STATEMENT OF DEPCINES AND PLAN OF CORRECTION  MADE OF PROVIDER OR SUPPLITE  ROLLING HILLS HEALTHCARE CENTER  ROLLING HILLS HEALTHCARE CENTER  ROLLING HILLS HEALTHCARE CENTER  ROLLING HILLS HEALTHCARE CENTER  As ERRORD  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: 100260970  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 106/25/24  E 0015  SSS=F  10, PROVIDER ON STRUCTION  An 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 106/25/24  E 0015  SSS=F  10, PROFINS TATE, IPP COD 3025 ST JOSEPH RD NEW ALBANY, IN 47150  PROFINS TAGE PROFINS TATE ADDRESS. CITY, STATE, IPP COD 3025 ST JOSEPH RD NEW ALBANY, IN 47150  This Plan of Correction is the center's oredible allegation of compliance. Preparation and/or execution of this plan of correction of agreement by the provider of the truth of the facts alleged or conclusions act forth in the statement of deficiencies. The plan of correction is the center's oredible allegation of compliance. Preparation and/or execution of this plan of correction is the center's oredible allegation of organization of agreement by the provider of the truth of the facts alleged or conclusions act forth in the statement of deficiencies. The plan of correction is the center's oredible allegation of compliance of the truth of the facts alleged or conclusions act forth in the statement of deficiencies. The plan of cor	CENTERS FOI	R MEDICARE & MEDIC	CAID SERVICES			OMB NO. 0938-039	
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NAME OF PROVIDER OR SUPPLIER  ROLLING HILLS HEALTHCARE CENTER  (xs) ID PREETX (tach the prictionary Must are practiced by FULL TAG  REGULATORY OR LS: IDENTIFYING INFORMATION  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: 000266 Provider 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  403.748(b)(1), 483.475(b)(1), 483.73(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, nisk assessment at paragraph (a)) of this section, nisk assessment at paragraph (a)) of this section, and the	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED	
NAME OF PROVIDER OR SUPPLIER  ROLLING HILLS HEALTHCARE CENTER  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION E 00000    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: 103266970   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 fibs survey.  Quality Review completed on 06/25/24   403, 748(0)(1), 483.475(b)(1), 483.73(b)(1), 485.825(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) of this section, insk assessment at paragraph (a) of this section, insk assessment at paragraph (a) of this section, insk assessment at paragraph (a) of this section, and the content of the provider of the provider of the paragraph (a) of this section, insk assessment at paragraph (a) of this section, insk assessment at paragraph (a) of this section, and the content of the providers and procedures, based on the emergency plan set forth in paragraph (a) of this section, and the content of the providers and procedures, based on the emergency plan set forth in paragraph (a) of this section, and the providers and paragraph (a) of this section, and the paragraph (a) of this section, and the providers and procedures, based on the emergency plan set forth in paragraph (a) of this section, and the paragraph (a) of this section, and the providers and procedures are provided to the paragraph (a) of this section, and the providers are provided to the paragraph (a) of this section, and the provided to the paragraph (a) of this section, and the			155488	B. WING		06/11/2024	
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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 0015 SS=F (1), 148.113(b)(6)(iii), 441.184(b) (1), 482.15(b)(1), 483.475(b)(1), 483.73(b)(1), S441.184(b)(1), §483.475(b)(1), §482.15(b)(1), S441.184(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 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 (1), 148.113(b)(6)(iii), 441.184(b) (1), 485.625(b)(1) SS=F (1), 148.113(b)(6)(iii), 481.13(b)(6)(iii), S441.184(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 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 eventure of systems of 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 careaus of correction.  In onitoring tools and review of systemic changes even the torrection.  In onito		accordance with 42	2 CFR 483.73.		compliance. Preparation and/o	or	
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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 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), §482.15(b)(1), §441.184(b)(1), §460.84(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							
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 0015 SS=F (1), 482.15(b)(1), 418.113(b)(6)(iii), 441.184(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), §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		At this Emergency	Preparedness survey. Rolling		1 7	se it	
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 0015 SS=F (1), 482.15(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), §448.113(b)(6)(iii), §441.184(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					-		
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 0015 SS=F I(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), §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					1		
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 0015 SS=F (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), §448.113(b)(6)(iii), §441.184(b)(1), §460.84(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		-			-	1001	
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 0015 403.748(b)(1), 418.113(b)(6)(iii), 441.184(b) (SS=F (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		_			1	;	
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 0015					_		
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 0015 SS=F (1), 482.15(b)(1), 418.113(b)(6)(iii), 441.184(b) 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					1 -		
Census of 106 at the time of this survey.    Quality Review completed on 06/25/24		The facility has a c	apacity of 115 and had a		1		
Quality Review completed on 06/25/24  E 0015							
E 0015 SS=F (1), 482.15(b)(1), 483.475(b)(1), 483.73(b)(1), Bldg 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			3				
SS=F (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		Quality Review con	mpleted on 06/25/24				
SS=F (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	E 0015	402 740/b)/4) 44	9 112/b)/g)/iii)				
Bldg. — 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							
Subsistence Needs for Staff and Patients §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(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			463.473(b)(1), 463.73(b)(1),				
§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	Diag	` '\ '	de for Stoff and Dationta				
§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							
§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							
[(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		- ' ' ' ' -					
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		9403.73(b)(1), 94	·03.473(b)(1), 9403.023(b)(1)				
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		(h) Policies and	orogoduros [Eggilitics]				
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		- ' '					
on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the							
(a) of this section, risk assessment at paragraph (a)(1) of this section, and the							
paragraph (a)(1) of this section, and the							
		` '					
Communication plan at paragraph (c) of this							
		Communication p	an at paragraph (c) of this				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE

E (X6) DATE

Samantha Lawson RDO 07/08/2024

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclodays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 6NH621 Facility ID: 000526 If continuation sheet Page 1 of 48

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155488		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DAT	E SURVEY PLETED 1/2024	
	PROVIDER OR SUPPLIER		3625 S	ADDRESS, CITY, STATE, ZIP COE T JOSEPH RD LBANY, IN 47150	)	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP		(X5) COMPLETION
TAG	section. The police be reviewed and unique [annually for LTC] the policies and puthe following:	cies and procedures must updated every 2 years facilities]. At a minimum, rocedures must address	TAG	DEFICIENCY)		DATE
	shelter in place, ir to the following: (i) Food, water, m supplies (ii) Alternate source the following:	whether they evacuate or nolude, but are not limited edical and pharmaceutical ces of energy to maintain to protect patient health				
	and safety and for storage of provision (B) Emergency lig	the safe and sanitary ons. hting. , extinguishing, and alarm				
	Policies and proce (6) The following of for hospice-opera only. The policies address the follow	are additional requirements ted inpatient care facilities and procedures must				
	hospice employed they evacuate or are not limited to (A) Food, water, r supplies. (B) Alternate sour	es and patients, whether shelter in place, include, but				
		to protect patient health the safe and sanitary ons.				

FORM CMS-2567(02-99) Previous Versions Obsolete

(2) Emergency lighting.

Event ID:

6NH621

Facility ID: 000526

If continuation sheet

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PRINTED: 07/10/2024 FORM APPROVED

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED B. WING STREET ADDRESS, CITY, STATE, ZIP COD	)	
STREET ADDRESS, CITY, STATE, ZIP COD	COMPLETED 06/11/2024	
ROLLING HILLS HEALTHCARE CENTER  3625 ST JOSEPH RD NEW ALBANY, IN 47150		
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPL	(X5) MPLETION DATE	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DA'  (3) Fire detection, extinguishing, and alarm systems.  (C) Sewage and waste disposal.	/05/2024	

FORM CMS-2567(02-99) Previous Versions Obsolete

Director and the Rolling Hills Maintenance

Event ID:

6NH621

Facility ID: 000526

plan quarterly and as needed to

If continuation sheet

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/10/2024 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER  155488	A. BUILDING B. WING		COMPLETED 06/11/2024
	PROVIDER OR SUPPLIER		3625 S	ADDRESS, CITY, STATE, ZIP COD T JOSEPH RD ILBANY, IN 47150	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
E 0018 SS=F Bldg	and (v), 441.184(b 483.475(b)(2), 483.475(b)(2), 483.485.920(b)(1), 486. Procedures for Tra §403.748(b)(2), §46.11 §482.15(b)(2), §46.12 §485.625(b)(2), §46.12 §494.62(b)(1). If (b) Policies and p must develop and preparedness polion the emergency (a) of this section, paragraph (a)(1) ocommunication pla section. The polici reviewed and updates.	6.54(b)(1), 418.113(b)(6)(ii) 6)(2), 482.15(b)(2), 6.360(b)(1), 494.62(b)(1) 6.360(b)(1), 494.62(b)(1) 6.360(b)(1), §418.113(b)(6) 84(b)(2), §460.84(b)(2), 83.73(b)(2), §483.475(b)(2), 885.920(b)(1), §486.360(b)		ensure plan appropriate and effective. The Administrator/Designee will observe emergency food and to ensure it is immediately available 5 times per week x 4 weeks, 2 times per week x 4 weeks, then weekly ongoing. results of these audits monthly the QAPI committee for no less than 3 months. Any patterns are identified will have an Acti Plan initiated. The QAPI committee will determine whe 100% compliance is achieved ongoing monitoring is required.	The y to es that on or if

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

6NH621

Facility ID: 000526

If continuation sheet

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/10/2024 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155488	l í	ILDING	NSTRUCTION	(X3) DATE COMPI 06/11	LETED
	PROVIDER OR SUPPLIEI			3625 ST	DDRESS, CITY, STATE, ZIP COD JOSEPH RD BANY, IN 47150	-	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	the policies and p the following:]	rocedures must address					
	on-duty staff and [facility's] care du on-duty staff and relocated during t must document th	em to track the location of sheltered patients in the ring an emergency. If sheltered patients are the emergency, the [facility] the specific name and deiving facility or other					
	§483.73(b), ICF/II §460.84(b):] Polic system to track th and sheltered res ICF/IID or PACE] emergency. If on residents are relo emergency, the [F PACE] must docu	Ds at §483.475(b), PACE at ies and procedures. (2) A e location of on-duty staff idents in the [PRTF's, LTC, care during and after anduty staff and sheltered cated during the PRTF's, LTC, ICF/IID or ment the specific name e receiving facility or other					
	Policies and procedii) Safe evacuation includes consider needs of evacueed transportation; ideal location(s) and procedition of communication assistance.  (v) A system to transport on the hospice's cared the on-duty employer are relocated duri	spice at §418.113(b)(6):] edures. on from the hospice, which ation of care and treatment s; staff responsibilities; entification of evacuation imary and alternate means with external sources of ack the location of hospice ty and sheltered patients in e during an emergency. If oyees or sheltered patients ing the emergency, the ument the specific name					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

