STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155551	A. BUILDING -- B. WING	01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROLLING MEADOWS HEALTH CARE CENTER	604 RENNAKER ST LA FONTAINE, IN 46940

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 01/26/24 Facility Number: 000447 Provider Number: 155551 AIM Number: 1002689950 At this Emergency Preparedness survey, Rolling Meadows Health Care Center was found 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 88 at the time of this survey. Quality Review completed on 01/31/24	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 01/26/24 Facility Number: 000447 Provider Number: 155551 AIM Number: 1002689950 At this Life Safety Code survey, Rolling Meadows Health Care Center was found not in compliance with Requirements for Participation in	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Peyton Byrd	Health Facility Administrator	02/12/2024

Any defiencystatement 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 disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type VIII construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and in the resident sleeping rooms. The facility has a capacity of 115 and had a census of 88 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 01/31/24			
K 0355 SS=D Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to inspect 1 of over 20 portable fire extinguishers each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 7.2.1.2 states fire extinguishers shall be inspected either manually or by means of an electronic device / system at a minimum of 30-day intervals. Section 7.2.2 states periodic inspection or electronic monitoring of fire extinguishers shall include a check of at least the following items: (1) Location in designated place (2) No obstruction to access or visibility	K 0355	**Plan of Correction** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents experienced adverse reactions to this deficient practice. **2. How other residents having the potential to be affected by the same deficient practice will be identified and**	01/29/2024

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	(3) Pressure gauge reading or indicator in the operable range or position (4) Fullness determined by weighing or hefting for self expelling-type extinguishers, cartridge-operated extinguishers, and pump tanks (5) Condition of tires, wheels, carriage, hose, and nozzle for wheeled extinguishers (6) Indicator for nonrechargeable extinguishers using push to-test pressure indicators. Section 7.2.4.1 states personnel making manual inspections shall keep records of all fire extinguishers inspected, including those found to require corrective action. Section 7.2.4.3 requires where at least monthly manual inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded. Section 7.2.4.4 requires where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or by an electronic method. Section 7.2.4.5 requires records shall be kept to demonstrate that at least the last 12 monthly inspections have been performed. This deficient practice could affect 10 residents. Findings include: Based on observation during a tour of the facility with the Executive Director (ED) and Maintenance Director (MD) on 01/26/24 at 01:15 p.m., the monthly inspection tag on the fire extinguisher located by room 113 lacked documentation of a monthly inspections for September and October of 2023. Based on interview at the time of observation, the MD confirmed the fire extinguisher located by room 113 lacked the monthly inspections previously mentioned.		**what corrective action(s) will be taken?** All residents have potential to be affected by this deficient practice. Each month, the Maintenance Director will check and initial tag on extinguisher to ensure compliance. **3. What measures will be put into place or what systemic changes will be made to ensure that deficient practice does not recur?** Administrator will round monthly to ensure inspections complete on monthly basis. **4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur?** Maintenance Director will have a check sheet that will be logged every month. In addition, fire extinguisher inspection sheet completion will be part of QAPI for the next 6 months. If deficient practice recurs, it will be added to QAPI for an additional 6 months. If compliance is the result, then it will be discontinued from QAPI. **5. By what date will the systematic changes be completed?** 1/29/24	

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	This finding was reviewed with the ED and MD at the exit conference. 3.1-19(b)			
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 2 of 8 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 8.5.6.2 requires penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of restricting the movement of smoke. This deficient practice could affect staff and at least 20 residents in four smoke compartments.	K 0372	**Plan of Correction** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were affected by the deficient practice. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All residents have potential to be affected by this deficient practice. Every 3 months, Maintenance Director will inspect smoke	01/29/2024

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	Findings include: Based on observations with the Executive Director (ED) and Maintenance Director (MD) on 01/26/24 at 02:10 p.m. in Oak Lane and at 02:35 p.m. in Birch Lane the following unsealed penetrations were discovered: a) In Oak Lane above the smoke door and drop ceiling there was 2 inch sprinkler pipe unsealed passing through. b) In the south end of the attic above the Birch Lane smoke wall there was a 3" unsealed hole in the drywall. The MD sealed the penetrations at the time of discovery. Based on interview at the time of observation, the Maintenance Director (MD) agreed the aforementioned smoke wall contained unsealed penetrations. These findings were reviewed with the ED and MD during the exit conference. 3.1-19(b)		barriers, and or if any work is done around smoke barriers. **3. What measures will be put into place or what systemic changes will be made to ensure that deficient practice does not recur?** Administrator will round every 3 months to ensure inspections complete on quarterly basis, and or if any work is done around smoke barriers **4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur?** Maintenance Director will have a check sheet that will be logged every quarter. In addition, Administrator will round with Maintenance Director every 3 months to assure inspection was complete. **5. By what date will the systematic changes be completed?** 1/29/24	
K 0920 SS=D Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in			

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	the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 1 of over 50 resident rooms did not used multi-plug adaptors as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects 2 residents. Findings include: Based on observation with the Executive Director (ED) and Maintenance Director (MD) on 01/26/24 at 02:05 p.m., resident rooms 205 contained a multi-plug adaptor powering electronic equipment. Based on interview at the time of observations, the ED and MD agreed a multi-plug adaptor was in use in room 205. The multi-plug was removed at the time of observation.	K 0920	**Plan of Correction** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The residents in room 205, their families, and staff have been educated on the importance of the NFPA code. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All residents have potential to be affected by this deficient practice. All rooms have been checked for multi-plugs. A monthly inspection sheet has also been made for each hall to be checked each month for multi-plugs. If any	02/09/2024

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	This finding was reviewed with the ED and MD at the exit conference. 3.1-19(b)		issues arise. It will be addressed immediately. **3. What measures will be put into place or what systemic changes will be made to ensure that deficient practice does not recur?** Maintenance Director will be responsible for the monthly inspection of multi-plugs, and the filing of multi-plug inspection sheet. **4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur?** Administrator will round with Maintenance Director each month to ensure monthly inspection has been completed. **5. By what date will the systematic changes be completed?** 02/09/2024	