other was sitting on the bed. She inquired about the two females in the male resident's room and the staff reported that there was nothing going on. It was not appropriate for females to be in a male residents room and she had the staff remove them and told the staff that visiting needed to be done in a social areas of the unit. Review of Resident B's care plan lacked documentation related to the behavior of the resident seeking out Resident C. 2. The clinical record for Resident D was reviewed 12/19/24 at 1:41 p.m. The resident's diagnoses included, but were not limited to, dementia with behavioral disturbance and vascular dementia with psychotic disturbance. During an interview on 12/19/24 at 10:15 a.m., the Memory Care unit manager indicated Resident D would actively seek out Resident C and had done so for a couple of months. She did not know if the resident had been care planned for the behavior. Review of Resident D's care plan lacked documentation related to the behavior of the resident seeking out Resident C. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/20/2024
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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. The clinical record for Resident C was reviewed on 12/18/24 at 2:15 p.m. The resident's diagnosis included, but was not limited to, dementia with agitation. The care plan, dated 10/6/20, indicated Resident C had a potential behavior related to sexually acting out. The interventions included, but were not limited to, anticipate and meet resident's needs, assist in developing more appropriate methods of coping and interacting such as encouraging more male friends in group/public areas with male/female setting; observe and discourage resident wanting to focus continually on one female; encourage to be in eye sight of staff when out of room. 4. The clinical record for Resident G was reviewed on 12/18/24 at 3:00 p.m. The resident's diagnoses included, but were not limited to, alcohol induced persisting dementia and dementia with behavioral disturbance. The care plan, dated 10/14/24, indicated the resident had a behavior problem as follows: known to have bowel movements in inappropriate places, yelling/demanding food at all times, verbal aggression towards staff and sexual comments towards others and to monitor behavioral episodes. Review of the November 2024 behavior tracking log lacked documentation of behavior monitoring for day shift on the following days: 11/7/24, 11/8/24, 11/10/24, 11/16/24, 11/22/24, 11/23/24, 11/28/24 and 11/29/24. Review of the December 2024 behavior tracking log lacked documentation of behavior monitoring for day shift on the following days: 12/2/24, 12/8/24, 12/11/24 and 12/18/24. During an interview on 12/20/24 at 12:39 p.m., Qualified Medication Aide (QMA) 13 indicated all behaviors should be documented on the behavior log in the medication demonstration record regardless of whether they have those behaviors or no behaviors. The medication administration record will bring up a list of behaviors for the residents and we click on the behavior if any and, if no behaviors, click a zero to show no behaviors. On 12/20/24 at 11:36 a.m., the Regional Director of Clinical Operations provided a current, undated copy of the document titled 'Behavior Management General. It included, but was not limited to, Policy .It is the policy of the facility to identify and safely manage residents who are exhibiting behaviors .Residents will be provided with a resident centered behavior management care plan to safely manage the residents and others .Document the assessment of the behavior in electronic medical record .Complete a care plan This Citation relates to Complaint IN00448446 3.1-43(a)(1)

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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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. 34231 Based on observation, interview and record review, the facility failed to ensure affective interventions were in place for a resident with increased sexually inappropriate behaviors for 1 of 8 residents reviewed for dementia care. (Resident C) Findings include: 1. The clinical record for Resident C was reviewed on 12/18/24 at 2:15 p.m. The resident's diagnosis included, but was not limited to, dementia with agitation. The care plan, dated 10/6/24, indicated the potential for behavior problem related to a history of sexually acting out. The interventions included, but were not limited to, assist in developing more appropriate methods of coping and interacting and to encourage more male friends and group/public areas with male and female setting; discourage resident wanting to focus continually on one female per family recommendation; encourage the resident be in in eye sight of staff when out of room and if reasonable, discuss behaviors; intervene as necessary to protect the rights and safety of others. The progress note, dated 10/27/24 at 8:42 p.m., indicated the resident continued to be on one-on-one supervision (one staff to one resident supervision) due to inappropriate behaviors observed. The psychiatric note, dated 10/28/24 at 8:10 a.m., indicated the resident had attempted sexually inappropriate behaviors with another female resident with staff intervention. The progress note, dated 10/20/24 at 6:36 a.m. indicated the resident continued to be on one-on-one supervision. The progress note, dated 11/3/24 at 8:19 p.m., indicated the resident continued to be on one-on-one supervision. The progress note, dated 11/4/24 at 5:44 p.m., indicated the resident had attempted to be inappropriate to a female resident in the dining area. The resident waved a staff member away and told the staff member to mind their own business when the staff member attempted to intervene. The female resident had to be taken to a different area. The resident was then observed next to another female resident with his hand located on her lap. Staff immediately approached the two residents and relocated the female resident to her room. The staff had observed that the resident expressed increased behaviors when met with authority or correction pertaining to the female residents. The resident continued to seek female company when exiting his room or in the dining room. One on one supervision continued as needed while the resident was out of his room. During an interview on 12/19/24 at 9:20 a.m., Staff Member 5 indicated Resident C would always get close to Resident B and try to put his hand down her brief. She had witnessed Resident C kiss Resident D. She would always report incidents and was just told to separate the residents and that was what she did. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/19/24 at 9:28 a.m., Staff Member 7 indicated she had witnessed Resident C kiss Resident B. She removed Resident C away from Resident D and reported the incident to her nurse. During an interview on 12/19/24 at 9:31 a.m., Staff Member 6 indicated Resident C was a toucher, would rub the ladies back and things like that. He was a ladies man. During an interview on 12/19/24 at 10:09 a.m., the Social Services on the Memory Care unit indicated Resident C did have inappropriate behaviors, although not consistently. He talked to the ladies a lot. During an interview on 12/19/24 at 10:15 a.m., the Memory Care Unit Manager indicated Resident C was very friendly with the men and women. He liked to sit beside them, comfort them, give them a kiss and we would separate. He was just a little too loving at times. During an interview on 12/20/24 at 10:40 a.m., Staff Member 12 indicated she had witnessed Resident C rub Resident B's thighs and kiss the following residents: Resident B, Resident D, Resident F, Resident H and Resident L. Staff member 12 would intervene and separate, however, Resident C would be right back at it. Once the resident was placed on one on one supervisor she had not observed the behaviors. The clinical record for Resident B was reviewed on 12/19/24 at 1:24 p.m. The resident's diagnosis included, but was not limited to, dementia with agitation. The clinical record for Resident D was reviewed on 12/19/24 at 1:41 p.m. The resident's diagnoses included, but were not limited to, dementia with behavioral disturbance and vascular dementia with psychotic disturbance. The clinical record for Resident F was reviewed on 12/19/24 at 2:11 p.m. The resident's diagnoses included, but were not limited to, dementia and cognitive communication deficit. The clinical record for Resident H was reviewed on 12/19/24 at 2:24 p.m. The resident's diagnoses included, but were not limited to, Alzheimer's with early onset, dementia with agitation and bipolar. The clinical record for Resident L was reviewed on 12/20/24 at 12:10 p.m. The resident's diagnoses included, but were not limited to, disorganized schizophrenia, schizoaffective disorder of the bipolar type and dementia with agitation. On 12/19/24 and 12/20/24, Residents B, D, F, H, and L were all observed on the unit. The residents were pleasantly confused and showed no signs of any psychosocial distress. On 12/20/24 at 11:41 a.m., the Regional Director of Clinical Operations provided a current, undated copy of the document titled Dementia Care Resident Rights and Privileges. It included, but was not limited to, Policy . It is the policy of this facility to provide resident centered care .Safety is a primary concerns .Residents with dementia and/or dementia-related diagnosis will be treated with the same respect and dignity and afforded the same resident rights regardless This Citation relates to Complaint IN00448446 (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-37(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 - Few	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 the anti-psychotic medication was documented as administered (Resident G) and failed to ensure resident's (Resident C and Resident E) medication administration records reflected the administration of narcotic medication for 3 of 5 residents reviewed for medical records. Findings include: 1. The clinical record for Resident G was reviewed on 12/18/24 at 3:00 p.m. The resident's diagnosis included, but was not limited to, dementia with behavioral disturbance. The physician's order, dated 10/28/24, indicated the resident was to receive Divalproex Sodium (mood stabilizer) delayed release, 125 mg (milligrams) three times a day in the morning, afternoon and at bedtime. The November 2024 medication administration record (MAR) indicated the medication was not signed out as given on the following scheduled administration times: - On 11/12/24 in the morning - On 11/18/24 in the morning On 11/25/24, the Divalproex Sodium was discontinued and a new order was implemented for Divalproex Sodium 500 mg three times a day in the morning, afternoon and at bedtime. The November 2024 and December 2024 MAR indicated the medication was not signed out as given on the following scheduled administration times: - On 11/25/24 at bedtime - On 11/28/24 at bedtime - On 11/29/24 at bedtime - On 12/06/24 at bedtime - On 12/08/24 at bedtime - On 12/11/24 in the afternoon and bedtime 2. The clinical record for Resident C was reviewed on 12/18/24 at 2:15 p.m. The resident diagnosis included, but was not limited to, pain. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The physician's order, dated 10/4/24, indicated the resident was to receive Hydrocodone-Acetaminophen (narcotic pain medication) 5-325 mg in the morning, afternoon and at bedtime. The October 2024 controlled drug record indicated the medication was administered on 10/26/24 in the afternoon. The October 2024 MAR lacked documentation of the administration of the resident's medication. 3. The clinical record for Resident E was reviewed on 12/19/24 at 2:03 p.m. The resident's diagnoses included, but were not limited to, pain and anxiety. The physician's order, dated 5/29/24, indicated the resident was to receive Lorazepam (narcotic anxiety medication) 0.75 ml (milliliters) every 4 hours for anxiety at 12:00 a.m., 4:00 a.m., 8:00 a.m., 12:00 p.m., 4:00 p.m. and 8:00 p.m. The November 2024 controlled drug record and the November 2024 MAR lacked documentation of the administration of the narcotic medication at 4:00 p.m. on 11/12/24. The December 2024 controlled drug record indicated on 12/8/24 at 4:00 p.m., the medication was administered to the resident. The December 2024 MAR lacked documentation of the administration of the resident's medication on 12/8/24 at 4:00 p.m. The physician's order, dated 6/18/24, indicated the resident was to receive Morphine Sulfated (narcotic pain medication) 0/25 ml every 4 hours for pain at 12:00 a.m., 4:00 a.m., 8:00 a.m., 12:00 p.m., 4:00 p.m. and 8:00 p.m. The November 2024 controlled drug record and the November 2024 MAR lacked documentation of the administration of the narcotic medication at 4:00 p.m. on 11/12/24. The December 2024 controlled drug record indicated on 12/8/24 at 4:00 p.m., the medication was administered to the resident. The December 2024 MAR lacked documentation of the administration of the resident's medication on 12/8/24 at 4:00 p.m. During an interview on 12/20/24 at 12:39 p.m., Qualified Medication Aide (QMA) 13 indicated the MAR and controlled drug record should be signed off to show the medications and narcotics were administered. On 12/20/24 at 11:36 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 medications 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 IN00448446 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-50(a)(2)