6NH621

Facility ID: 000526

If continuation sheet

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PRINTED: 07/10/2024 FORM APPROVED

CENTERS FOI	R MEDICARE & MEDIC	CAID SERVICES			OM	IB NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<u></u>	COMPLETED	
		155488	B. WING		06/11/	/2024
		1	STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF 1	PROVIDER OR SUPPLIEI	R		T JOSEPH RD		
ROLLING	G HILLS HEALTHC	ARE CENTER	NEW A	LBANY, IN 47150		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	<b>†</b>	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
		e receiving facility or other				
	location.					
	**F 01410 10	)405 000(I) I B III :				
	-	\$485.920(b):] Policies and				
	. , ,	afe evacuation from the				
		ludes consideration of care				
		eds of evacuees; staff				
		ansportation; identification				
		ation(s); and primary and				
		of communication with				
	external sources	or assistance.				
	*[For ODOs at \$ /	196 260/h):I Deligion and				
		186.360(b):] Policies and				
	. , ,	system of medical				
		at preserves potential and				
	actual donor infor					
		potential and actual donor				
		secures and maintains the				
	availability of reco	oras.				
	*IFor ESRD at § 4	194.62(b):] Policies and				
		afe evacuation from the				
	' ' '	hich includes staff				
		nd needs of the patients.				
		view and interview, the facility	E 0018	E 018		08/05/2024
		ergency preparedness policies		Corrective action for the		50.05.202
		lude a system to track the		residents found to have been		
	_	staff and in the LTC facility's		affected by the deficient		
	1	er an emergency. If on-duty		practice:No residents were		
	_	during the emergency, the LTC		affected by the alleged deficier	nt	
		nent the specific name and		practice. Corrective action		
		eiving facility or other location		taken for those residents		
		42 CFR 483.73(b) (2). This		having the potential to be		
		ould affect all staff.		affected by the same deficien	t	
				practice:Emergency		
	Findings include:			preparedness plan reviewed a	nd	
				updated to include mechanism		
	Based on review of	f the emergency preparedness		tracking the location of on-duty		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

plan on 06/10/2024 between 9:30 AM and 3:30 PM

with the Executive Director, Wedgwood

6NH621

Facility ID: 000526

If continuation sheet

staff and sheltered patients in the

facility care during an emergency.

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/10/2024 FORM APPROVED OMB NO. 0938-039

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 06/11/2024
	ROVIDER OR SUPPLIER		3625 \$	ADDRESS, CITY, STATE, ZIP COD ST JOSEPH RD ALBANY, IN 47150	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	Director, and the Re Operations, the poli in an emergency sta staff, but did not prohow the staff would Director was able to contained columns locations and rows loon interview at the t Executive Director the staff schedule to and their location.	or, Rolling Hills Maintenance agional Director of Clinical cy regarding tracking of staff ted the facility would track ovide a written explanation of be tracked. The Executive provide a blank chart which abeled for names and below to be filled out. Based time of record review, the stated the facility would use track the staff in the building viewed with the Executive lling Hills Maintenance conference.		Measures/systemic changes into place to ensure the deficient practice does not recur:RDO educated IDT Terequirements for 42 CFR 483 (b) (2) on 7.10.2024 Correctications to be monitored to ensure the deficient practications will not recur:The Administrator/Designee will reemergency preparedness plaquarterly and as needed to eplan appropriate and effective results of these audits month the QAPI committee for no let than 3 months. Any patterns are identified will have an Act Plan initiated. The QAPI committee will determine who 100% compliance is achieved ongoing monitoring is required.	am on 3.73 ive  e eview an ansure e. The ly to ss that tion en d or if
E 0041 SS=F Bldg	§482.15(e) Condit (e) Emergency and The hospital must standby power systemergency plan so this section and in procedures plan so (i) and (ii) of this so §483.73(e), §485.0 (e) Emergency and The [LTC facility as implement emergency	LTC Emergency Power ion for Participation: d standby power systems. implement emergency and stems based on the et forth in paragraph (a) of the policies and et forth in paragraphs (b)(1) ection.  625(e) d standby power systems. Ind the CAH] must ency and standby power the emergency plan set			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

6NH621 Facility ID: 000526

If continuation sheet

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/10/2024 FORM APPROVED OMB NO. 0938-039

	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155488	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 06/11/2024
	PROVIDER OR SUPPLIER		3625 S	ADDRESS, CITY, STATE, ZIP COD T JOSEPH RD LBANY, IN 47150	•
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE COMPLETION
IAU	§482.15(e)(1), §48 Emergency gener generator must be the location requir Care Facilities Co Interim Amendme 12-4, TIA 12-5, an Code (NFPA 101 Amendments TIA and TIA 12-4), and structure is built of structure or buildir 482.15(e)(2), §483 Emergency gener The [hospital, CAI implement the em inspection, testing requirements foun Facilities Code, Ni Code.  482.15(e)(3), §483 Emergency gener and LTC facilities] source to power e have a plan for ho power systems op emergency, unles  *[For hospitals at 6 §483.73(g), and C The standards inc this section are ap reference by the E Federal Register i 552(a) and 1 CFR the material from to you may inspect a	ator location. The elocated in accordance with ements found in the Health de (NFPA 99 and Tentative ints TIA 12-2, TIA 12-3, TIA and TIA 12-6), Life Safety and Tentative Interim 12-1, TIA 12-2, TIA 12-3, d NFPA 110, when a new or when an existing ing is renovated.  3.73(e)(2), §485.625(e)(2) ator inspection and testing. Health Care inspection and testing. Health Care in the Health Care in t	IAG		DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

6NH621 Facility ID: 000526

If continuation sheet

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	OF CORRECTION	IDENTIFICATION NUMBER  155488		ILDING	NSTRUCTION	COMPL 06/11/	ETED
NAME OF I	PROVIDER OR SUPPLIEF	2	_		DDRESS, CITY, STATE, ZIP COD		
ROLLING	S HILLS HEALTHO	ARE CENTER			BANY, IN 47150		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION
TAG		ore, MD or at the National		TAG	DEFICIENC 11		DATE
	(NARA). For infor	ords Administration mation on the availability of ARA, call 202-741-6030, or					
	http://www.archive _of_federal_regul	es.gov/federal_register/code ations/ibr_locations.html. this edition of the Code are					
	incorporated by re document in the F announce the cha						
	Batterymarch Parl Quincy, MA 02169						
	2012 edition, issue (ii) Technical inter NFPA 99, issued						
	2012.	FPA 99, issued August 9, FPA 99, issued March 7,					
		PA 99, issued August 1,					
	2014.	FPA 99, issued March 3,					
	edition, issued Au (viii) TIA 12-1 to N 11, 2011.	IFPA 101, issued August					
	30, 2012.	FPA 101, issued October FPA 101, issued October					
	(xi) TIA 12-4 to NF 22, 2013.	FPA 101, issued October tandard for Emergency and					
	Standby Power St	ystems, 2010 edition, chapter 7, issued August 6,					

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6NH621

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/10/2024 FORM APPROVED OMB NO. 0938-039

	ENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCT		ONSTRUCTION	r í		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	COMPLETED	
		155488	B. W	ING		06/11/2024
NAME OF P	PROVIDER OR SUPPLIER	3			ADDRESS, CITY, STATE, ZIP COD	
					T JOSEPH RD	
ROLLING	HILLS HEALTHC	ARE CENTER		NEW A	LBANY, IN 47150	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	` ·	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR		
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
	2009	. 1		0.41		00/05/2024
		review and interview, the	E 0	041	Corrective action for the	08/05/2024
		plement the emergency power			residents found to have bee	n
		testing, and maintenance			affected by the deficient	
	-	in the Health Care Facilities			practice:	
		and Life Safety Code in			No residents were affected by	the
		CFR 483.73(e)(2). Based on			alleged deficient practice.	
		nterview, the facility failed to				
	_	e written record of monthly				
	-	ng for 4 of the last 12 months. (a) of 2012 NFPA 99 requires			Compositive action taken for	
	-	the generator serving the			Corrective action taken for	
		al system to be in accordance			those residents having the	
		e Standard for Emergency and			potential to be affected by the	ie
		stems, Chapter 8. NFPA 110			same deficient practice:	
		l generator sets in service to be				
	-	nce monthly, for a minimum of				
		r 6.4.4.2 of NFPA 99 requires a			Congretor load test complete	nd on
	-	spection, performance,			Generator load test complete 7/9/2024 by facility maintenar	
		and repairs for the generator to			director. Generator inspection	
		ined and available for			completed on 7/9/2024.	was
		thority having jurisdiction.			Completed on 179/2024.	
		ice could affect all occupants.				
	- Ins action pract	and antere and occupantion				
	Findings include:				Measures/systemic change	s
					put into place to ensure the	
		the emergency preparedness			deficient practice does not	
	•	between 9:30 AM and 3:30 PM			recur:	
		Director, Wedgwood				
		tor, Rolling Hills Maintenance			RDO educated Maintenance	
		egional Director of Clinical			Director on requirements for 4	
	_	amentation for monthly load			CFR 483.73 € (2) on 7.10.202	24
	-	e for September, October,				
	· ·	ember 2023. Based on interview				
		d review, the Rolling Hills				
		tor agreed there was no			Corrective actions to be	
		monthly load test for the			monitored to ensure the	
	aforementioned mo	nths.			deficient practice will not	
					recur:	
	This finding was re	viewed with the Executive				

