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	06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROLLING HILLS HEALTHCARE CENTER	3625 ST JOSEPH RD NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Dates: 06/10/24-06/11/24 Facility Number: 000526 Provider Number: 155488 AIM Number: 100266970 At this Emergency Preparedness survey, Rolling Hills Healthcare Center was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 115 and had a census of 106 at the time of this survey. Quality Review completed on 06/25/24	E 0000	This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission of agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. We request that our plan of correction, monitoring tools and review of systemic changes we have made be considered for a paper compliance desk review.	
E 0015 SS=F Bldg. --	403.748(b)(1), 418.113(b)(6)(iii), 441.184(b)(1), 482.15(b)(1), 483.475(b)(1), 483.73(b)(1), 485.625(b)(1) Subsistence Needs for Staff and Patients §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.625(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Samantha Lawson	RDO	07/08/2024

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	06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROLLING HILLS HEALTHCARE CENTER	3625 ST JOSEPH RD NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting.			

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	06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROLLING HILLS HEALTHCARE CENTER	3625 ST JOSEPH RD NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include at a minimum, (1) The provision of subsistence needs for staff and residents, whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical, and pharmaceutical supplies. (ii) Alternate sources of energy to maintain - (A) Temperatures to protect resident health and safety and for the safe and sanitary storage of provisions; (B) Emergency lighting; (C) Fire detection, extinguishing, and alarm systems; and (D) Sewage and waste disposal in accordance with 42 CFR 483.73(b)(1). This deficient practice could affect all occupants. Findings include: Based on review of the emergency preparedness plan on 06/10/2024 between 9:30 AM and 3:30 PM with the Executive Director, Wedgwood Maintenance Director, Rolling Hills Maintenance Director, and the Regional Director of Clinical Operations, the subsistence needs for staff and residents did not address obtaining water or other necessary supplies in the event outside assistance was able to come to the facility. Based on interview at the time of record review, the Regional Director of Clinical Operations stated the facility would be aware of some events and would request the necessary subsistence items in advance. The policy regarding subsistence needs for staff and residents did not address obtaining the necessary subsistence items in advance. This finding was reviewed with the Executive Director and the Rolling Hills Maintenance	E 0015	**Corrective action for the residents found to have been affected by the deficient practice:** No residents were affected by the alleged deficient practice. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** Emergency preparedness plan reviewed and updated to include facility specific plan as it relates to obtaining necessary food and water when outside assistance unable to come to facility. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** RDO educated Maintenance Director and Dietary Manager on requirements for 42 CFR 483.73 (b) (1) on 7.10.2024 **Corrective actions to be monitored to ensure the deficient practice will not recur:** The Administrator/Designee will review emergency preparedness plan quarterly and as needed to	08/05/2024

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	06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROLLING HILLS HEALTHCARE CENTER	3625 ST JOSEPH RD NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Director at the exit conference.		ensure plan appropriate and effective. The Administrator/Designee will observe emergency food and water to ensure it is immediately available 5 times per week x 4 weeks, 2 times per week x 4 weeks, then weekly ongoing. The results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	
E 0018 SS=F Bldg. --	403.748(b)(2), 416.54(b)(1), 418.113(b)(6)(ii) and (v), 441.184(b)(2), 482.15(b)(2), 483.475(b)(2), 483.73(b)(2), 485.625(b)(2), 485.920(b)(1), 486.360(b)(1), 494.62(b)(1) Procedures for Tracking of Staff and Patients §403.748(b)(2), §416.54(b)(1), §418.113(b)(6)(ii) and (v), §441.184(b)(2), §460.84(b)(2), §482.15(b)(2), §483.73(b)(2), §483.475(b)(2), §485.625(b)(2), §485.920(b)(1), §486.360(b)(1), §494.62(b)(1). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum,			

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	06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROLLING HILLS HEALTHCARE CENTER	3625 ST JOSEPH RD NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the policies and procedures must address the following:] [(2) or (1)] A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location. *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name			

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	06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROLLING HILLS HEALTHCARE CENTER	3625 ST JOSEPH RD NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and location of the receiving facility or other location. *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include a system to track the location of on-duty staff and in the LTC facility's care during and after an emergency. If on-duty staff are relocated during the emergency, the LTC facility must document the specific name and location of the receiving facility or other location in accordance with 42 CFR 483.73(b) (2). This deficient practice could affect all staff. Findings include: Based on review of the emergency preparedness plan on 06/10/2024 between 9:30 AM and 3:30 PM with the Executive Director, Wedgwood	E 0018	**E 018** **Corrective action for the residents found to have been affected by the deficient practice:**No residents were affected by the alleged deficient practice. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:**Emergency preparedness plan reviewed and updated to include mechanism for tracking the location of on-duty staff and sheltered patients in the facility care during an emergency.	08/05/2024

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	06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROLLING HILLS HEALTHCARE CENTER	3625 ST JOSEPH RD NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Maintenance Director, Rolling Hills Maintenance Director, and the Regional Director of Clinical Operations, the policy regarding tracking of staff in an emergency stated the facility would track staff, but did not provide a written explanation of how the staff would be tracked. The Executive Director was able to provide a blank chart which contained columns labeled for names and locations and rows below to be filled out. Based on interview at the time of record review, the Executive Director stated the facility would use the staff schedule to track the staff in the building and their location. This finding was reviewed with the Executive Director and the Rolling Hills Maintenance Director at the exit conference.		**Measures/systemic changes put into place to ensure the deficient practice does not recur:**RDO educated IDT Team on requirements for 42 CFR 483.73 (b) (2) on 7.10.2024 **Corrective actions to be monitored to ensure the deficient practice will not recur:**The Administrator/Designee will review emergency preparedness plan quarterly and as needed to ensure plan appropriate and effective. The results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1) (i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section.			

