

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155488	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  08/05/2015
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NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-ROLLING HILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 3625 ST JOSEPH RD NEW ALBANY, IN 47150
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K 0000  Bldg. 01	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 08/06/15</p> <p>Facility Number: 000526 Provider Number: 155488 AIM Number: 100266970</p> <p>At this Life Safety Code survey, Rolling Hills Health Care Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and nine resident sleeping rooms in the 100B hall. The facility has a capacity of 115 and had a census of 94 at the time of this survey.</p>	K 0000	<p>K 000 PREPARATION AND/ OR EXECUTION OF THIS PLAN OF CORRECTION IN GENERAL OR THIS CORRECTIVE ACTION IN PARTICULAR, DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THIS FACILITY OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THIS STATEMENT OF DEFICIENCIES. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. The facility is requesting a Desk Review of compliance for this plan of correction.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

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K 0048 SS=F Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1</p> <p>Based on record review and interview, the facility failed to provide a complete written fire safety plan for the protection of 94 of 94 residents to accurately address all life safety systems such as, the use of the K-class fire extinguisher in the kitchen, and staff response to battery operated smoke detectors in resident sleeping rooms, plus a system addressing all items required by NFPA 101, 2000 edition, Section 19.7.2.2. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following:</p> <ol style="list-style-type: none"> <li>(1) Use of alarms</li> <li>(2) Transmission of alarm to the fire department</li> <li>(3) Response to alarms</li> <li>(4) Isolation of fire</li> <li>(5) Evacuation of immediate area</li> <li>(6) Evacuation of smoke compartment</li> <li>(7) Preparation of floors and building for evacuation</li> <li>(8) Extinguishment of fire</li> </ol> <p>This deficient practice could affect all occupants in the event of an emergency.</p> <p>Findings include:</p> <p>Based on a review of the Fire Discovery</p>	K 0048	<p>1.No residents were found to be affected. The Disaster Preparedness Manual was updated to address the use of the K-class fire extinguisher only after activation of the range hood suppression system in relationship to the use of the kitchen rang hood extinguishing system and staff response to the activation of battery operated smoke detectors in resident sleeping rooms on 8/21/15. The disaster preparedness manual follows the RACE protocols for extinguishment of non K-class type small fires, and is located in the disaster plan. The Maintenance Director was in-serviced on 8/21/15 on the requirements of K 048. All staff education related to the updates made to the Disaster Preparedness Manual to be completed by 9/4/15 by the Administrator or designee.</p> <p>2.All residents have the potential to be affected by this deficient practice. The Maintenance Director was in-serviced on 8/21/15 on the requirements of K 048. The Disaster Preparedness Manual was updated to address the use of the K-class fire extinguisher in relationship with the use of the kitchen rang hood extinguishing</p>	09/04/2015			

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	<p>and Announcement in the Emergency Response Plan on 08/05/15 at 11:10 a.m. with the Maintenance Supervisor present, the Fire Discovery and Announcement plan was a generic plan which did not address the use of the K-class fire extinguisher in the kitchen in relationship with the use of the kitchen overhead extinguishing system, and staff response to battery operated smoke detectors in most resident sleeping rooms.</p> <p>Furthermore, under Instructions at #8 stated "Utilize a fire extinguisher only if the fire is small .....", and #16 stated "If the fire is small ....." . Based on interview at the time of record review, the Maintenance Supervisor acknowledged the Fire Discovery and Announcement was a generic plan, and was not a complete and accurate plan.</p> <p>3.1-19(b)</p>		<p>system and staff response to the activation of battery operated smoke detectors in resident sleeping rooms on 8/21/15. All staff education related to the updates made to the Disaster Preparedness Manual to be completed by 9/4/15 by the Administrator or designee.</p> <p>3.The facility Disaster Preparedness Manual will be reviewed monthly to ensure it remains current by the Administrator or designee. The facility Disaster Preparedness Manual will continue to be part of the new employee orientation. The verification process for staff response to a resident sleeping room smoke detector as well as the use of the kitchen K-Class fire extinguisher will be added to the monthly facility fire drill. All staff education related to the updates made to the Disaster Preparedness Manual to be completed by 9/4/15 by the Administrator or designee. Any changes to the Disaster Preparedness Manual will be reviewed through the facility QA committee.</p> <p>4.The Maintenance Director or designee will audit the Disaster Preparedness manuals within the facility to ensure that they remain complete and any recommendations related to policy changes will be brought through the facility QA committee; weekly x4 and monthly x6 reporting results to the</p>		