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING		COMPL	ETED
		155488	B. W	ING		06/11/	2024
			-	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	t .			Γ JOSEPH RD		
ROLLING	G HILLS HEALTHC	ARE CENTER		NEW A	LBANY, IN 47150		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
		olling Hills Maintenance			The Administrator/Designee v		
	Director at the exit	conference.			review audit generator load tes	sting	
	2.1.10(1)				completion monthly. The		
	3.1-19(b)				Administrator/Designee will au		
	2 Događan masanda	review and interview, the			generator inspection completion		
		plement the emergency power			weekly x 4 weeks, then month 2 months. The results of these		
		testing, and maintenance			audits monthly to the QAPI	;	
		in the Health Care Facilities			committee for no less than 3		
	_	and Life Safety Code in			months. Any patterns that are		
		CFR 483.73(e)(2). Based on			identified will have an Action P		
		nterview, the facility failed to			initiated. The QAPI committee		
	ensure a written record of weekly inspections for				determine when 100% complia	ance	
	the generator was n	naintained for 19 of 52 weeks.			is achieved or if ongoing		
		requires onsite generators shall			monitoring is required.		
		cordance with NFPA 110,					
	_	ency and Standby Power					
		0, 8.4.1 requires an Emergency					
		em (EPSS) including all					
		nents, shall be inspected					
		ed monthly. NFPA 99, 6.4.4.2					
	requires a written re	-					
	_	ising period, and repairs for the					
	-	ularly maintained and available					
	for inspection by th	e authority having efficient practice could affect all					
	residents, staff and						
	residents, start and	v 1511015.					
	Findings include:						
	Based on review of	the emergency preparedness					
		between 9:30 AM and 3:30 PM					
	_	Director, Wedgwood					
		tor, Rolling Hills Maintenance					
		egional Director of Clinical					
	· ·	entation for the weekly					
	-	r the following weeks were not					
	available for review	_					
	a. between 06/19/24	4 and 07/28/23					
	b. between 08/18/23	3 and 09/22/23					

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DEPARTMENT OF HEALTH AND HU	MAN SERVICES			FORM APPROVED
CENTERS FOR MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	JLTIPLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BU	TILDING	COMPLETED
	155488	B. WI	NG	06/11/2024
NAME OF PROVIDER OR SUPPLIES			STREET ADDRESS, CITY, STATE, ZIP C	COD
NAME OF FROVIDER OR SUFFLIER			3625 ST JOSEPH RD	
ROLLING HILLS HEALTHCA	ARE CENTER	NEW ALBANY, IN 47150		

(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	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				
<b>J</b>	A Life Safety Code Recertification and State	K 0000	This Plan of Correction is the	
	Licensure Survey was conducted by the Indiana	11 0000	center's credible allegation of	
	Department of Health in accordance with 42 CFR		compliance. Preparation and/or	
	483.90(a).		execution of this plan of correction	
			does not constitute admission of	
	Survey Dates: 06/10/224-06/11/24		agreement by the provider of the truth of the facts alleged or	
	Facility Number: 000526		conclusions set forth in the	
	Provider Number: 155488		statement of deficiencies. The	
	AIM Number: 100266970		plan of correction is prepared	
			and/or executed solely because it	
	At this Life Safety Code survey, Rolling Hills		is required by the provisions of	
	Healthcare Center was found not in compliance		federal and state law. We request	
	with Requirements for Participation in		that our plan of correction,	
	Medicare/Medicaid, 42 CFR Subpart 483.90(a),		monitoring tools and review of	
	Life Safety from Fire and the 2012 edition of the		systemic changes we have made	
	National Fire Protection Association (NFPA) 101,		be considered for a paper	
	Life Safety Code (LSC), Chapter 19, Existing		compliance desk review.	
	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			1

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155488		(X2) MULTIPLE C A. BUILDING B. WING	(X3) DATE SURVEY  COMPLETED  06/11/2024		
	PROVIDER OR SUPPLIER		3625 S	ADDRESS, CITY, STATE, ZIP COD ST JOSEPH RD ALBANY, IN 47150	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0100 SS=E Bldg. 01	spaces open to the of sleeping rooms in the rooms are equipped alarms. The facility a census of 106 at the All areas where resist were sprinklered and services with the services were sprinklered and services were spr	nents - Other Nents - Other Nests - Other Nests - Other Nests section any LSC 19.1 General Requirements Seed by the provided ficient. This information, Nicable Life Safety Code or tation, should be included Note: Attention and interview, the facility of 1 carbon monoxide detectors was properly maintained. NFPA Attention and interview, the facilities shall facted, maintained and the the possibility of a fire of the evacuation of occupants. The and interview, the facility on and interview, the facility of a fire of the possibility of a fire	K 0100	Corrective action for the residents found to have been affected by the deficient practice:  No residents were affected by alleged deficient practice.  Corrective action taken for those residents having the potential to be affected by the same deficient practice:  The carbon monoxide detected.	the e
	based on observation	on during a tour of the facility		The carbon monoxide detector	ors in

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07/10/2024 PRINTED: FORM APPROVED

OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 06/11/2024 155488 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 3625 ST JOSEPH RD ROLLING HILLS HEALTHCARE CENTER NEW ALBANY, IN 47150 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE on 06/11/2024 between 9:30 AM and 1:10 PM with the boiler room were inspected the Executive Director and Rolling Hills and any concerns addressed. Maintenance Director, the door to the 200 hall nurses' station, which was exposed to the The 100 hall break room self corridor, was leaning on the wall in the nurses' closing device was repaired and station and was not on the hinges. This door tested for appropriate configuration does not allow the door to close function. completely and latch in the event of an emergency. Based on interview at the time of the observation, the Executive Director and the Latching hardware between 100A Rolling Hills Maintenance Director agreed the & 100B, and 200 dining were door was not on hinges and was unable to be repaired and doors tested for closed and latched in the event of an emergency. appropriate function. The 200 hall smoke door was This finding was reviewed with the Executive inspected and metal rating label Director and the Rolling Hills Maintenance replaced. Director at the exit conference. The 200 hall nurse's station door was replaced on the hinges and 3.1-19(b) tested for appropriate function. 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 Measures/systemic changes safety features obvious to the public if not put into place to ensure the required by the Code, shall be either maintained or deficient practice does not removed. This deficient practice could affect staff. recur: Findings include: **ED** educated Maintenance Director on requirements for NFPA Based on observation during a tour of the facility standards as references in NFPA on 06/11/2024 between 9:30 AM and 1:10 PM with 101 at 19.1.1.3.1 on 7.9.2024 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 Corrective actions to be not fully functional as the device was in 2 monitored to ensure the

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Event ID:

separate pieces. Based on interview at the time of

observation, the Rolling Hills Maintenance

Director acknowledged the self-closer was not

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recur:

deficient practice will not

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155488	B. W		<del>-</del>	06/11/	
						****	
NAME OF F	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
					T JOSEPH RD		
ROLLING	HILLS HEALTHC	ARE CENTER		NEW A	LBANY, IN 47150		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		ATE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	operational.				The Administrator/Designee	will	
	This finding was reviewed with the Maintenance				audit carbon monoxide detect	tor	
					inspections monthly. The		
	Director and Admir	nistrator at the exit conference.			Administrator/designee will au	ıdit 5	
	3.1-19(b)				doors per week x 4 weeks, the	en 3	
					doors per week x 4 weeks, ar	nd	
					then 1 door per week x 4 wee	ks.	
		ation and interview, the facility			The results of these audits		
	failed to maintain latching hardware on 1 of 1				monthly to the QAPI committe	ee	
	smoke doors between 100A and 100B and 1 of 1				for no less than 3 months. Ar	ny	
	200 dining room hall smoke barrier doors per				patterns that are identified wil	l	
	4.6.12.3. LSC 4.6.12.3 requires existing life safety				have an Action Plan initiated.	The	
	features obvious to the public if not required by				QAPI committee will determin	ie	
	the Code, shall be either maintained or removed.				when 100% compliance is		
	This deficient pract	ice could affect all staff,			achieved or if ongoing monito	ring	
	residents, and visito	ors in these smoke			is required.		
	compartments.						
	Findings include:						
	Dagad on absorpation	on duning a tour of the facility					
		on during a tour of the facility yeen 9:30 AM and 1:10 PM with					
		etor and Rolling Hills					
		tor, the smoke doors between					
		B did not latch into the frame					
		ning room smoke doors did not					
		. Based on interview at the time					
		Executive Director and Rolling					
		_					
	Hills Maintenance l	oke doors did not latch into the					
	frame.	oke doors did not laten into the					
	name.						
	This finding was re	viewed with the Executive					
	This finding was reviewed with the Executive Director and the Rolling Hills Maintenance						
	Director at the exit						
	3.1-19(b)						
		ation and interview, the facility					
	failed to maintain th	ne metal rating label on the					

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB	8 NO. 0938-039	
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED		
		155488	B. WING		06/11/2	2024	
NAME OF F	PROVIDER OR SUPPLIER	8		ADDRESS, CITY, STATE, ZIP COD			
				T JOSEPH RD			
ROLLING	HILLS HEALTHCA	ARE CENTER	NEW A	LBANY, IN 47150			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID			(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION	
TAG				CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE		
TAG		R LSC IDENTIFYING INFORMATION	TAG			DATE	
		200 hallway nearest the dining					
		LSC 4.6.12.3 requires existing life					
		ous to the public if not					
		le, shall be either maintained or					
	removed. This defic	cient practice could affect all					
	staff, residents, and	visitors in these smoke					
	compartments.						
	Based on observation	on during a tour of the facility					
		veen 9:30 AM and 1:10 PM with					
		etor and Rolling Hills					
		for, the metal fire rating label					
	on the smoke door in the 200 hallway nearest the						
		formation that was worn or					
	I	sed on interview at the time of					
		ecutive Director agreed there					
	was information on	the fire rating label that was					
	worn or scratched a	way.					
	This finding was re	viewed with the Executive					
	_	lling Hills Maintenance					
	Director at the exit	_					
	Director at the exit	conference.					
	3.1-19(b)						
K 0222	NFPA 101						
SS=E	Egress Doors						
Bldg. 01	Egress Doors						
J	_	d means of egress shall not					
	1	a latch or a lock that					
		of a tool or key from the					
	_ ·	s using one of the following					
	•	•					
	special locking arr	-					
		S OR SECURITY THREAT					
	LOCKING						
		king arrangements for the					
	1	eeds of the patient are					
	used, only one loc	king device shall be					
	permitted on each	door and provisions shall					

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be made for the rapid removal of occupants