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	06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROLLING HILLS HEALTHCARE CENTER	3625 ST JOSEPH RD NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	§482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security			

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	06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROLLING HILLS HEALTHCARE CENTER	3625 ST JOSEPH RD NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6,			

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	06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROLLING HILLS HEALTHCARE CENTER	3625 ST JOSEPH RD NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	2009.. 1. Based on record review and interview, the facility failed to implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 4 of the last 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. NFPA 110 8.4.2 requires diesel generator sets in service to be exercised at least once monthly, for a minimum of 30 minutes. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all occupants. Findings include: Based on review of the emergency preparedness plan on 06/10/2024 between 9:30 AM and 3:30 PM with the Executive Director, Wedgwood Maintenance Director, Rolling Hills Maintenance Director, and the Regional Director of Clinical Operations, no documentation for monthly load testing was available for September, October, November, or December 2023. Based on interview at the time of record review, the Rolling Hills Maintenance Director agreed there was no documentation of a monthly load test for the aforementioned months. This finding was reviewed with the Executive	E 0041	**Corrective action for the residents found to have been affected by the deficient practice:** No residents were affected by the alleged deficient practice. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** Generator load test completed on 7/9/2024 by facility maintenance director. Generator inspection was completed on 7/9/2024. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** RDO educated Maintenance Director on requirements for 42 CFR 483.73 € (2) on 7.10.2024 **Corrective actions to be monitored to ensure the deficient practice will not recur:**	08/05/2024

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	06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROLLING HILLS HEALTHCARE CENTER	3625 ST JOSEPH RD NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Director and the Rolling Hills Maintenance Director at the exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). Based on record review and interview, the facility failed to ensure a written record of weekly inspections for the generator was maintained for 19 of 52 weeks. NFPA 99, 6.4.4.1.3 requires onsite generators shall be maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 8.4.1 requires an Emergency Power Supply System (EPSS) including all appurtenant components, shall be inspected weekly and exercised monthly. NFPA 99, 6.4.4.2 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of the emergency preparedness plan on 06/10/2024 between 9:30 AM and 3:30 PM with the Executive Director, Wedgwood Maintenance Director, Rolling Hills Maintenance Director, and the Regional Director of Clinical Operations, documentation for the weekly generator testing for the following weeks were not available for review: a. between 06/19/24 and 07/28/23 b. between 08/18/23 and 09/22/23		The Administrator/Designee will review audit generator load testing completion monthly. The Administrator/Designee will audit generator inspection completion weekly x 4 weeks, then monthly x 2 months. The results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

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	06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROLLING HILLS HEALTHCARE CENTER	3625 ST JOSEPH RD NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	c. between 09/22/23 and 11/03/23 d. between 11/07/23 and 12/01/23 e. between 12/01/23 and 01/17/24 Based on interview at the time of record review, the Rolling Hills Maintenance Director agreed there was no documentation available during the aforementioned weeks. This finding was reviewed with the Executive Director and the Rolling Hills Maintenance Director at the exit conference. 3.1-19(b)			
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Dates: 06/10/224-06/11/24 Facility Number: 000526 Provider Number: 155488 AIM Number: 100266970 At this Life Safety Code survey, Rolling Hills Healthcare Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system	K 0000	This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission of agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. We request that our plan of correction, monitoring tools and review of systemic changes we have made be considered for a paper compliance desk review.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155488	A. BUILDING 01 B. WING	06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROLLING HILLS HEALTHCARE CENTER	3625 ST JOSEPH RD NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	with hard wired smoke detection in the corridors, spaces open to the corridors, and nine resident sleeping rooms in the 100B hall. All other resident rooms are equipped with battery operated smoke alarms. The facility has a capacity of 115 and had a census of 106 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 06/25/24			
K 0100 SS=E Bldg. 01	NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. 1. Based on observation and interview, the facility failed to ensure 1 of 1 carbon monoxide detectors in the boiler room was properly maintained. NFPA 101 at 19.1.1.3.1 states all health care facilities shall be designed, constructed, maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. Based on observation and interview, the facility failed to ensure 1 of 1 200 hall nurses' station doors to the corridor would close completely and latch into the door frame. This deficient practice could affect staff, visitors, and residents in this smoke compartment. Findings include: Based on observation during a tour of the facility	K 0100	**Corrective action for the residents found to have been affected by the deficient practice:** No residents were affected by the alleged deficient practice. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** The carbon monoxide detectors in	08/05/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155488	A. BUILDING 01 B. WING	06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROLLING HILLS HEALTHCARE CENTER	3625 ST JOSEPH RD NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	on 06/11/2024 between 9:30 AM and 1:10 PM with the Executive Director and Rolling Hills Maintenance Director, the door to the 200 hall nurses' station, which was exposed to the corridor, was leaning on the wall in the nurses' station and was not on the hinges. This configuration does not allow the door to close completely and latch in the event of an emergency. Based on interview at the time of the observation, the Executive Director and the Rolling Hills Maintenance Director agreed the door was not on hinges and was unable to be closed and latched in the event of an emergency. This finding was reviewed with the Executive Director and the Rolling Hills Maintenance Director at the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to maintain self-closing devices on 1 of 1 rooms on the right wall of the 100 hall break area per 4.6.12.3. LSC 4.6.12.3 requires existing life safety features obvious to the public if not required by the Code, shall be either maintained or removed. This deficient practice could affect staff. Findings include: Based on observation during a tour of the facility on 06/11/2024 between 9:30 AM and 1:10 PM with the Executive Director and Rolling Hills Maintenance Director, the room on the right wall of the break area in the 100 hallway was equipped with a self-closing device however the device was not fully functional as the device was in 2 separate pieces. Based on interview at the time of observation, the Rolling Hills Maintenance Director acknowledged the self-closer was not		the boiler room were inspected and any concerns addressed. The 100 hall break room self closing device was repaired and door tested for appropriate function. Latching hardware between 100A & 100B, and 200 dining were repaired and doors tested for appropriate function. The 200 hall smoke door was inspected and metal rating label replaced. The 200 hall nurse's station door was replaced on the hinges and tested for appropriate function. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** ED educated Maintenance Director on requirements for NFPA standards as references in NFPA 101 at 19.1.1.3.1 on 7.9.2024 **Corrective actions to be monitored to ensure the deficient practice will not recur:**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155488	A. BUILDING 01 B. WING	06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROLLING HILLS HEALTHCARE CENTER	3625 ST JOSEPH RD NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	operational. This finding was reviewed with the Maintenance Director and Administrator at the exit conference. 3.1-19(b) 3. Based on observation and interview, the facility failed to maintain latching hardware on 1 of 1 smoke doors between 100A and 100B and 1 of 1 200 dining room hall smoke barrier doors per 4.6.12.3. LSC 4.6.12.3 requires existing life safety features obvious to the public if not required by the Code, shall be either maintained or removed. This deficient practice could affect all staff, residents, and visitors in these smoke compartments. Findings include: Based on observation during a tour of the facility on 06/11/2024 between 9:30 AM and 1:10 PM with the Executive Director and Rolling Hills Maintenance Director, the smoke doors between halls 100A and 100B did not latch into the frame and the 200 hall dining room smoke doors did not latch into the frame. Based on interview at the time of observation, the Executive Director and Rolling Hills Maintenance Director agreed the aforementioned smoke doors did not latch into the frame. This finding was reviewed with the Executive Director and the Rolling Hills Maintenance Director at the exit conference. 3.1-19(b) 4. Based on observation and interview, the facility failed to maintain the metal rating label on the		The Administrator/Designee will audit carbon monoxide detector inspections monthly. The Administrator/designee will audit 5 doors per week x 4 weeks, then 3 doors per week x 4 weeks, and then 1 door per week x 4 weeks. The results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155488	A. BUILDING 01 B. WING	06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROLLING HILLS HEALTHCARE CENTER	3625 ST JOSEPH RD NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	smoke door in the 200 hallway nearest the dining room per 4.6.12.3. LSC 4.6.12.3 requires existing life safety features obvious to the public if not required by the Code, shall be either maintained or removed. This deficient practice could affect all staff, residents, and visitors in these smoke compartments. Based on observation during a tour of the facility on 06/11/2024 between 9:30 AM and 1:10 PM with the Executive Director and Rolling Hills Maintenance Director, the metal fire rating label on the smoke door in the 200 hallway nearest the dining room had information that was worn or scratched away. Based on interview at the time of observation, the Executive Director agreed there was information on the fire rating label that was worn or scratched away. This finding was reviewed with the Executive Director and the Rolling Hills Maintenance Director at the exit conference. 3.1-19(b)			
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155488	A. BUILDING 01 B. WING	06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROLLING HILLS HEALTHCARE CENTER	3625 ST JOSEPH RD NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155488	A. BUILDING 01 B. WING	06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROLLING HILLS HEALTHCARE CENTER	3625 ST JOSEPH RD NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility failed to maintain 1 of 1 smoking area egress gate and 1 of 1 egress gate outside hall 100 was free of all obstructions or impediments to full instant use in the case of fire or other emergency in accordance with LSC 7.1.10.1. This deficient practice could staff, residents, and visitors Findings include: Based on observation during a tour of the facility on 06/11/2024 between 9:30 AM and 1:10 PM with the Executive Director and Rolling Hills Maintenance Director, the egress fence gates in the smoking area and outside the 100 hallway had key locks, which were locked and no key appeared readily available to unlock the gates. Based on interview at the time of observation, the Rolling Hills Maintenance Director stated he would need to get the keys to open the egress gates. The Maintenance Director removed the lock on the egress door in the smoking area at the time of observation. This finding was reviewed with the Executive Director and the Rolling Hills Maintenance Director at the exit conference. 3.1-19(b)	K 0222	**K0222** **Corrective action for the residents found to have been affected by the deficient practice:** No residents were affected by the alleged deficient practice. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** The lock was immediately removed from the gate to provide egress access. A new key box was ordered and place to allow for keys to be secured and to allow immediate access to key and ensure egress access. **Measures/systemic changes put into place to ensure the**	07/22/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155488	A. BUILDING 01 B. WING	06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROLLING HILLS HEALTHCARE CENTER	3625 ST JOSEPH RD NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			deficient practice does not recur: ED educated Maintenance Director on requirements for LSC 7.1.10.1 on 7.5.2024 **Corrective actions to be monitored to ensure the deficient practice will not recur:** The Administrator/Designee will observe courtyard gates to ensure key secure and immediately available to ensure egress access 5 times per week to ensure adequate coverage x 4 weeks, 2 times per week x 4 weeks, then weekly ongoing. The results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	
K 0300 SS=F Bldg. 01	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155488	A. BUILDING 01 B. WING	06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROLLING HILLS HEALTHCARE CENTER	3625 ST JOSEPH RD NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on record review, interview and observation, the facility failed to ensure documentation for the preventative maintenance of all resident rooms was complete. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, 29.10 Maintenance and Tests. Fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect all residents, staff, and visitors in the resident rooms. Findings include: Based on record review on 06/10/2024 between 9:30 AM and 3:30 PM with the Executive Director, Wedgwood Maintenance Director, and the Rolling Hills Maintenance Director, no documentation regarding the testing of the battery operated smoke detectors in resident rooms was available for review. Based on interview at the time of record review, the Rolling Hills Maintenance Director stated he tests the smoke alarms monthly but does not document it. Based on observation at the time of record review, the smoke detectors indicated they should be tested weekly. At the time of the exit conference, the Rolling Hills Maintenance Director stated he tests the smoke detectors weekly and checks the batteries monthly. This finding was reviewed with the Executive	K 0300	**Corrective action for the residents found to have been affected by the deficient practice:** No residents were affected by the alleged deficient practice. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All smoke detectors in resident rooms were tested. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** RDO educated Maintenance Director on requirements for K 0300 as it relates to smoke detector checks. **Corrective actions to be monitored to ensure the deficient practice will not recur:**	08/05/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155488	A. BUILDING 01 B. WING	06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROLLING HILLS HEALTHCARE CENTER	3625 ST JOSEPH RD NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Director and Rolling Hills Maintenance Director at the exit conference. 3.1-19(b)		The Administrator/Designee will audit smoke detector checks weekly x 4 weeks, then monthly x 3 months. The results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155488	A. BUILDING 01 B. WING	06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROLLING HILLS HEALTHCARE CENTER	3625 ST JOSEPH RD NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 activities/unit manager office in the 100A hall which was over 50 square feet in size, was provided with a self-closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could affect staff, visitors, and residents in this smoke compartment. Findings include: Based on observations on 06/11/24 between 9:30 AM and 1:10 PM with the Executive Director and the Rolling Hills Maintenance Director, the door to the activities/unit manager office in 100A hall had a significant amount of combustible materials, including activities supplies, and the door was not equipped a self-closing mechanism. Based on interview at the time of observation, the Rolling Hills Maintenance Director agreed the office had a significant amount of combustible materials and no self-closing mechanism. This finding was reviewed with the Executive Director and the Rolling Hills Maintenance Director at the exit conference.	K 0321	**Corrective action for the residents found to have been affected by the deficient practice:** No residents were affected by the alleged deficient practice. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** Activities/Unit Manager office had self-closing device installed on 7.10.2024. Facility tour completed to ensure no other areas required self-closing device installation. **Measures/systemic changes put into place to ensure the deficient practice does not**	08/05/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155488	A. BUILDING 01 B. WING	06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROLLING HILLS HEALTHCARE CENTER	3625 ST JOSEPH RD NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3.1-19(b)		**recur:** RDO educated Maintenance Director on requirements for NFPA 19.3.5.9 on 7.10.2024 **Corrective actions to be monitored to ensure the deficient practice will not recur:** The Administrator/Designee will audit identified areas requiring self-closing device monthly to ensure placement and function. The results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required. -	
K 0331 SS=E Bldg. 01	NFPA 101 Interior Wall and Ceiling Finish Interior Wall and Ceiling Finish 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155488	A. BUILDING 01 B. WING	06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROLLING HILLS HEALTHCARE CENTER	3625 ST JOSEPH RD NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 Indicate flame spread rating(s). Based on observation, interview and record review; the facility failed to ensure materials used as an interior finish on the 100 hall had a flame spread rating of Class A or Class B. LSC 101 10.2.3.4 states products required to be tested in accordance with NFPA 255, Standard Method of Test of Surface Burning Characteristics of Building Materials, shall be grouped in the following classes in accordance with their flame spread and smoke development. (a) Class A Interior Wall and Ceiling Finish. Flame spread 0-25; smoke development 0-450. Includes any material classified at 25 or less on the flame spread test scale and 450 or less on the smoke test scale. Any element thereof, when so tested, shall not continue to propagate fire. (b) Class B Interior Wall and Ceiling Finish. Flame spread 26-75; smoke development 0-450. Includes any material classified at more than 25 but not more than 75 on the flame spread test scale and 450 or less on the smoke test scale. (c) Class C Interior Wall and Ceiling Finish. Flame spread 76-200; smoke development 0-450. Includes any material classified at more than 75 but not more than 200 on the flame spread test scale and 450 or less on the smoke test scale. This deficient practice could affect all residents, staff, and visitors while in the 2 smoke compartments in the 100 hall. Findings include: Based on record review on 06/10/2024 between 9:30 AM and 3:30 PM with the Executive Director, Wedgwood Maintenance Director, and the	K 0331	**Corrective action for the residents found to have been affected by the deficient practice:** No residents were affected by the alleged deficient practice. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** Flame spread documentation obtained for kick plates and wallpaper. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** RDO educated Maintenance Director on requirements for NFPA 101 10.2, 19.3.3.1, 19.3.3.2. **Corrective actions to be monitored to ensure the**	08/05/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155488	A. BUILDING 01 B. WING	06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROLLING HILLS HEALTHCARE CENTER	3625 ST JOSEPH RD NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Rolling Hills Maintenance Director no documentation regarding flame spread rating for the plastic kickguards on the doors of the rooms on the 100 hall was available for review. Based on observation on 06/11/2024 between 9:30 AM and 1:10 PM with the Executive Director and Rolling Hills Maintenance Director, there were plastic kickguards on doors in the 100 hallway. Based on interview at the time of observation, the Executive Director agreed there was no documentation regarding the flame spread rating of the kickguards. This finding was reviewed with the Executive Director and the Rolling Hills Maintenance Director at the exit conference. 3.1-19(b)		**deficient practice will not recur:** The Administrator/Designee will audit life safety book monthly to ensure flame spread information maintained on record. The results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on observation and interview, the facility failed to maintain the fire alarm system to assure that it had accurate time information in accordance with the requirements of NFPA 101- 2012 edition, Sections 19.3.4 and 9.6 and NFPA 72 - 2010 edition, Sections 14.1, 14.1.1. This deficient practice could affect all residents, staff and visitors.	K 0345	**Corrective action for the residents found to have been affected by the deficient practice:**No residents were affected by the alleged deficient practice. **Corrective action taken for those residents**	08/05/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155488	A. BUILDING 01 B. WING	06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROLLING HILLS HEALTHCARE CENTER	3625 ST JOSEPH RD NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Findings include: Based on observation during a tour of the facility on 06/11/2024 at 11:20 AM with the Executive Director and Rolling Hills Maintenance Director, the fire alarm annunciator located in the 400 hall displayed the time as 10:25 AM and at 10:43 AM the fire alarm control panel in the central circular area displayed 9:49 AM. Based on interview at the time of observation, the Rolling Hills Maintenance Director agreed the time displayed on the fire panel and annunciator was incorrect. This finding was reviewed with the Executive Director and the Rolling Hills Maintenance Director at the exit conference. 