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Form Approved OMB
No. 0938-0391

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	04/29/2024

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35283 Based on record review and interview, the facility failed to provide prompt physical assessment of a resident complaining of having sustained a fall and experiencing hip pain, resulting in a delay in treatment for a hip fracture for 1 of 3 residents reviewed for accidents (Resident C). The deficient practice was corrected on 4/18/24, prior to the start of the survey, and was therefore past noncompliance. Findings include: Review of a facility reported incident, dated 4/15/24, indicated Resident C's family member had reported the resident was reporting right hip pain. The assessing nurse determined external rotation and swelling of the right leg. Resident C was transferred to the emergency department and found to have sustained a right hip fracture. Resident B's clinical record was reviewed on 4/26/24 at 9:22 a.m. Diagnoses included non-displaced right intertrochanteric (hip) fracture, chronic atrial fibrillation, osteoporosis, hypertension, muscle weakness, and Alzheimer's disease. Current physicians orders included, but were not limited to, metoprolol succinate extended release (blood pressure medication) 25 mg daily at bedtime, Aricept 5 mg (dementia medication), and Norco 5-325 mg (opioid pain medication) every four hours as needed for pain. A 3/5/24 Admission Functional Abilities assessment indicated Resident C had no upper or lower extremity impairments and used a wheelchair for mobility. The resident required substantial/maximum assistance to move from sit to stand, sit to lying, for chair/bed to chair transfers, toileting, and to walk ten feet in distance. A 3/5/24 quarterly fall risk evaluation indicated Resident C was at high risk for falls. A 3/13/24 Admission Minimum Data Set assessment, dated 3/13/24, indicated Resident C was severely cognitively impaired. Resident C's medication administration record dated 4/14/24 indicated Tylenol was administered at 4:49 p.m. for a pain level of 4 out of 10. LPN 5 recorded the resident's pain level at a 2 out of 10 at 5:49 p.m. (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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 4/14/24 at 11:03 p.m. Nurse Note indicated at approximately 6:35 p.m. that day, Resident C's family member reported the resident was complaining of having experienced a fall and was having very bad hip pain. The responding nurse observed the resident's foot to be rotated outward and her hip swollen. The resident was not able to move her leg and rated her pain at 8 out of a scale of 10. The ambulance was called at 7:49 p.m., and arrived at the facility at 8:10 p.m. A 4/14/24 at 11:33 p.m. Nurse Note indicated the resident was admitted to the hospital with a right hip fracture. A 4/15/24 at 11:20 a.m. interdisciplinary team note indicated Resident C had reported a fall on 4/14/24 at 6:35 p.m. The resident's care plan would be reviewed upon return to the facility. A hospital emergency department note dated 4/14/24 indicated the resident was seen by the provider at 8:55 p.m. Resident C had decreased range of motion to her right leg and pain with movement. She had an obvious deformity of her right hip. A 4/20/24 at 4:34 a.m. Nurse Note indicated the resident reported some pain with movement and an achy feeling at other times. During an interview, on 4/26/24 at 9:43 a.m., the DON indicated a review of the facility cameras showed Resident C standing in her doorway at around 4:00 p.m. on 4/14/24. The resident turned around and the bathroom door was observed to [NAME] open. A facility nurse had gone to Resident C to check on her and found the resident to be fine. Later in the day, around supper time, Resident C was complaining of pain. The resident had not experienced any falls while at the facility. During an interview, on 4/26/24 at 1:00 p.m., QMA 3 indicated she had started her shift on 4/14/24 at 2:00 p.m. CNA 8 reported to QMA 3 that Resident C was complaining of a fall and she couldn't move her leg. QMA 3 went to check on the resident, who was lying in bed. QMA 3 did not notice any bruising to indicate Resident C had fallen or that something was wrong with her hip. QMA 3 left to ask the nurse who had been on duty the day before if Resident C had fallen. She also asked the day shift CNA if the resident had fallen earlier in the day. They both said no. QMA 3 then reported to LPN 5 that Resident C was saying she had fallen, and QMA 3 had not seen any bruising. LPN 5 gave authorization for the QMA to administer Tylenol to the resident. She later reported to the oncoming nurse at shift change that Resident C had complained of having fallen. During an interview, on 4/26/24 at 11:15 a.m., LPN 5 indicated, on 4/14/24, she had heard Resident C holler out, and then the nurse heard a loud knock sound. LPN 5 ran into the resident's room, because it had sounded bad. The resident was sitting in her wheelchair, which was backed against the bathroom door. LPN 5 propelled the resident in her wheelchair, asking if she needed to use the bathroom. The resident said no. LPN 5 assisted the resident over near her bed, in the wheelchair, and gave her the call light. Resident C did not complain of pain or injury. When QMA 3 had notified her of Resident C's complaint of having fallen and hip pain, QMA 3 had told the nurse there was no bruising noted. LPN 5 felt the pain must have been related to arthritis. LPN 5 did not assess Resident C. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 4/29/24 at 9:14 a.m., LPN 5 indicated she should have assessed Resident C when she complained of having fallen and hip pain. She didn't normally work that hallway, or provide care for Resident C. When the resident's family member voiced concern about the resident's complaint, LPN 5 asked RN 13 if she would assess her, since it was the second time the resident had voiced the complaint. During an interview, on 4/29/24 at 11:21 a.m., RN 13 indicated, on 4/14/24 during shift report, she was told Resident C had told staff she had fallen, but no one witnessed a fall. No one had assisted her back to bed. QMA 3 reported to RN 13 that she had looked at Resident C, but hadn't seen any bruising, and LPN 5 had given authorization for Tylenol to be given for pain. When RN 13 went to assess Resident C, the resident's upper thigh was swollen and her foot was rotated outward. She called the doctor and had the resident sent to the emergency department. Resident C's family member came to the nurses station and reported to someone else the resident's complaints of pain and having fallen. RN 13 did not assess Resident C immediately, as the off-going staff wasn't too concerned about anything. She usually started her medication pass around 7:00 p.m., so she began with that. During an interview, on 4/29/24 at 10:10 a.m., the DON indicated QMAs are allowed to repeat what the resident reports, but the nurse should complete an assessment. Nursing staff had been educated about nurses completing the assessment themselves and not the QMA. It was very unusual for Resident C to be seen standing by herself, she required assistance with mobility. Review of a current, undated, facility job description titled Licensed Practical Nurse (LPN), provided by the DON on 4/29/24 at 11:21 a.m., indicated one of the primary purposes of the nurse's role included professional assessments and documentation of the resident's health. The LPN was also responsible for periodic resident visits to observe for symptoms, changes in condition, gauging unexpressed needs and ascertaining the need for additional or modified services. The deficient practice was corrected by 4/18/24 after the facility implemented a systemic plan that included the education of licensed and registered nurses regarding prompt assessment of residents complaining of injury, implemented a plan to review communication of reports of injury and pain, and ongoing monitoring in daily meetings and the facility Quality Assurance and Performance Improvement (QAPI) committee. This citation relates to Complaint IN00432566. 3.1-17(a) .