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STATEMEN	MENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u> COMPLETED			LETED
		155488	B. W	ING		06/11	/2024
			1	STREET /	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	8			T JOSEPH RD		
ROLLING	HILLS HEALTHC	ARE CENTER			LBANY, IN 47150		
INOLLING	· · · · · · · · · · · · · · · · · · ·	TILL OLIVILIN		INC VV A	LDANI, IN 47 IOU		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	1 -	l of locks; keying of all					
	· ·	ied by staff at all times; or					
		e means available to the					
	staff at all times.						
		.2.2.6, 19.2.2.2.5.1,					
	19.2.2.2.6						
	SPECIAL NEEDS						
	ARRANGEMENT						
	I -	king arrangements for the					
		e patient are used, all of					
		curity Locking requirements					
	_	addition, the locks must be					
	electrical locks that fail safely so as to						
	I -	of power to the device; the					
		ed by a supervised					
	-	er system and the locked					
		d by a complete smoke					
	I -	(or is constantly monitored					
		ation within the locked					
	l '	the sprinkler and detection					
	I -	ged to unlock the doors					
	upon activation.						
	18.2.2.2.5.2, 19.2	•					
	DELAYED-EGRE						
	ARRANGEMENT	=					
		lelayed-egress locking					
	I -	in accordance with					
		permitted on door					
		g low and ordinary hazard					
		igs protected throughout by					
		ervised automatic fire					
	1	or an approved, supervised					
	automatic sprinkle	•					
	18.2.2.2.4, 19.2.2						
	ACCESS-CONTR						
	LOCKING ARRAN						
		Egress Door assemblies					
		lance with 7.2.1.6.2 shall					
	be permitted.						
	18.2.2.2.4, 19.2.2	.2.4					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155488		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION  01	(X3) DATE SURVEY  COMPLETED  06/11/2024	
	PROVIDER OR SUPPLIER		3625 S	ADDRESS, CITY, STATE, ZIP COD ST JOSEPH RD ALBANY, IN 47150	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	accordance with 7 on door assemblie throughout by an a automatic fire dete approved, supervi system.  18.2.2.2.4, 19.2.2.	AGEMENTS It access door locking in I.2.1.6.3 shall be permitted is in buildings protected approved, supervised ection system and an sed automatic sprinkler	V 0222	Kanna	07/22/2024
	failed to maintain 1 and 1 of 1 egress ga all obstructions or in in the case of fire of accordance with LS	on and interview, the facility of 1 smoking area egress gate the outside hall 100 was free of impediments to full instant use other emergency in C 7.1.10.1. This deficient residents, and visitors	K 0222	K0222 Corrective action for the residents found to have bee affected by the deficient practice:  No residents were affected be alleged deficient practice.	
	on 06/11/2024 betw the Executive Direct Maintenance Direct the smoking area ar key locks, which we readily available to interview at the tim	on during a tour of the facility teen 9:30 AM and 1:10 PM with tor and Rolling Hills or, the egress fence gates in ad outside the 100 hallway had ere locked and no key appeared unlock the gates. Based on the of observation, the Rolling		Corrective action taken for those residents having the potential to be affected by the same deficient practice:	ne
	to get the keys to op Maintenance Direct egress door in the su observation.	Director stated he would need ben the egress gates. The or removed the lock on the moking area at the time of viewed with the Executive lling Hills Maintenance conference.		The lock was immediately removed from the gate to pro- egress access. A new key bo was ordered and place to allo keys to be secured and to allo immediate access to key and ensure egress access.	x w for
	3.1-19(b)			Measures/systemic change put into place to ensure the	s

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/10/2024 FORM APPROVED OMB NO. 0938-039

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155488		(X2) MULTII A. BUILDI B. WING	ple construction ng <u>01</u>	(X3) DATE SURVEY  COMPLETED  06/11/2024
	PROVIDER OR SUPPLIE	R	36	REET ADDRESS, CITY, STATE, ZIP C 25 ST JOSEPH RD EW ALBANY, IN 47150	_
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREI TA	FIX PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	DATE
				deficient practice doe recur:  ED educated Mainten: Director on requiremer 7.1.10.1 on 7.5.2024	ance
				Corrective actions to monitored to ensure t deficient practice will recur:	he
				The Administrator/Desobserve courtyard gate key secure and immed available to ensure egroup 5 times per week to en adequate coverage x 4 times per week x 4 weweekly ongoing. The rethese audits monthly to committee for no less to months. Any patterns identified will have an a initiated. The QAPI cordetermine when 100% is achieved or if ongoir monitoring is required.	es to ensure iately ress access sure weeks, 2 eks, then esults of the QAPI chan 3 that are Action Plan mmittee will compliance
K 0300 SS=F Bldg. 01	Section 18.3 and requirements that	r RKS section any LSC			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		ľ	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	<u>01</u>	COMPLETED	
		155488	B. WI	ING		06/11/	2024
	PROVIDER OR SUPPLIES			3625 S	ADDRESS, CITY, STATE, ZIP COD T JOSEPH RD		
ROLLING	G HILLS HEALTHC	ARE CENTER		NEW A	LBANY, IN 47150		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI		TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	with the applicable Life					
	Safety Code or NFPA standard citation, should be included on Form CMS-2567.						
	Based on record rev		K 0:	300	Corrective action for the		08/05/2024
		cility failed to ensure	I K U.	300	residents found to have been	1	06/03/2024
		the preventative maintenance			affected by the deficient	•	
		is was complete. NFPA 101 in			practice:		
	4.6.12.3 states exist	ting life safety features obvious			No residents were affected by	the	
	to the public, if not required by the Code, shall be			alleged deficient practice.			
		72, 29.10 Maintenance and					
	_	equipment shall be maintained					
	and tested in accordance with the manufacturer's published instructions and per the requirements						
					Corrective action taken for		
	of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy				those residents having the	_	
	_	this Code and conform to the			potential to be affected by the same deficient practice:		
	_	eturer's published instructions.			same deficient practice:		
		ice could affect all residents,					
	_	the resident rooms.					
	,				All smoke detectors in resider	nt	
	Findings include:				rooms were tested.		
		view on 06/10/2024 between					
		PM with the Executive Director,					
		nance Director, and the			Measures/systemic changes	;	
	_	tenance Director, no			put into place to ensure the		
	_	arding the testing of the			deficient practice does not		
		oke detectors in resident e for review. Based on			recur:		
		e for review. Based on the of record review, the Rolling			RDO educated Maintenance		
		Director stated he tests the			Director on requirements for K		
		thly but does not document it.			0300 as it relates to smoke	<u>.</u>	
		on at the time of record review,			detector checks.		
		s indicated they should be					
		ne time of the exit conference,					
	the Rolling Hills M	aintenance Director stated he					
		ectors weekly and checks the			Corrective actions to be		
	batteries monthly.				monitored to ensure the		
					deficient practice will not		
	This finding was re	viewed with the Executive			recur:		

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155488	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE COMPI 06/11	
	PROVIDER OR SUPPLIER		3625 S	ADDRESS, CITY, STATE, ZIP ( ST JOSEPH RD ALBANY, IN 47150	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR Director and Rollin	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION g Hills Maintenance Director at	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
K 0321	the exit conference. 3.1-19(b)			The Administrator/Deaudit smoke detector of weekly x 4 weeks, the 3 months. The results audits monthly to the 0 committee for no less months. Any patterns identified will have an initiated. The QAPI condetermine when 100% is achieved or if ongoin monitoring is required.	checks n monthly x of these QAPI than 3 that are Action Plan mmittee will compliance	
SS=E Bldg. 01	barrier having 1-hi (with 3/4 hour fire automatic fire extinaccordance with 8 approved automation option is used, the from other spaces partitions and doo Doors shall be sel automatic-closing nonrated or field-ado not exceed 48 the door.  Describe the floor	- Enclosure are protected by a fire our fire resistance rating rated doors) or an nguishing system in 1.7.1 or 19.3.5.9. When the cic fire extinguishing system e areas shall be separated by smoke resisting rs in accordance with 8.4.				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		a. Building <u>01</u>		COMPLETED	
		155488	B. WI	NG		06/11/2024	
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
	G HILLS HEALTHC				T JOSEPH RD LBANY, IN 47150		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE COM	PLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)	D	ATE
	Area	Automatic Sprinkler					
	Separation						
		-Fired Heater Rooms					
		er than 100 square feet) nance, and Paint Shops					
		nance, and raint Shops noms (exceeding 64					
	gallons)	onis (exceeding 04					
	e. Trash Collection	n Rooms					
	(exceeding 64 gal	lons)					
	f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe						
	Hazard - see K322)						
		on and interview, the facility	K 0	321	Corrective action for the		5/2024
		corridor door to 1 of 1			residents found to have bee	n	
		ger office in the 100A hall			affected by the deficient		
		square feet in size, was			practice:		
	_	f-closing device which would atomatically close and latch			No residents were affected by	/ tne	
		. This deficient practice could			alleged deficient practice.		
		, and residents in this smoke					
	compartment.	, and residents in this smoke					
					Corrective action taken for		
	Findings include:				those residents having the		
					potential to be affected by the	ne	
	Based on observation	ons on 06/11/24 between 9:30			same deficient practice:		
		vith the Executive Director and					
	_	aintenance Director, the door					
		t manager office in 100A hall					
		nount of combustible materials,			Activities/Unit Manager office		
		supplies, and the door was not			self-closing device installed o		
		sing mechanism. Based on			7.10.2024. Facility tour comp		
		e of observation, the Rolling Director agreed the office had a			to ensure no other areas requested self-closing device installation		
		of combustible materials and			Son-Gosing device installation	"	
	no self-closing mec						
	This finding was re	viewed with the Executive			Measures/systemic change	s	
		lling Hills Maintenance			put into place to ensure the		
	Director at the exit	conference.			deficient practice does not		