3.1-19(b)		**having the potential to be affected by the same deficient practice:** Time corrected on fire panel and annunciator. **Measures/systemic changes put into place to ensure the deficient practice does not recur:**RDO educated Maintenance Director on requirements for NFPA, 19.3.4 and 9.6 and NFPA, 14.1, 14.1.1. **Corrective actions to be monitored to ensure the deficient practice will not recur:**The Administrator/Designee will audit time display on fire panel and annunciator weekly x 4 weeks, then monthly thereafter. The results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155488	A. BUILDING 01 B. WING	06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROLLING HILLS HEALTHCARE CENTER	3625 ST JOSEPH RD NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on record review, observation and interview, the facility failed ensure 1 of 1 backflow prevention device in the sprinkler system piping was tested annually in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 13.6.2.1 states all backflow preventers installed in fire protection system piping shall be tested annually by conducting a forward flow test of the system at the designed flow rate, including hose stream demand, where hydrants or inside hose stations are located downstream of the backflow preventer. This deficient practice could affect all residents in the facility. Findings include: Based on record review on 06/10/2024 between 9:30 AM and 3:30 PM with the Executive Director, Wedgwood Maintenance Director, Rolling Hills Maintenance Director, and the Regional Director of Clinical Operations, documentation titled "Sprinkler: Backflow Prevention Test - Equipment" dated 01/11/2024 completed by SafeCare indicated the facility's backflow prevention failed the backflow prevention testing. No additional documentation regarding the backflow preventer was available for review. Based on interview at the time of record review, the Rolling Hills Maintenance Director stated he was not aware of any additional documentation	K 0353	**Corrective action for the residents found to have been affected by the deficient practice:** No residents were affected by the alleged deficient practice. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** Safe care contacted to inspect backflow prevention device. Repair/replacement for ceilings in 400 mechanical room, near 300 hall smoke door, Ceiling tiles near entrance to 100 hall, ceiling tile near room 123, ceiling by kitchen hood, and penetration near sprinkler head in room 108 completed. Safe care contacted to replace escutcheons in Iron Mountain closet and in laundry room.	08/05/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155488	A. BUILDING 01 B. WING	06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROLLING HILLS HEALTHCARE CENTER	3625 ST JOSEPH RD NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	regarding the backflow preventer. This finding was reviewed with the Executive Director and the Rolling Hills Maintenance Director at the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 1 400 hall mechanical rooms, 1 of 1 300 halls, 1 of 1 100 halls, 1 of 1 kitchens, and 1 of 1 room 108. NFPA 13, 2010 edition, Section 3.3.5.4 defines a smooth ceiling as a continuous ceiling free from significant irregularities, lumps, or indentations. The ceiling traps hot air and gases around the sprinkler and causes the sprinkler to operate at a specified temperature. Section 8.5.4.1.1 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect residents, staff, and visitors in the vicinity of those smoke compartments. Findings include: Based on observation during a tour of the facility on 06/11/2024 between 9:30 AM and 1:10 PM with the Executive Director and Rolling Hills Maintenance Director, the following was observed: a. a 1/2 inch penetration in the ceiling of the 400 hall mechanical room b. a ceiling tile missing near the 300 hall smoke door c. a ceiling tile missing in the 100 hall near the smoke door at the entrance to the 100 hall d. a 1 1/2 inch penetration in the ceiling tile near room 123		**Measures/systemic changes put into place to ensure the deficient practice does not recur:** RDO educated Maintenance Director on requirements for K 353 as it relates to maintenance of ceilings and escutcheons. **Corrective actions to be monitored to ensure the deficient practice will not recur:** The Administrator/Designee will audit 5 areas in the facility for ceiling and escutcheons in place weekly x 4 weeks, then 3 areas x 4 weeks, then 1 area x 4 weeks. The results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155488	A. BUILDING 01 B. WING	06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROLLING HILLS HEALTHCARE CENTER	3625 ST JOSEPH RD NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	e. a 5 inch penetration in the ceiling by the kitchen hood f. a 3 inch penetration in the ceiling by the kitchen hood g. a 24 inch penetration in the ceiling by the kitchen hood h. a 1.5 inch penetration in the ceiling by a sprinkler head in room 108 Based on interview at the time of observations, the Executive Director and Rolling Hills Maintenance Director agreed there were penetrations in the ceiling in the aforementioned locations and provided the measurements. The Executive Director and Rolling Hills Maintenance Director stated there is construction occurring in the kitchen as evidenced by the plastic sheeting which was hanging in the kitchen, however the kitchen was still in active use at the time of observation. This finding was reviewed with the Executive Director and the Rolling Hills Maintenance Director at the exit conference. 3.1-19(b) 3. Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 1 Iron Mountain closets in the employee break room and 1 of 2 laundry room in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, Section 6.2.7.1 states plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic, or shall be listed for use around a sprinkler. This deficient practice could affect staff, residents, and visitors in this smoke compartment. Findings include:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155488	A. BUILDING 01 B. WING	06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROLLING HILLS HEALTHCARE CENTER	3625 ST JOSEPH RD NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Based on observation during a tour of the facility on 06/11/2024 between 9:30 AM and 1:10 PM with the Executive Director and Rolling Hills Maintenance Director, an escutcheon was missing in the Iron Mountain closet in the employee break room and 1 of 2 escutcheons in the laundry room near the washers. Based on interview at the time of observation, the Rolling Hills Maintenance Director agreed there were missing escutcheons in the aforementioned locations. This finding was reviewed with the Executive Director and the Rolling Hills Maintenance Director at the exit conference. 3.1-19(b)			
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 1. Based on observation and interview, the facility failed to ensure 1 of 1 portable fire extinguishers in the kitchen were installed in accordance with NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition. Section 6.1.3.4 states portable fire extinguishers other than wheeled extinguishers shall be installed using any of the following means. (1) Securely on a hanger intended for the extinguishers. (2) In the bracket supplied by the extinguisher manufacturer. (3) In a listed bracket approved for such purpose. (3) In a cabinet or wall recess. This deficient practice was not in a resident care area but could affect all staff in the kitchen.	K 0355	**Corrective action for the residents found to have been affected by the deficient practice:** No residents were affected by the alleged deficient practice. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** Safecare contacted to request	08/05/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155488	A. BUILDING 01 B. WING	06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROLLING HILLS HEALTHCARE CENTER	3625 ST JOSEPH RD NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Findings include: Based on observation during a tour of the facility on 06/11/2024 between 9:30 AM and 1:10 PM with the Executive Director and the Rolling Hills Maintenance Director, the ABC portable fire extinguisher located in the 200 hall mechanical room was sitting on the floor. Based on interview at the time of observation, the Rolling Hills Maintenance Director agreed the fire extinguisher was sitting on the counter, not mounted. This finding was reviewed with the Executive Director and the Rolling Hills Maintenance Director. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 400 hall mechanicals room fire extinguishers and 1 of 1 fire extinguishers in the activities office was given maintenance at periods not more than one year apart. NFPA 10, the Standard for Portable Fire Extinguishers, at Section 7.3.1.1.1 requires that fire extinguishers shall be subjected to maintenance at intervals of not more than 1 year, at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. Section 3.3.15 defines extinguisher maintenance as a thorough examination of the fire extinguisher that is intended to give maximum assurance that a fire extinguisher will operate effectively and safely and to determine if physical damage or condition will prevent its operation, if any repair or replacement is necessary, and if hydrostatic testing or internal maintenance is required. Section 7.3.3 states each fire extinguisher shall have a tag or label securely attached that indicates the month and year the maintenance was		inspection of fire extinguishers identified on the survey. Safe care was contacted to request proper installation of fire extinguisher in 200 hall mechanical room and kitchen. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** RDO educated Maintenance Director on K355 requirements as they related to fire extinguisher installation and inspection. **Corrective actions to be monitored to ensure the deficient practice will not recur:** The Administrator/Designee will audit 5 fire extinguishers per month for completion of inspection and for proper installation x 3 months. The results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155488	A. BUILDING 01 B. WING	06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROLLING HILLS HEALTHCARE CENTER	3625 ST JOSEPH RD NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	performed, identifies the person performing the work, and identifies the name of the agency performing the work. This deficient practice could affect all residents, as well as staff and visitors in this smoke compartment. Findings include: Based on observation during a tour of the facility on 06/11/2024 between 9:30 AM and 1:10 PM with the Executive Director and Rolling Hills Maintenance Director, the fire extinguisher located in the 400 hall mechanical room had a tag which indicated it last had an annual check in November 2022. Based on interview at the time of observation, the Rolling Hills Maintenance Director agreed the tag indicated the fire extinguisher had last been checked in November of 2022, but stated the contractor had been to the facility to check the fire extinguishers. This finding was reviewed with the Executive Director and the Rolling Hills Maintenance Director at the exit conference. 3.1-19(b) 3. Based on observation and interview, the facility failed to inspect 1 of 1 fire extinguishers in the clean linen room and 1 of 1 fire extinguishers in the activities office. Based on observation and interview, the facility failed to inspect 1 of 2 portable fire extinguishers in the north hallway each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 7.2.1.2 states fire extinguishers shall be inspected either manually or by means of an electronic device / system at a minimum of 30-day intervals. Section 7.2.2 states periodic inspection or electronic monitoring of fire extinguishers shall include a check of at least the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155488	A. BUILDING 01 B. WING	06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROLLING HILLS HEALTHCARE CENTER	3625 ST JOSEPH RD NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	following items: (1) Location in designated place (2) No obstruction to access or visibility (3) Pressure gauge reading or indicator in the operable range or position (4) Fullness determined by weighing or hefting for self expelling-type extinguishers, cartridge-operated extinguishers, and pump tanks (5) Condition of tires, wheels, carriage, hose, and nozzle for wheeled extinguishers (6) Indicator for nonrechargeable extinguishers using push-to-test pressure indicators. Section 7.2.4.1 states personnel making manual inspections shall keep records of all fire extinguishers inspected, including those found to require corrective action. Section 7.2.4.3 requires where at least monthly manual inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded. Section 7.2.4.4 requires where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or by an electronic method. Section 7.2.4.5 requires records shall be kept to demonstrate that at least the last 12 monthly inspections have been performed. This deficient practice could affect all residents, staff, and visitors to those smoke compartments. Findings include: Based on observation during a tour of the facility on 06/11/2024 between 9:30 AM and 1:10 PM with the Executive Director and Rolling Hills Maintenance Director, the monthly inspection tag on the fire extinguisher located in the clean linen room indicated it had not been checked from May 2023-December 2023 and the fire extinguisher			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155488	A. BUILDING 01 B. WING	06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROLLING HILLS HEALTHCARE CENTER	3625 ST JOSEPH RD NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	located in the activities office indicated it had only been checked in April 2024. This finding was reviewed with the Executive Director and the Rolling Hills Maintenance Director at the exit conference. 3.1-19(b)			
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155488	A. BUILDING 01 B. WING	06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROLLING HILLS HEALTHCARE CENTER	3625 ST JOSEPH RD NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. 1. Based on observation and interview, the facility failed to ensure 1 of 1 doors to the dishwashing room to the dining room would close completely and latch into the door frame without issue. This deficient practice could affect staff, visitors, and residents in this smoke compartment. Findings include: Based on observation during a tour of the facility on 06/11/2024 between 9:30 AM and 1:10 PM with the Executive Director and Rolling Hills Maintenance Director, the door to the dishwashing area was able to be closed, however the frame shifted during closing at the top left corner of the door assembly revealing the left side and top of the frame were not connected and it could not be assured the door was constructed to resist the passage of smoke. Based on interview at the time of observation, the Executive Director and Rolling Hills Maintenance Director agreed the door frame was not connected on the left and top. This finding was reviewed with the Executive Director and the Rolling Hills Maintenance Director at the exit conference. 3.1-19(b)	K 0363	**Corrective action for the residents found to have been affected by the deficient practice:** No residents were affected by the alleged deficient practice. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** The kitchen dish room door was inspected and repaired to ensure closure and latch to form a smoke barrier. Room 122 hall door was inspected and repaired to ensure closure and latch to form a smoke barrier. **Measures/systemic changes put into place to ensure the**	08/05/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155488	A. BUILDING 01 B. WING	06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROLLING HILLS HEALTHCARE CENTER	3625 ST JOSEPH RD NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	2. Based on observation and interview, the facility failed to ensure 1 of 1 doors to room 122 was able to close and latch into the frame. This deficient practice could affect up to staff, visitors, and 2 residents. Findings include: Based on observation during a tour of the facility on 06/11/2024 between 9:30 AM and 1:10 PM with the Executive Director and Rolling Hills Maintenance Director, the door to room 122 was unable to close and latch into the frame. Based on interview at the time of observation, the Executive Director and Rolling Hills Maintenance Director agreed the door to room 122 was unable to close and latch into the frame. This finding was reviewed with the Executive Director and the Rolling Hills Maintenance Director at the exit conference. 3.1-19(b)		**deficient practice does not recur:** ED educated Maintenance Director on requirements for NFPA standards as references in NFPA 101 at 19.3.6.3 on 7.10.2024 **Corrective actions to be monitored to ensure the deficient practice will not recur:** The Administrator/designee will audit 5 doors per week x 4 weeks, then 3 doors per week x 4 weeks, and then 1 door per week x 4 weeks. The results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required	