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K 0052 SS=C Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>Based on record review and interview, the facility failed to ensure the documentation for the annual testing of 57 of 57 smoke detectors, plus all pull stations and other devices connected to the fire alarm system was complete. LSC 9.6 refers to NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires fire alarm system devices such as smoke detectors be tested annually. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's quarterly fire alarm system inspection/testing reports in the Life Safety Book on 08/05/15 at 10:00 p.m. with the Maintenance Supervisor present, the quarterly fire alarm system inspection reports dated 10/28/14, 01/21/15,</p>	K 0052	<p>QA committee. The QA committee will determine need for further review.</p> <p>1.No residents were found to be affected. Testing of all devices connected to the fire alarm system scheduled for September 1, 2015 with a testing report to include itemized list showing results for all devices tested. The Maintenance Director was in-serviced on 8/21/15 on the requirements of K 052 and the need to have an itemized listing of the devices tested and the result.</p> <p>2.All residents have the potential to be affected by this deficient practice. The Maintenance Director was in-serviced on 8/21/15 on the requirements of K 052 and the need to have an itemized listing of the devices tested and the result. Testing of all devices connected to the fire alarm system scheduled for September 1, 2015 with a testing report to include itemized list showing results for all devices tested. The Maintenance Director or designee will ensure that upon completion</p>	09/04/2015

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K 0154 SS=F Bldg. 01	<p>04/23/15, and 07/30/15 did not include complete information. There was no itemized list of all devices connected to the fire alarm system. The main information provided was number of devices installed, number tested, and condition of device, i.e., satisfactory or unsatisfactory. During an interview at the time of record review, the Maintenance Supervisor acknowledged the four quarterly fire alarm system inspection reports over the past twelve months did not include complete information such as an itemized list of devices tested.</p> <p>3-1.19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the</p>		<p>of fire alarm system testing an itemized report will be received.</p> <p>3. Testing of all devices connected to the fire alarm system scheduled for September 1, 2015 with a testing report to include itemized list showing results for all devices tested. The Maintenance Director was in-serviced on 8/21/15 on the requirements of K 052 and the need to have an itemized listing of the devices tested and the result. The Maintenance Director or designee will ensure that upon completion of fire alarm system testing an itemized report will be received. The Maintenance Director or designee to review testing reports to ensure provider documentation includes itemized list of results of all devices tested.</p> <p>4. The Maintenance Director or designee will audit the facility fire alarm system testing reports to ensure testing of all devices connected to the fire alarm system with a testing report to include itemized list showing results for all devices tested; weekly x4 and monthly x6 reporting results to the QA committee. The QA committee will determine need for further review.</p>	

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	<p>building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1</p> <p>Based on record review and interview, the facility failed to provide a written policy for the protection of 94 of 94 residents containing procedures to be followed in the event the automatic sprinkler system has to be placed out of service for 4 hours or more in a 24 hour period in accordance with LSC, Section 9.7.6.1. LSC 9.7.6.2 requires sprinkler impairment procedures comply with NFPA 25, Standard for Inspection, Testing and Maintenance of Water Based Fire Protection Systems. NFPA 25, 11-5(d) requires the local fire department be notified of a sprinkler impairment and 11-5(e) requires the insurance carrier, alarm company, building owner/manager and other authorities having jurisdiction also be notified. This deficient practice could affect all occupants in the facility.</p> <p>Findings include:</p> <p>Based on review of the Fire Watch Policy on 08/05/15 at 11:00 a.m. with the Maintenance Supervisor present, the facility did have a written policy and procedure for an impaired sprinkler system, however, it did not address issues required in a Fire Watch Policy such as:</p>	K 0154	<p>1.No residents were found to be affected. The facility Fire Watch policy ERP 200 was found under #3 on page 1 of 2 to include notification of the Local Fire Department and Insurance Company when the system is out of service for more than four hours in a 24-hour period. The Maintenance Director was in-serviced on 8/21/15 on the requirements of K 154 and the inclusion of the contact numbers on the Fire Watch policy. The facility policy was updated on 8/21/15 to include the phone numbers for the agencies to notify as previously the numbers were listed on the Emergency Codes, Notification Sequence and Telephone List in the Emergency Response Plan.</p> <p>2.All residents have the potential to be affected by this deficient practice. The Maintenance Director was in-serviced on 8/21/15 on the requirements of K 154 and the inclusion of the contact numbers on the Fire Watch policy. The facility policy was updated on 8/21/15 to include the phone numbers for the agencies to notify.</p> <p>3.The facility Disaster Preparedness Manual will be reviewed monthly to ensure it</p>	09/04/2015