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155488		(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION  01	(X3) DATE SURVEY  COMPLETED  06/11/2024	
	PROVIDER OR SUPPLIER		3625	ET ADDRESS, CITY, STATE, ZIP COD ST JOSEPH RD ALBANY, IN 47150	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	DBE COMPLETION
	3.1-19(b)			recur:	
	\			RDO educated Maintenar Director on requirements f 19.3.5.9 on 7.10.2024	
				Corrective actions to be monitored to ensure the deficient practice will not recur:	
				The Administrator/Design audit identified areas requiself-closing device monthly ensure placement and fund The results of these audits monthly to the QAPI common for no less than 3 months. patterns that are identified have an Action Plan initiat QAPI committee will deter when 100% compliance is achieved or if ongoing mosts required.	iring y to oction. s nittee Any will ed. The mine
K 0331 SS=E Bldg. 01	exposed interior s as fixed or movab columns, and hav				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		f '			(X3) DATE	X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	COMPLETED	
		155488	B. W	ING _		06/11	/2024	
NA 55 55 5	NOTHER OF STATE		-	STREE	T ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	PROVIDER OR SUPPLIEF	C .			ST JOSEPH RD			
ROLLING	HILLS HEALTHC	ARE CENTER		NEW	ALBANY, IN 47150			
(X4) ID		STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	` ·	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCE		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 spr							
	maioato namo opi	odd raung(o).						
	Based on observation	on, interview and record	K 0	331	Corrective action for the		08/05/2024	
	review; the facility	failed to ensure materials used			residents found to have bee	n		
	as an interior finish on the 100 hall had a flame				affected by the deficient			
		ss A or Class B. LSC 101			practice:			
	10.2.3.4 states products required to be tested in				No residents were affected by	/ the		
		FPA 255, Standard Method of			alleged deficient practice.			
		rning Characteristics of						
	-	shall be grouped in the						
	following classes in accordance with their flame spread and smoke development.				Corrective action taken for			
	-	Wall and Ceiling Finish. Flame		those residents having the				
		development 0-450. Includes		potential to be affected by th		10		
	-	ied at 25 or less on the flame			same deficient practice:	ie		
	•	d 450 or less on the smoke test			Sums demoient practice.			
	-	thereof, when so tested, shall						
	not continue to prop	pagate fire.						
		Wall and Ceiling Finish. Flame			Flame spread documentation	า		
	*	te development 0-450. Includes		obtained for kick plates an				
	-	ied at more than 25 but not			wallpaper.			
		e flame spread test scale and						
	450 or less on the st							
		Wall and Ceiling Finish. Flame ske development 0-450.			Moscuros/systemia sharra	•		
	_	al classified at more than 75			Measures/systemic change put into place to ensure the	5		
	•	00 on the flame spread test			deficient practice does not			
		ss on the smoke test scale.			recur:			
		ice could affect all residents,						
	staff, and visitors w				RDO educated Maintenance			
	compartments in the	e 100 hall.			Director on requirements for	NFPA		
					101 10.2, 19.3.3.1, 19.3.3.2.			
	Findings include:							
	Based on record rev	view on 06/10/2024 between						
	9:30 AM and 3:30 l	PM with the Executive Director,			Corrective actions to be			
	Wedgwood Mainter	nance Director, and the	1		monitored to ensure the		1	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES							FORM APPROVED OMB NO. 0938-039	
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155488	A. BUI	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 06/11/2024	
	PROVIDER OR SUPPLIE			3625 S	ADDRESS, CITY, STATE, ZIP COD			
ROLLING HILLS HEALTHCARE CENTER			NEW A	ALBANY, IN 47150				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E	(X5) COMPLETION DATE	
	documentation regarest the plastic kickguards on the 100 hall was observation on 06/1:10 PM with the E Hills Maintenance kickguards on door interview at the time Director agreed the regarding the flame kickguards.  This finding was regarded.	tenance Director no arding flame spread rating for rds on the doors of the rooms available for review. Based on 11/2024 between 9:30 AM and Executive Director and Rolling Director, there were plastic rs in the 100 hallway. Based on the of observation, the Executive are was no documentation respread rating of the reviewed with the Executive conference.			deficient practice will not recur:  The Administrator/Designed audit life safety book monthl ensure flame spread informal maintained on record. The record these audits monthly to the QAPI committee for no less months. Any patterns that a identified will have an Action initiated. The QAPI committee determine when 100% compiles achieved or if ongoing monitoring is required.	y to ation esults e than 3 re I Plan ee will		
K 0345 SS=F Bldg. 01	in accordance with complying with the National Electric (National Fire Alar Records of system and testing are respected on observational failed to maintain that it had accurate with the requireme	m - Testing and m is tested and maintained h an approved program e requirements of NFPA 70, Code, and NFPA 72, m and Signaling Code. m acceptance, maintenance	K 03	45	Corrective action for the residents found to have be affected by the deficient practice:No residents were	en	08/05/2024	

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visitors.

edition, Sections 14.1, 14.1.1. This deficient

practice could affect all residents, staff and

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affected by the alleged deficient

practice. Corrective action

taken for those residents

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE			(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u> COMPLE			ETED
		155488	B. WING 06/11/2024			2024	
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER	L			Γ JOSEPH RD		
ROLLING	HILLS HEALTHCA	ARE CENTER	NEW ALBANY, IN 47150				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG	REGULATORY OR	LISC IDENTIFYING INFORMATION	+	TAG			DATE
	Findings include:				having the potential to be affected by the same deficien		
					practice: Time corrected on fi	re	
		on during a tour of the facility			panel and annunciator.		
		:20 AM with the Executive			Measures/systemic change	s	
		g Hills Maintenance Director, neiator located in the 400 hall			put into place to ensure the		
		as 10:25 AM and at 10:43 AM			deficient practice does not	0000	
		ol panel in the central circular			recur:RDO educated Mainten Director on requirements for	ance	
		AM. Based on interview at the			NFPA, 19.3.4 and 9.6 and NF		
		, the Rolling Hills Maintenance			14.1, 14.1.1. <b>Corrective action</b>		
		time displayed on the fire			to be monitored to ensure th		
	panel and annunciator was incorrect.				deficient practice will not	Ĭ	
	1				recur:The Administrator/Design	nee	
	This finding was rev	viewed with the Executive			will audit time display on fire p		
		lling Hills Maintenance			and annunciator weekly x 4		
	Director at the exit	conference.			weeks, then monthly thereafte	r.	
					The results of these audits		
	3.1-19(b)				monthly to the QAPI committe	е	
					for no less than 3 months. An	у	
					patterns that are identified will		
					have an Action Plan initiated.	The	
					QAPI committee will determine	е	
					when 100% compliance is		
					achieved or if ongoing monitor	ring	
					is required.		
K 0353	NEDA 101						
SS=F	NFPA 101	- Maintenance and Testing					
Bldg. 01		•					
Diag. 01	· ·	- Maintenance and Testing er and standpipe systems					
	-	ted, and maintained in					
	-	IFPA 25, Standard for the					
		g, and Maintaining of					
		Protection Systems.					
		n design, maintenance,					
	•	sting are maintained in a					
		nd readily available.					
		system last checked					
	· ·	<u>-</u> 					
			1				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	<u>01</u>	COMPLETED	
		155488	B. W	B. WING 06/11/			
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 3625 ST JOSEPH RD NEW ALBANY, IN 47150				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		DROWIDERIC DLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OF	GULATORY OR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
	b) Who provided	system test					
	c) Water system supply source						
	Provide in REMAR	RKS information on					
	coverage for any non-required or partial						
	automatic sprinkle						
	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		K 0	353	Corrective action for the	08/05/2024	
					residents found to have bee	n	
					affected by the deficient		
	was tested annually in accordance with NFPA 25.				practice:		
	NFPA 25, Standard for the Inspection, Testing,				No residents were affected by	/ the	
	and Maintenance of Water-Based Fire Protection				alleged deficient practice.		
	-	ion, Section 13.6.2.1 states all					
	-	s installed in fire protection					
		be tested annually by					
	-	rd flow test of the system at			Corrective action taken for		
	-	ate, including hose stream			those residents having the		
		rants or inside hose stations			potential to be affected by the	ne	
		ream of the backflow preventer.			same deficient practice:		
	-	ice could affect all residents in					
	the facility.						
	Findings include:				Safe care contacted to inspec	ct	
					backflow prevention device.		
		view on 06/10/2024 between					
		PM with the Executive Director,			Repair/replacement for ceiling	gs in	
	_	nance Director, Rolling Hills			400 mechanical room, near 30	00	
		tor, and the Regional Director			hall smoke door, Ceiling tiles	near	
	•	ons, documentation titled			entrance to 100 hall, ceiling til		
		w Prevention Test -			near room 123, ceiling by kitch	hen	
		01/11/2024 completed by			hood, and penetration near		
		the facility's backflow			sprinkler head in room 108		
	-	e backflow prevention testing.			completed.		
		mentation regarding the					
	_	was available for review.			Safe care contacted to replace		
		at the time of record review,			escutcheons in Iron Mountain		
	-	aintenance Director stated he			closet and in laundry room.		
	was not aware of any additional documentation						

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLETED			ETED	
		155488	B. W	ING		06/11/	2024
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	8			T JOSEPH RD		
ROLLING	S HILLS HEALTHC	ARE CENTER			LBANY, IN 47150		
INOLLING	THELO HEALTHU	TILL OLIVILIA		INE VV A	LDANI, IN 47 IOU		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX			COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	regarding the backf	low preventer.					
	This finding was reviewed with the Executive Director and the Rolling Hills Maintenance				Measures/systemic changes	5	
					put into place to ensure the		
	Director at the exit	conference.			deficient practice does not		
					recur:		
	3.1-19(b)						
					RDO educated Maintenance		
		ation and interview, the facility			Director on requirements for k	353	
		ne ceiling construction in 1 of 1			as it relates to maintenance of	f	
		l rooms, 1 of 1 300 halls, 1 of 1			ceilings and escutcheons.		
	100 halls, 1 of 1 kitchens, and 1 of 1 room 108.						
	NFPA 13, 2010 edition, Section 3.3.5.4 defines a						
	_	continuous ceiling free from					
	-	rities, lumps, or indentations.			Corrective actions to be		
		ot air and gases around the			monitored to ensure the		
	-	s the sprinkler to operate at a			deficient practice will not		
		re. Section 8.5.4.1.1 states the			recur:		
		e sprinkler deflector and the					
	-	be selected based on the type			The Administrator/Designee v	will	
	-	type of construction. This			audit 5 areas in the facility for		
	-	ould affect residents, staff, and			ceiling and escutcheons in pla		
	visitors in the vicin	ity of those smoke			weekly x 4 weeks, then 3 area		
	compartments.				4 weeks, then 1 area x 4 weel	ks.	
					The results of these audits		
	Findings include:				monthly to the QAPI committe		
					for no less than 3 months. An	-	
		on during a tour of the facility			patterns that are identified will		
		veen 9:30 AM and 1:10 PM with			have an Action Plan initiated.		
		etor and Rolling Hills			QAPI committee will determin	е	
		tor, the following was			when 100% compliance is		
	observed:				achieved or if ongoing monitor	ring	
		ation in the ceiling of the 400			is required.		
	hall mechanical roo						
		sing near the 300 hall smoke					
	door						
	c. a ceiling tile missing in the 100 hall near the						
		entrance to the 100 hall					
	_	tration in the ceiling tile near					
	room 123		1				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER				COMPL	
		155488	B. WING		_	06/11/	/2024
NAME OF P	DOMDED OF CHIPPLYEE		STF	REET A	ADDRESS, CITY, STATE, ZIP COD	-	
NAME OF P	PROVIDER OR SUPPLIEF	C.	36	25 ST	Γ JOSEPH RD		
	HILLS HEALTHC	ARE CENTER		W Al	LBANY, IN 47150		
(X4) ID		STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)			COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	j .	DEFICIENCY		DATE
	hood	on in the ceiling by the kitchen					
		on in the ceiling by the kitchen					
	hood	on in the centing by the kitchen					
		tion in the ceiling by the					
	kitchen hood						
		ation in the ceiling by a					
	sprinkler head in ro	<del>-</del> -					
	-	at the time of observations,					
		etor and Rolling Hills					
	Maintenance Direct	or agreed there were					
	-	ceiling in the aforementioned					
	_	ded the measurements. The					
		and Rolling Hills Maintenance					
		e is construction occurring in					
		enced by the plastic sheeting					
		in the kitchen, however the					
		active use at the time of					
	observation.						
	This finding was re	viewed with the Executive					
	-	Illing Hills Maintenance					
	Director at the exit	_					
	3.1-19(b)						
	3. Based on observa	ation and interview, the facility					
		ne ceiling construction in 1 of 1					
		ets in the employee break room					
		room in accordance with NFPA					
	•	Installation of Sprinkler					
		, 2010 edition, Section 6.2.7.1					
	states plates, escute	heons, or other devices used					
		space around a sprinkler shall					
		be listed for use around a					
	_	cient practice could affect staff,					
	residents, and visito	ors in this smoke compartment.					
	E' 1' ' 1 1						
	Findings include:						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155488		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY  COMPLETED  06/11/2024			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 3625 ST JOSEPH RD NEW ALBANY, IN 47150				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
K 0355 SS=E Bldg. 01	on 06/11/2024 between the Executive Direct Maintenance Direct in the Iron Mountain room and 1 of 2 escenear the washers. Be of observation, the I Director agreed them the aforementioned  This finding was reconstructed by the aforementioned  This finding was reconstructed by the aforementioned  This finding was reconstructed and the Ro Director and the Ro Director at the exit of the state of t	riewed with the Executive Illing Hills Maintenance conference.  Inguishers Inguishers Inguishers are selected, Id, and maintained in IFPA 10, Standard for Inguishers.	K 0355	Corrective action for the residents found to have been affected by the deficient practice: No residents were affected by alleged deficient practice.  Corrective action taken for those residents having the potential to be affected by the same deficient practice:  Safecare contacted to requesting the resident practice.	the le		