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155488	A. BUILDING 01 B. WING	06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROLLING HILLS HEALTHCARE CENTER	3625 ST JOSEPH RD NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 1 of 1 smoke barrier walls near the staff development coordinator office was protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. This deficient practice could affect staff, residents, and visitors in this smoke compartment. Findings include: Based on observation during a tour of the facility on 06/11/2024 between 9:30 AM and 1:10 PM with the Executive Director and Rolling Hills Maintenance Director, a 2 inch by 3 inch penetration around wires and an 8 inch by 4 inch penetration around a conduit were located in the smoke barrier wall near the staff development coordinator office. Based on interview at the time of observation, the Rolling Hills Maintenance Director agreed there were penetrations in the smoke barrier wall at the aforementioned location and provided the measurements. This finding was reviewed with the Executive Director and the Rolling Hills Maintenance Director at the exit conference.	K 0372	**Corrective action for the residents found to have been affected by the deficient practice:** No residents were affected by the alleged deficient practice. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** The penetration in smoke barrier wall near the staff development coordinator office was repaired on 7.11.2024. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** RDO educated Maintenance Director on requirements as it relates to K372.	08/05/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155488	A. BUILDING 01 B. WING	06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROLLING HILLS HEALTHCARE CENTER	3625 ST JOSEPH RD NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3.1-19(b)		**Corrective actions to be monitored to ensure the deficient practice will not recur:** The Administrator/Designee will observe 5 areas for smoker barrier wall penetrations x 4 weeks, then 3 areas x 4 weeks, then 1 area x 4 weeks. The results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 1. Based on observation and interview, the facility failed to ensure 1 of 1 electrical light switch outlets in the 300 clean utility room was protected. NFPA 70, 2011 Edition. Article 406.6, Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting	K 0511	**STEP 1 Corrective action for the residents found to have been affected by the deficient practice:** No residents were harmed by the alleged deficient practice.	08/05/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155488	A. BUILDING 01 B. WING	06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROLLING HILLS HEALTHCARE CENTER	3625 ST JOSEPH RD NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	surface. This deficient practice could affect residents, staff, and visitors in the 300 hall. Findings include: Based on observation during a tour of the facility on 06/11/2024 between 9:30 AM and 1:10 PM with the Executive Director and Rolling Hills Maintenance Director, the outlet cover in the 300 hall clean utility room was laying on the counter in the clean utility room below the outlet the cover was supposed to be on. Based on interview at the time of observation, the Rolling Hills Maintenance Director and the Executive Director agreed the outlet did not have a cover plate. This finding was reviewed with the Executive Director and the Rolling Hills Maintenance Director at the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 wet locations in the activities office were provided with ground fault circuit interrupter (GFCI) protection against electric shock. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily accessible location. (B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in 210.8(B)(1)		**STEP 2 Corrective action taken for those residents having the potential to be affected by the same deficient practice:** The 300 clean utility room receptacle faceplate was installed. The activities office GFCI receptacle was replaced. **STEP 3 Measures/systemic changes put into place to ensure the deficient practice does not recur:** The RDO/Designee held an in-service with facility maintenance director on K511 as it relates to receptacle faceplate coverage and GFCI protection. **STEP 4 Corrective actions to be monitored to ensure the deficient practice will not recur:** The Maintenance Director/Designee will audit 5 receptacles weekly x 4 weeks, then 3 receptacles weekly x 4 weeks, then 1 receptacle weekly x 4 weeks to ensure faceplate installed and GFCI function when appropriate.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155488	A. BUILDING 01 B. WING	06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROLLING HILLS HEALTHCARE CENTER	3625 ST JOSEPH RD NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	through (8) shall have ground-fault circuit-interrupter protection for personnel. (1) Bathrooms (2) Kitchens (3) Rooftops (4) Outdoors Exception No. 1 to (3) and (4): Receptacles that are not readily accessible and are supplied by a branch circuit dedicated to electric snow-melting, deicing, or pipeline and vessel heating equipment shall be permitted to be installed in accordance with 426.28 or 427.22, as applicable. Exception No. 2 to (4): In industrial establishments only, where the conditions of maintenance and supervision ensure that only qualified personnel are involved, an assured equipment grounding conductor program as specified in 590.6(B)(2) shall be permitted for only those receptacle outlets used to supply equipment that would create a greater hazard if power is interrupted or having a design that is not compatible with GFCI protection. (5) Sinks - where receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink. Exception No. 1 to (5): In industrial laboratories, receptacles used to supply equipment where removal of power would introduce a greater hazard shall be permitted to be installed without GFCI protection. Exception No. 2 to (5): For receptacles located in patient bed locations of general care or critical care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection shall not be required. (6) Indoor wet locations (7) Locker rooms with associated showering facilities (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools, or portable lighting equipment are to be		The Maintenance Director/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155488	A. BUILDING 01 B. WING	06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROLLING HILLS HEALTHCARE CENTER	3625 ST JOSEPH RD NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	used. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect staff while at the hand washing sink in the Dining Room. Findings include: Based on observation during a tour of the facility on 06/11/2024 between 9:30 AM and 1:10 PM with the Executive Director and Rolling Hills Maintenance Director, the electrical receptacle in the activities office near the sink was provided with a ground fault circuit interrupter, however when tested, the circuit did not break. Based on interview at the time of observation, the Executive Director agreed the circuit did not break in the activities office when tested. This finding was reviewed with the Executive Director and the Rolling Hills Maintenance Director at the exit conference. 3.1-19(b)			