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K 0155 SS=F Bldg. 01	<p>Notifying the local Fire Department and Insurance Company when the system is out of service for 4 hours or more within a 24 hour time period, plus phone numbers for the insurance company, and local Fire Department. This was acknowledged by the Maintenance Supervisor at the time of record review.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 Based on record review and interview, the facility failed to provide a written policy for the protection of 94 of 94 residents containing procedures to be</p>	K 0155	<p>remains current by the Administrator or designee. The facility Disaster Preparedness Manual will continue to be part of the new employee orientation. All staff education related to the updates made to the Disaster Preparedness Manual to be completed by 9/4/15 by the Administrator or designee. Any changes to the Disaster Preparedness Manual will be reviewed through the facility QA committee.</p> <p>4. The Maintenance Director or designee will audit the Disaster Preparedness manuals within the facility to ensure that they remain complete and any recommendations related to policy changes will be brought through the facility QA committee; weekly x4 and monthly x6 reporting results to the QA committee. The QA committee will determine need for further review.</p> <p>1. No residents were found to be affected. The facility Fire Watch policy ERP 200 was found under #3 on page 1 of 2 to include notification of the Local Fire</p>	09/04/2015			

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	<p>followed in the event the fire alarm system has to be placed out of services for 4 hours or more in a 24 hour period in accordance with LSC, Section 9.6.1.8. LSC, 19.7.1.1 requires every health care occupancy to have in effect and available to all supervisory personnel a plan for the protection of all persons. All employees shall periodically be instructed and kept informed with respect to their duties under the plan. The provisions of 19.7.1.2 through 19.7.2.3 shall apply. 19.7.2.2 requires all fire safety plans to provide for the use of alarms, the transmission of the alarm to the fire department and response to alarms. 19.7.2.3 requires health care personnel to be instructed in the use of a code phrase to assure transmission of the alarm during a malfunction of the building fire alarm system. This deficient practice could affect all occupants in the facility.</p> <p>Findings include:</p> <p>Based on review of the Fire Watch Policy on 08/05/15 at 11:00 a.m. with the Maintenance Supervisor present, the facility did have a written policy and procedure for an impaired sprinkler system, however, it did not address issues required in a Fire Watch Policy such as: Notifying the local Fire Department and Insurance Company when the system is</p>		<p>Department and Insurance Company when the system is out of service for more than four hours in a 24-hour period. The Maintenance Director was in-serviced on 8/21/15 on the requirements of K 155 and the inclusion of the contact numbers on the Fire Watch policy. The facility policy was updated on 8/21/15 to include the phone numbers for the agencies to notify as previously the numbers were listed on the Emergency Codes, Notification Sequence and Telephone List in the Emergency Response Plan.</p> <p>2.All residents have the potential to be affected by this deficient practice. The Maintenance Director was in-serviced on 8/21/15 on the requirements of K 155 and the inclusion of the contact numbers on the Fire Watch policy. The facility policy was updated on 8/21/15 to include the phone numbers for the agencies to notify. All staff education related to the updates made to the Disaster Preparedness Manual to be completed by 9/4/15 by the Administrator or designee.</p> <p>3.The facility Disaster Preparedness Manual will be reviewed monthly to ensure it remains current by the Administrator or designee. The facility Disaster Preparedness Manual will continue to be part of the new employee orientation. All staff education related to the</p>	

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	out of service for 4 hours or more within a 24 hour time period, plus phone numbers for the insurance company, and local Fire Department. This was acknowledged by the Maintenance Supervisor at the time of record review.  3.1-19(b)				updates made to the Disaster Preparedness Manual to be completed by 9/4/15 by the Administrator or designee. Any changes to the Disaster Preparedness Manual will be reviewed through the facility QA committee.  4. The Maintenance Director or designee will audit the Disaster Preparedness manuals within the facility to ensure that they remain complete and any recommendations related to policy changes will be brought through the facility QA committee; weekly x4 and monthly x6 reporting results to the QA committee. The QA committee will determine need for further review.		