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07/10/2024 PRINTED: FORM APPROVED

OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 06/11/2024 155488 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 3625 ST JOSEPH RD ROLLING HILLS HEALTHCARE CENTER NEW ALBANY, IN 47150 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Findings include: inspection of fire extinguishers identified on the survey. Safe care Based on observation during a tour of the facility was contacted to request proper on 06/11/2024 between 9:30 AM and 1:10 PM with installation of fire extinguisher in the Executive Director and the Rolling Hills 200 hall mechanical room and Maintenance Director, the ABC portable fire kitchen. extinguisher located in the 200 hall mechanical room was sitting on the floor. Based on interview Measures/systemic changes at the time of observation, the Rolling Hills put into place to ensure the Maintenance Director agreed the fire extinguisher deficient practice does not was sitting on the counter, not mounted. recur: This finding was reviewed with the Executive **RDO** educated Maintenance Director and the Rolling Hills Maintenance Director on K355 requirements as Director. they related to fire extinguisher installation and inspection. 3.1-19(b) Corrective actions to be 2. Based on observation and interview, the facility monitored to ensure the failed to ensure 1 of 1 400 hall mechanicals room deficient practice will not fire extinguishers and 1 of 1 fire extinguishers in recur: the activities office was given maintenance at periods not more than one year apart. NFPA 10, The Administrator/Designee will the Standard for Portable Fire Extinguishers, at audit 5 fire extinguishers per Section 7.3.1.1.1 requires that fire extinguishers month for completion of inspection shall be subjected to maintenance at intervals of and for proper installation x 3 not more than 1 year, at the time of hydrostatic months. The results of these test, or when specifically indicated by an audits monthly to the QAPI inspection or electronic notification. Section committee for no less than 3 3.3.15 defines extinguisher maintenance as a months. Any patterns that are thorough examination of the fire extinguisher that identified will have an Action Plan is intended to give maximum assurance that a fire initiated. The QAPI committee will extinguisher will operate effectively and safely determine when 100% compliance and to determine if physical damage or condition is achieved or if ongoing will prevent its operation, if any repair or monitoring is required. replacement is necessary, and if hydrostatic testing or internal maintenance is required.

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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

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155488	B. WING 06			06/11/	/2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	R			T JOSEPH RD		
ROLLING	S HILLS HEALTHO	ARE CENTER			LBANY, IN 47150		
NOLLING	COLLING HILLS HEALTHCARE CENTER			INEW A	LDAN1, IN 47 130		
(X4) ID		STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		ГЕ	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE
	_	es the person performing the					
		s the name of the agency					
		k. This deficient practice could					
		as well as staff and visitors in					
	this smoke compart	ment.					
	Findings include:						
		0.1 0.31					
		on during a tour of the facility					
		veen 9:30 AM and 1:10 PM with					
		ctor and Rolling Hills tor, the fire extinguisher					
		nall mechanical room had a tag					
		ast had an annual check in					
		ased on interview at the time of					
		lling Hills Maintenance					
		tag indicated the fire					
	_	st been checked in November					
	1	the contractor had been to the					
	facility to check the						
	lucinty to eneck the	The extinguishers.					
	This finding was re	viewed with the Executive					
		olling Hills Maintenance					
	Director at the exit	•					
	3.1-19(b)						
	3. Based on observa	ation and interview, the facility					
	failed to inspect 1 o	of 1 fire extinguishers in the					
	clean linen room an	nd 1 of 1 fire extinguishers in					
	the activities office.	. Based on observation and					
	interview, the facili	ty failed to inspect 1 of 2					
	portable fire exting	uishers in the north hallway					
		10, Standard for Portable Fire					
	Extinguishers, Sect	ion 7.2.1.2 states fire					
	extinguishers shall	be inspected either manually or					
		etronic device / system at a					
	minimum of 30-day	y intervals. Section 7.2.2 states					
	periodic inspection	or electronic monitoring of fire					
	extinguishers shall	include a check of at least the					

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	l í	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155488	A. BU B. W		01	06/11	
NAME OF I	PROVIDER OR SUPPLIER	<b>.</b>			ADDRESS, CITY, STATE, ZIP COD	1	
ROLLING	G HILLS HEALTHC	ARE CENTER			LBANY, IN 47150		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	following items:						
	(1) Location in desi	-					
	1 1	to access or visibility					
	(3) Pressure gauge	reading or indicator in the					
	operable range or p	osition					
	(4) Fullness determ	ined by weighing or hefting for					
	self expelling-type	extinguishers,					
	cartridge-operated	extinguishers, and pump tanks					
	(5) Condition of tire	es, 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 ke	ep records of all fire					
	extinguishers inspec	cted, including those found to					
	require corrective a	ction. Section 7.2.4.3 requires					
	where at least mont	hly manual inspections are					
		the manual inspection was					
		initials of the person					
	1 ~	pection shall be recorded.					
		ires where manual inspections					
		ords for manual inspections					
		ag or label attached to the fire					
	_	inspection checklist					
	1	or by an electronic method.					
	· ·	aires records shall be kept to					
		least the last 12 monthly					
		en performed. This deficient					
		et all residents, staff, and					
	visitors to those sm						
		•					
	Findings include:						
	Based on observation	on during a tour of the facility					
		veen 9:30 AM and 1:10 PM with					
		etor and Rolling Hills					
		tor, the monthly inspection tag					
		sher located in the clean linen					
	_						
	room indicated it had not been checked from May 2023-December 2023 and the fire extinguisher						

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155488		l í	ILDING	NSTRUCTION  01	(X3) DATE COMPL 06/11/	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 3625 ST JOSEPH RD NEW ALBANY, IN 47150					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	]	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	located in the activi been checked in Ap	ties office indicated it had only ril 2024.						
	Director and the Ro Director at the exit	viewed with the Executive Illing Hills Maintenance conference.						
K 0363 SS=E Bldg. 01	than required enciexits, or hazardou of smoke and are solid-bonded core capable of resistir minutes. Doors in compartments are passage of smoke to rooms containing combustible mate hardware. Roller I. CMS regulation. The apply to auxiliary a flammable or complying to a covering is not expected by the door scomplying to the door closed with a covering of the door release when the permitted. Nonrate unlimited height a meeting 19.3.6.3.4 frames shall be lated.	rials have positive latching atches are prohibited by These requirements do not spaces that do not contain						