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155488	A. BUILDING 01 B. WING	06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROLLING HILLS HEALTHCARE CENTER	3625 ST JOSEPH RD NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to conduct 2nd shift quarterly fire drills for 2 of 4 quarters. LSC 19.7.1.6 requires drills to be conducted quarterly on each shift under varied conditions. This deficient practice affects all staff and residents. Findings include: Based on record review on 06/10/2024 between 9:30 AM and 3:30 PM with the Executive Director, Wedgwood Maintenance Director, and Rolling Hills Maintenance Director, no documentation for 2nd shift fire drills during the 3rd and 4th quarters of 2023 was available for review. Based on interview at the time of record review, the Rolling Hills Maintenance Director agreed there was no documentation of fire drills during the 3rd and 4th quarter of 2023 for 2nd shift. This finding was reviewed with the Executive Director and the Rolling Hills Maintenance Director. 3.1-19(b) 3.1-51(c)	K 0712	**K712** **STEP 1 Corrective action for the residents found to have been affected by the deficient practice:** No residents were harmed by the alleged deficient practice. **STEP 2 Corrective action taken for those residents having the potential to be affected by the same deficient practice:** Random fire drill was conducted on second shift. **STEP 3 Measures/systemic changes put into place to ensure the deficient practice does not recur:** The RDO/Designee held an in-service with facility maintenance director on K-712 as it relates to conducting fire drills at unexpected times under varying conditions	08/05/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155488	A. BUILDING 01 B. WING	06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROLLING HILLS HEALTHCARE CENTER	3625 ST JOSEPH RD NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			STEP 4 Corrective actions to be monitored to ensure the deficient practice will not recur: The Maintenance Director/Designee will audit monthly fire drills to insure they were conducted at unexpected times under varying conditions. The Maintenance Director/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	
K 0761 SS=E Bldg. 01	Based on observation, records review, and interview, the facility failed to ensure annual inspection and testing of 1 of 1 oxygen room fire door assemblies were completed in accordance with LSC 19.1.1.4.1.1. Communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed,	K 0761	**K761** **STEP 1 Corrective action for the residents found to have been affected by the deficient practice:** No residents were harmed by the alleged deficient practice.	08/05/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155488	A. BUILDING 01 B. WING	06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROLLING HILLS HEALTHCARE CENTER	3625 ST JOSEPH RD NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.3.1 states functional testing of fire door and window assemblies shall be performed by individuals with knowledge and understanding of the operating components of the type of door being subject to testing. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position.		**STEP 2 Corrective action taken for those residents having the potential to be affected by the same deficient practice:** The Oxygen Room door was inspected on 7.11.2024. **STEP 3 Measures/systemic changes put into place to ensure the deficient practice does not recur:** The RDO/Designee held an in-service with facility maintenance director on K761 as it relates to annual door inspections. **STEP 4 Corrective actions to be monitored to ensure the deficient practice will not recur:** The Administrator/Designee will review TELS for completion of all door inspections annual to ensure completion. The Administrator/Designee will present the results of these audits annually to the QAPI committee. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155488	A. BUILDING 01 B. WING	06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROLLING HILLS HEALTHCARE CENTER	3625 ST JOSEPH RD NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all occupants in the 200 hall. Findings include: Based on record review on 06/10/2024 between 9:30 AM and 3:30 PM with the Executive Director, Wedgwood Maintenance Director, and the Rolling Hills Maintenance Director, no annual inspection for the oxygen room fire door assembly was available for review. Based on interview at the time of record review, the Rolling Hills Maintenance Director stated his boss completed the door assembly inspections and must have missed the oxygen room door. This finding was reviewed with the Executive Director and the Rolling Hills Maintenance Director at the exit conference. 3.1-19(b)		is required.	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155488	A. BUILDING 01 B. WING	06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROLLING HILLS HEALTHCARE CENTER	3625 ST JOSEPH RD NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	1. Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 4 of the last 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. NFPA 110 8.4.2 requires diesel generator sets in service to be exercised at least once monthly, for a minimum of 30 minutes. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the	K 0918	**Corrective action for the residents found to have been affected by the deficient practice:** No residents were affected by the alleged deficient practice. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** Generator load test completed by facility maintenance director. Generator inspection was	08/05/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155488	A. BUILDING 01 B. WING	06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROLLING HILLS HEALTHCARE CENTER	3625 ST JOSEPH RD NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all occupants. Findings include: Based on review of the emergency preparedness plan on 06/10/2024 between 9:30 AM and 3:30 PM with the Executive Director, Wedgwood Maintenance Director, Rolling Hills Maintenance Director, and the Regional Director of Clinical Operations, no documentation for monthly load testing was available for September, October, November, or December 2023. Based on interview at the time of record review, the Rolling Hills Maintenance Director agreed there was no documentation of a monthly load test for the aforementioned months. This finding was reviewed with the Executive Director and the Rolling Hills Maintenance Director at the exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure a written record of weekly inspections for the generator was maintained for 19 of 52 weeks. NFPA 99, 6.4.4.1.3 requires onsite generators shall be maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 8.4.1 requires an Emergency Power Supply System (EPSS) including all appurtenant components, shall be inspected weekly and exercised monthly. NFPA 99, 6.4.4.2 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having		completed. **Measures/systemic changes put into place to ensure the deficient practice does not recur:**RDO educated Maintenance Director on requirements for 42 CFR 483.73 € (2) on 7.10.2024 **Corrective actions to be monitored to ensure the deficient practice will not recur:**The Administrator/Designee will review audit generator load testing completion monthly. The Administrator/Designee will audit generator inspection completion weekly x 4 weeks, then monthly x 2 months. The results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155488	A. BUILDING 01 B. WING	06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROLLING HILLS HEALTHCARE CENTER	3625 ST JOSEPH RD NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of the emergency preparedness plan on 06/10/2024 between 9:30 AM and 3:30 PM with the Executive Director, Wedgwood Maintenance Director, Rolling Hills Maintenance Director, and the Regional Director of Clinical Operations, documentation for the weekly generator testing for the following weeks were not available for review: a. between 06/19/24 and 07/28/23 b. between 08/18/23 and 09/22/23 c. between 09/22/23 and 11/03/23 d. between 11/07/23 and 12/01/23 e. between 12/01/23 and 01/17/24 Based on interview at the time of record review, the Rolling Hills Maintenance Director agreed there was no documentation available during the aforementioned weeks. This finding was reviewed with the Executive Director and the Rolling Hills Maintenance Director at the exit conference. 3.1-19(b)			