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Facility ID: 000526

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i i		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		155488	B. WI	ING		06/11/2024	
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD	•	
					T JOSEPH RD		
ROLLING	G HILLS HEALTHCA	ARE CENTER		NEW A	LBANY, IN 47150		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE	
TAG	unless the smoke			TAG		DATE	
		fire window assemblies are					
	l .	n sprinklered compartments					
		ictions in area or fire					
		s or frames in window					
	assemblies.						
	19.3.6.3, 42 CFR 483, and 485	Parts 403, 418, 460, 482,					
	l '	(S details of doors such as					
		ngs, automatics closing					
	devices, etc.						
	1. Based on observation and interview, the facility failed to ensure 1 of 1 doors to the dishwashing		K 0	363	Corrective action for the	08/05/2024	
			11.0		residents found to have been		
	room to the dining	room would close completely			affected by the deficient		
	and latch into the do	oor frame without issue. This			practice:		
	_	ould affect staff, visitors, and			No residents were affected by	the	
	residents in this sm	oke compartment.			alleged deficient practice.		
	Findings include:						
	Dagad on absorpation	an duning a taun of the facility			Competitive settion taken for		
		on during a tour of the facility ween 9:30 AM and 1:10 PM with			Corrective action taken for those residents having the		
		etor and Rolling Hills			potential to be affected by th	ne	
	Maintenance Direct	_			same deficient practice:		
		vas able to be closed, however					
	_	uring closing at the top left			The kitchen dish room door w	vas	
	corner of the door a	assembly revealing the left side			inspected and repaired to ens	ure	
	_	e were not connected and it			closure and latch to form a sm	noke	
		d the door was constructed to			barrier.		
		f smoke. Based on interview at					
		tion, the Executive Director			Room 122 hall door was		
		faintenance Director agreed the			inspected and repaired to ens		
	door frame was not	connected on the left and top.			closure and latch to form a sm barrier.	юке	
	This finding was re	viewed with the Executive			baillet.		
	_	olling Hills Maintenance					
	Director at the exit	_					
					Measures/systemic changes	s	
	3.1-19(b)				put into place to ensure the		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155488		A. BU	A. BUILDING <u>01</u> C			SURVEY ETED	
		155488	B. W	-		06/11/	2024
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 3625 ST JOSEPH RD NEW ALBANY, IN 47150			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ιΤΕ	(X5) COMPLETION DATE
mo	2. Based on observa failed to ensure 1 of to close and latch in	ation and interview, the facility and the frame. This deficient are tup to staff, visitors, and 2		140	deficient practice does not recur:  ED educated Maintenance Director on requirements for Notandards as references in NF 101 at 19.3.6.3 on 7.10.2024		DATE
	on 06/11/2024 betw the Executive Direct Maintenance Direct unable to close and interview at the tim Director and Rollin agreed the door to r and latch into the fr	viewed with the Executive Iling Hills Maintenance			Corrective actions to be monitored to ensure the deficient practice will not recur:  The Administrator/designee vaudit 5 doors per week x 4 we then 3 doors per week x 4 we and then 1 door per week x 4 weeks. The results of these amonthly to the QAPI committee for no less than 3 months. An patterns that are identified will have an Action Plan initiated. QAPI committee will determine when 100% compliance is achieved or if ongoing monitor is required	eeks, eks, udits ee by The e	
K 0372 SS=E Bldg. 01	Barrie Subdivision of Bui Barrier Construction 2012 EXISTING Smoke barriers sh 1/2-hour fire resist	Iding Spaces - Smoke Iding Spaces - Smoke on Iding Spaces - Smoke on Iding Spaces - Smoke on Iding Spaces - Smoke					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 01 COMPLETED				
		155488	B. WING 06/11/2024			/2024	
NAME OF E	PROVIDER OR SUPPLIER	,		STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
					T JOSEPH RD		
ROLLING	G HILLS HEALTHC	ARE CENTER		NEW A	LBANY, IN 47150		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF C			(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE.	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		e dampers are not required ns in fully ducted HVAC					
		approved sprinkler system					
	l -	oke compartments adjacent					
	to the smoke barr						
	19.3.7.3, 8.6.7.1(1						
	1	hanical smoke control					
	system in REMAR						
		on and interview, the facility	K 0	372	Corrective action for the		08/05/2024
		penetrations caused by the			residents found to have been	n	
		or conduit through 1 of 1 near the staff development			affected by the deficient		
		vas protected to maintain the			practice: No residents were affected by	the	
		Eeach smoke barrier. LSC			alleged deficient practice.	uic	
		quires smoke barriers to be			g		
	constructed in accor	rdance with LSC Section 8.5					
		nimum ½ hour fire resistive					
		nt practice could affect staff,			Corrective action taken for		
	residents, and visito	ors in this smoke compartment.			those residents having the		
	Findings in the fact				potential to be affected by the	ie	
	Findings include:				same deficient practice:		
	Based on observation	on during a tour of the facility					
	on 06/11/2024 betw	veen 9:30 AM and 1:10 PM with			The penetration in smoke bar	rier	
		tor and Rolling Hills			wall near the staff developme	nt	
		tor, a 2 inch by 3 inch			coordinator office was repaire	d on	
	1 ^	wires and an 8 inch by 4 inch			7.11.2024.		
	1 ~	a conduit were located in the					
		near the staff development  Based on interview at the time					
		Rolling Hills Maintenance			Measures/systemic changes	3	
		re were penetrations in the			put into place to ensure the	-	
	_	at the aforementioned location			deficient practice does not		
	and provided the m	easurements.			recur:		
	TT1 ' C' 1'	' 1 M A E d'					
	_	viewed with the Executive			RDO educated Maintenance		
	Director and the Ro	olling Hills Maintenance			Director on requirements as it relates to K372.		
	Director at the exit	comordiac.			TOTALES TO NOTZ.		

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155488		A. BUILDING  B. WING	01	COMPLETED 06/11/2024	
	PROVIDER OR SUPPLIER		3625 S	ADDRESS, CITY, STATE, ZIP COD T JOSEPH RD LBANY, IN 47150	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	3.1-19(b)			Corrective actions to be monitored to ensure the deficient practice will not recur:  The Administrator/Designee with observe 5 areas for smoker be wall penetrations x 4 weeks, the 3 areas x 4 weeks, then 1 area 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 Finitiated. The QAPI committee determine when 100% complicits achieved or if ongoing monitoring is required.	arrier hen a x e Plan e will
K 0511 SS=E Bldg. 01	complies with NFF Code, electrical wi complies with NFF Code. Existing ins service provided n 18.5.1.1, 19.5.1.1, 1. Based on observa failed to ensure 1 of outlets in the 300 cl NFPA 70, 2011 Edi Faceplates (Cover P faceplates shall be in	Electric gas or related gas piping PA 54, National Fuel Gas ring and equipment PA 70, National Electric tallations can continue in o hazard to life.	K 0511	STEP 1 Corrective action for the residents found to have been affected by the deficier practice: No residents were harmed by alleged deficient practice.	nt Solosia 2021

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DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 06/11/2024 155488 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 3625 ST JOSEPH RD ROLLING HILLS HEALTHCARE CENTER NEW ALBANY, IN 47150 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE surface. This deficient practice could affect residents, staff, and visitors in the 300 hall. STEP 2 Corrective action taken Findings include: for those residents having the potential to be affected by the Based on observation during a tour of the facility same deficient practice: on 06/11/2024 between 9:30 AM and 1:10 PM with the Executive Director and Rolling Hills The 300 clean utility room Maintenance Director, the outlet cover in the 300 receptacle faceplate was installed. The activities office GFCI hall clean utility room was laying on the counter in the clean utility room below the outlet the cover receptacle was replaced. 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. STEP 3 Measures/systemic changes put into place to This finding was reviewed with the Executive ensure the deficient practice Director and the Rolling Hills Maintenance does not recur: Director at the exit conference. The RDO/Designee held an 3.1-19(b) in-service with facility maintenance director on K511 as it relates to 2. Based on observation and interview, the facility receptacle faceplate coverage and failed to ensure 1 of 1 wet locations in the GFCI protection. 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 STEP 4 Corrective actions to electrical wiring and equipment to comply with be monitored to ensure the NFPA 70, National Electrical Code. NFPA 70, deficient practice will not NEC 2011 Edition at 210.8 Ground-Fault recur: Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for The Maintenance personnel shall be provided as required in Director/Designee will audit 5 210.8(A) through (C). The ground-fault receptacles weekly x 4 weeks, circuit-interrupter shall be installed in a readily then 3 receptacles weekly x 4

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accessible location.

(B) Other Than Dwelling Units. All 125-volt,

installed in the locations specified in 210.8(B)(1)

single-phase, 15- and 20-ampere receptacles

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appropriate.

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weeks, then 1 receptacle weekly x

installed and GFCI function when

4 weeks to ensure faceplate

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155488		ľ	JILDING	onstruction 01	(X3) DATE COMPL <b>06/11</b> /	ETED	
	PROVIDER OR SUPPLIEF			3625 ST	ADDRESS, CITY, STATE, ZIP COD T JOSEPH RD LBANY, IN 47150		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	· · · · · · · · · · · · · · · · · · ·	DATE
	through (8) shall ha circuit-interrupter p (1) Bathrooms (2) Kitchens (3) Rooftops (4) Outdoors Exception No. 1 to not readily accessib branch circuit dediction, or pipeline shall be permitted twith 426.28 or 427. Exception No. 2 to only, where the consupervision ensure are involved, an asseconductor program shall be permitted foutlets used to support outlets used to support a greater haz having a design that protection. (5) Sinks - where read the support of the exception No. 1 to receptacles used to removal of power with the protection. Exception No. 2 to patient bed location care areas of health covered under 210.8(B)(1), GFCI (6) Indoor wet locar	R LSC IDENTIFYING INFORMATION  The ground-fault protection for personnel.  (3) and (4): Receptacles that are ple and are supplied by a cated to electric snow-melting, and vessel heating equipment to be installed in accordance (22, as applicable.  (4): In industrial establishments additions of maintenance and that only qualified personnel sured equipment grounding as specified in 590.6(B)(2) for only those receptacle ply equipment that would ard if power is interrupted or at is not compatible with GFCI exceptacles are installed within poutside edge of the sink.  (5): In industrial laboratories, supply equipment where would introduce a greater mitted to be installed without  (5): For receptacles located in as of general care or critical care facilities other than those protection shall not be required.			CROSS-REFERENCED TO THE APPROPRIA	the v to s hat on or if	
	electrical diagnostic	e bays, and similar areas where c equipment, electrical hand ghting equipment are to be					

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155488		A. BUILDING B. WING	01	COMP	LETED 1/2024	
	PROVIDER OR SUPPLIER		3625 S	ADDRESS, CITY, STATE, ZIP COD T JOSEPH RD JLBANY, IN 47150		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE	(X5) COMPLETION DATE
K 0740	receptacles and fixe the wet location to hinterrupter (GFCI) preduce the contact relectrical insulation. This deficient practithe hand washing sites a seed on observation of 11/2024 between the Executive Direct Maintenance Direct the activities office with a ground fault when tested, the circuiterview at the time Director agreed the activities office when the activities office when the seed of the activities of the seed of	viewed with the Executive				
K 0712 SS=F Bldg. 01	alarm signal and s conditions. Fire dri and unexpected tin conditions, at leas The staff is familia	he transmission of a fire imulation of emergency fire ills are held at expected mes under varying t quarterly on each shift. It with procedures and is the part of established				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 01 COMPLETED				
		155488	B. WING 06/11/2024				2024
	ROVIDER OR SUPPLIER		•	3625 S	ADDRESS, CITY, STATE, ZIP COD T JOSEPH RD LBANY, IN 47150	•	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		.TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
TAG	routine. Where dr 9:00 PM and 6:00 announcement ma audible alarms. 19.7.1.4 through 1 Based on record rev failed to conduct 2n of 4 quarters. LSC 1 conducted quarterly conditions. This def and residents.  Findings include:  Based on record rev 9:30 AM and 3:30 F Wedgwood Mainter Hills Maintenance I 2nd shift fire drills of 2023 was availab interview at the time Hills Maintenance I documentation of fi quarter of 2023 for 1	ills are conducted between AM, a coded ay be used instead of 9.7.1.7 view and interview, the facility id shift quarterly fire drills for 2 19.7.1.6 requires drills to be on each shift under varied ficient practice affects all staff view on 06/10/2024 between PM with the Executive Director, mance Director, and Rolling Director, no documentation for during the 3rd and 4th quarters ble for review. Based on e of record review, the Rolling Director agreed there was no re drills during the 3rd and 4th	K 0		K712 STEP 1 Corrective action for the residents found to have been affected by the deficier practice:  No residents were harmed by alleged deficient practice.  STEP 2 Corrective action tal for those residents having the potential to be affected by the same deficient practice:  Random fire drill was conduction 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 mainten director on K-712 as it relates to conducting fire drills at unexpected times under varying conditions	the ken he he ted	08/05/2024

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155488	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 06/11/2024		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 3625 ST JOSEPH RD NEW ALBANY, IN 47150				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE		
				STEP 4 Corrective actions to be monitored to ensure the deficient practice will not recur:	0		
				The Maintenance Director/Designee will audit monthly fire drills to insure the were conducted at unexpecte times under varying condition	d		
				The Maintenance Director/Designee will presen results of these audits monthl the QAPI committee for no les than 3 months. Any patterns are identified will have an Act Plan initiated. The QAPI committee will determine whe 100% compliance is achieved ongoing monitoring is required	y to es that on or if		
K 0761 SS=E Bldg. 01							
	interview, the facili inspection and testin door assemblies we with LSC 19.1.1.4.1 dividing fire barrier permitted only in co by approved self-cle (See also Section 8. required to have a f	on, records review, and ty failed to ensure annual ing of 1 of 1 oxygen room fire re completed in accordance 1.1. Communicating openings in is required by 19.1.1.4.1 shall be orridors and shall be protected cosing fire door assemblies. 3.) LSC 8.3.3.1 Openings ire protection rating by Table faceted by approved, listed,	K 0761	K761 STEP 1 Corrective action for the residents found to have been affected by the deficier practice:  No residents were harmed by alleged deficient practice.	nt		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155488		A. B	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 06/11/2024		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD T JOSEPH RD		
ROLLING	G HILLS HEALTHC	ARE CENTER			LBANY, IN 47150		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	CTION (X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		semblies and fire window			STEP 2 Corrective action tal	_	
		r accompanying hardware,			for those residents having the		
	including all frames, closing devices, anchorage, and sills in accordance with the requirements of				potential to be affected by the same deficient practice:	е	
		I for Fire Doors and Other			Same dencient practice.		
	·	s, except as otherwise			The Oxygen Room door was		
	specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not				inspected on 7.11.2024.		
	less than annually,	and a written record of the					
	_	signed and kept for inspection					
	by the AHJ. NFPA 80, 5.2.3.1 states functional testing of fire door and window assemblies shall				STEP 3 Measures/systemic		
					changes put into place to		
	be performed by individuals with knowledge and understanding of the operating components of				ensure the deficient practice		
	_				does not recur:		
		ing subject to testing. NFPA			T. 550/5		
		re door assemblies shall be			The RDO/Designee held an		
	overall condition of	From both sides to assess the			in-service with facility mainten director on K761 as it relates t		
	overall colluition of	i door assembly.			annual door inspections.	.0	
	NFPA 80, 5,2,4,2 s	tates as a minimum, the			amuai door inspections.		
	following items sha						
		or breaks exist in surfaces of					
	either the door or fr	rame.			STEP 4 Corrective actions to	0	
	` ,	light frames, and glazing beads			be monitored to ensure the		
		rely fastened in place, if so			deficient practice will not		
	equipped.				recur:		
		e, hinges, hardware, and			T. A		
		reshold are secured, aligned,			The Administrator/Designee		
	damage.	er with no visible signs of			review TELS for completion of door inspections annual to en		
	(4) No parts are mis	ssing or broken			completion.	sure	
		s do not exceed clearances			completion.		
	listed in 4.8.4 and 6				The Administrator/Designee v	will	
		g device is operational; that is,			present the results of these au		
		apletely closes when operated			annually to the QAPI committee		
	from the full open p	position.			Any patterns that are identified		
		is installed, the inactive leaf			have an Action Plan initiated.		
	closes before the ac				QAPI committee will determine	е	
		are operates and secures the			when 100% compliance is		
	door when it is in the	he closed position.			achieved or if ongoing monitor	ring	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING <u>01</u> COMPLETED B. WING 06/11/2024			
		155488	B. WIN	G		06/11/	/2024
	PROVIDER OR SUPPLIER			3625 ST	NDDRESS, CITY, STATE, ZIP COD Γ JOSEPH RD LBANY, IN 47150		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDENCEN AN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL	P	PROVIDER'S PLAN OF CORRECTION PREFIX  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	15	DATE
		vare items that interfere or are not installed on the door or			is required.		
	(10) No field modifications to the door assembly have been performed that void the label.						
		edge seals, where required, are					
		their presence and integrity.					
	This deficient pract in the 200 hall.	ice could affect all occupants					
	Findings include:					ļ	
	Based on record rev	view on 06/10/2024 between					
		PM with the Executive Director,					
	_	nance Director, and the					
	_	enance Director, no annual					
	_	xygen room fire door assembly					
		eview. Based on interview at the					
		ew, the Rolling Hills for stated his boss completed					
		nspections and must have					
	missed the oxygen	-				ļ	
		viewed with the Executive					
	Director and the Ro Director at the exit	olling Hills Maintenance conference.					
	3.1-19(b)						
K 0918	NFPA 101						
SS=F		s - Essential Electric Syste					
Bldg. 01	1	s - Essential Electric					
	System Maintena						
	The generator or	other alternate power					
		iated equipment is capable					
		ce within 10 seconds. If the					
		n is not met during the					
		ocess shall be provided to					
	· ·	his capability for the life					
	i salety and critical	branches. Maintenance				l.	I

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CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039	
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED 06/11/2024	
		155488	B. WING			
			CTREET	ADDRESS CITY STATE ZID COD		
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD ST JOSEPH RD		
DOLLIN	G HILLS HEALTHC	ADE CENTED		ALBANY, IN 47150		
KOLLIN	G HILLS HEALTHU	ARE CENTER	INEVV F	ALBAN1, IN 47 150		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	-	generator and transfer				
		ormed in accordance with				
	NFPA 110.					
	Generator sets ar	e inspected weekly,				
		oad 30 minutes 12 times a				
	•	intervals, and exercised				
	once every 36 mg	onths for 4 continuous hours.				
		nder load conditions include				
		ated cold start and				
		ual transfer of all EES				
		nducted by competent				
		enance and testing of stored				
		ırces (Type 3 EES) are in				
		NFPA 111. Main and feeder				
		re inspected annually, and a				
		dically exercising the				
		tablished according to				
		uirements. Written records				
		nd testing are maintained				
		ble. EES electrical panels				
		arked, readily identifiable,				
	i i	n normal power circuits.				
		ssibility of damage of the				
		r source is a design				
	consideration for					
		(NFPA 99), NFPA 110,				
	NFPA 111, 700.1		17.0010		00/05/0004	
		review and interview, the	K 0918	Corrective action for the	08/05/2024	
	1	nintain a complete written record		residents found to have been		
		or load testing for 4 of the last		affected by the deficient		
		r 6.4.4.1.1.4(a) of 2012 NFPA 99		practice:	L -	
		esting of the generator serving		No residents were affected by t	ne	
		trical system to be in		alleged deficient practice.		
		FPA 110, the Standard for		Corrective action taken for		
		andby Powers Systems, Chapter		those residents having the		
		requires diesel generator sets in		potential to be affected by the		
		ised at least once monthly, for a		same deficient		
		nutes. Chapter 6.4.4.2 of NFPA		practice: Generator load test		
	99 requires a writte	n record of inspection,	1	completed by facility maintenan	ice	

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performance, exercising period, and repairs for the

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director. Generator inspection was

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			EY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 01 COMPLETED				
		155488	B. W	ING		06/11/2024	
NAME OF F	PROVIDER OR SUPPLIER	•	_		ADDRESS, CITY, STATE, ZIP COD		
					T JOSEPH RD		
ROLLING	HILLS HEALTHC	ARE CENTER		NEW A	LBANY, IN 47150		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COM	IPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	I	DATE
		ularly maintained and available			completed. Measures/systen	nic	
	for inspection by the authority having				changes put into place to		
	· ·	eficient practice could affect all			ensure the deficient practice		
	occupants.				does not recur:RDO educate	<sup>3</sup>	
	Findings in ded.				Maintenance Director on	70.6	
	Findings include:				requirements for 42 CFR 483.	/3€	
	Raced on raview of	the emergency preparedness			(2) on 7.10.2024 Corrective actions to be monitored to		
		between 9:30 AM and 3:30 PM			ensure the deficient practice		
	1 ^	Director, Wedgwood			will not recur:The		
		for, Rolling Hills Maintenance			Administrator/Designee will re	/iew	
		egional Director of Clinical			audit generator load testing	/icw	
	Operations, no documentation for monthly load				completion monthly. The		
	testing was available for September, October,				Administrator/Designee will au	dit	
	_	mber 2023. Based on interview			generator inspection completion		
		d review, the Rolling Hills			weekly x 4 weeks, then month		
	Maintenance Direct	for agreed there was no			2 months. The results of these	- 1	
	documentation of a	monthly load test for the			audits monthly to the QAPI		
	aforementioned mo	nths.			committee for no less than 3		
					months. Any patterns that are		
	This finding was re-	viewed with the Executive			identified will have an Action F	lan	
		lling Hills Maintenance			initiated. The QAPI committee	will	
	Director at the exit	conference.			determine when 100% compli	ance	
					is achieved or if ongoing		
	3.1-19(b)				monitoring is required.		
	2. Based on record	review and interview, the					
		sure a written record of weekly					
	1	generator was maintained for					
		FPA 99, 6.4.4.1.3 requires onsite					
		maintained in accordance with					
		d for Emergency and Standby					
	· ·	FPA 110, 8.4.1 requires an					
	I -	Supply System (EPSS)					
		enant components, shall be					
		nd exercised monthly. NFPA					
		a written record of inspection,					
	performance, exerci	ising period, and repairs for the					
	generator to be regu	ılarly maintained and available					
	for inspection by the						

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>			COMPLETED	
		155488	B. WI	NG		06/11/2024	
	PROVIDER OR SUPPLIER		•	3625 ST	ADDRESS, CITY, STATE, ZIP COD I JOSEPH RD LBANY, IN 47150		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	1	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IIE	DATE
		eficient practice could affect all					
	Based on review of plan on 06/10/2024 with the Executive Maintenance Direct Director, and the Re Operations, docume generator testing for available for review a. between 06/19/24 b. between 08/18/23 c. between 09/22/23 d. between 11/07/23 e. between 12/01/23 Based on interview the Rolling Hills Mathere was no docum aforementioned wear This finding was review of the plant of the p	and 07/28/23 3 and 09/22/23 5 and 11/03/23 5 and 12/01/23 5 and 01/17/24 at the time of record review, aintenance Director agreed tentation available during the					
	Director at the exit of 3.1-19(b)						

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