STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155488 NAME OF PROVIDER OR SUPPLIER			X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE			ETED	
	HILLS HEALTHC				T JOSEPH RD LBANY, IN 47150		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		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 APPROPRI	ΔTF	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	AIL	DATE
E 0000							
Bldg	conducted by the Irin accordance with Survey Date: 03/2 Facility Number: 0 Provider Number: 100 At this Emergency Hills Healthcare Cowith Emergency Properties and Medicare and Medicare and Suppliers, 42 0 capacity of 115 and time of this survey	1/22 000526 155488 0266970 Preparedness survey, Rolling enter was found in compliance reparedness Requirements for icaid Participating Providers CFR 483.73. The facility has a d had a census of 102 at the	E 00	000	This Plan of Correction is the center's credible allegation compliance. Preparation and/or execution this plan of correction does constitute admission or agreement by the provider of the truth of the facts alleged conclusions set forth in the statement of deficiencies. The plan of correction is preparated and correction is preparated by the provision of federal and state law. Row Hills would like to request a DESK REVIEW in lieu of Follow-Up Revisit to the factorial complete.	of on of a not of of or The ed ause ons Illing	
K 0000							
Bldg. 01	Licensure Survey of Department of Heat CFR 483.90(a). Survey Date: 03/2 Facility Number: 09/2 Provider Number: 100/2 At this Life Safety Healthcare Center 19/2	000526 155488	K 0	000	This Plan of Correction is the center's credible allegation compliance. Preparation and/or execution this plan of correction does constitute admission or agreement by the provider of the truth of the facts alleged conclusions set forth in the statement of deficiencies. The plan of correction is preparationally in the provision of federal and state law. Roley because the provision of federal and state law. Roley because the provision of federal and state law.	of of on of of of or of of or of ed or ed or ed or or ed ons	

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

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	TOF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA			DNSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		UILDING	01	COMPL	
		155488	B. W	ING		03/21/	2022
NAME OF D	DOMDED OD CHIDDLIED		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			3625 ST	T JOSEPH RD		
ROLLING	HILLS HEALTHCA	ARE CENTER		NEW A	LBANY, IN 47150		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	1	ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	•	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	Medicare/Medicaid.	, 42 CFR Subpart 483.90(a),			Hills would like to request a		
		re and the 2012 edition of the			DESK REVIEW in lieu of		
	•	ction Association (NFPA)			Follow-Up Revisit to the faci		
	101, Life Safety Co	de (LSC), Chapter 19,					
	Existing Health Car	e Occupancies and 410 IAC					
	16.2.						
	This one story facili	ty was determined to be of					
		ruction and was fully					
	_	cility has a fire alarm system					
		oke detection in the corridors,					
	spaces open to the corridors, and nine resident sleeping rooms in the 100B hall. All other						
	resident rooms are equipped with battery operated smoke alarms. The facility has a						
	_						
		had a census of 102 at the					
	time of this survey.						
	All areas where resi	dents have customary access					
		d all areas providing facility					
	services were sprink						
	•						
	Quality Review con	npleted on 03/24/22					
K 0222	NFPA 101						
SS=E	Egress Doors						
Bldg. 01	Egress Doors						
	Doors in a require	d means of egress shall					
		ith a latch or a lock that					
	•	f a tool or key from the					
	_	s using one of the following					
	special locking arr	~					
		OR SECURITY THREAT					
	LOCKING	din n. annan n. ana ant - f 41					
		king arrangements for the					
	•	eds of the patient are king device shall be					
		door and provisions shall					
		pid removal of occupants					
		of locks; keying of all					
	by. Ichiole contion	or rooks, keying or all					

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Event ID:

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	OF CORRECTION IDENTIFICATION NUMBER: 155488	A. BUILDING B. WING	<u>01</u>	COMPLETED 03/21/2022
	PROVIDER OR SUPPLIER G HILLS HEALTHCARE CENTER	3625 S	ADDRESS, CITY, STATE, ZIP CODE T JOSEPH RD LBANY, IN 47150	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS			

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155488	r í	JILDING	onstruction 01	(X3) DATE COMPI 03/21 ,	LETED
ROLLING	PROVIDER OR SUPPLIEF			3625 S	ADDRESS, CITY, STATE, ZIP CODE T JOSEPH RD LBANY, IN 47150		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES ICY 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)	TE	(X5) COMPLETION DATE
	accordance with 7 on door assemblie throughout by an automatic fire dete approved, supervisystem. 18.2.2.2.4, 19.2.2 Based on observation failed to ensure the 11 delayed egress to for residents, staff, Delayed Egress Localisted, delayed-egres permitted to be instand ordinary hazard protected throughout automatic fire detect accordance with Se supervised automatic in accordance with permitted in Chapte (4*) A readily visibless than 1 inch high stroke width on a coreads as follows sha adjacent to the releasegress: PUSH UNT CAN BE OPENED deficient practice coresidents, staff and facility. Findings include: Based on observation 12:30 p.m. and 3:00 facility with the Market approved the market and staff and facility with the Market approved to the market and staff and facility with the Market approved to the market app	t access door locking in 7.2.1.6.3 shall be permitted as in buildings protected approved, supervised action system and an ised automatic sprinkler 7.2.4 on and interview, the facility means of egress through 1 of ocks were readily accessible and visitors. LSC 7.2.1.6.1, cking Systems, says approved, as locking systems shall be alled on doors serving low decontents in buildings at by an approved, supervised action system installed in action 9.6, or an approved, its sprinkler system installed Section 9.7, and where are 11 through 43, provided: alle, durable sign in letters not and not less than 1/8 inch in contrasting background that all be located on the door leaf as device in the direction of TIL ALARM SOUNDS DOOR IN 15 SECONDS. This build affect up to 22 visitors in the 400 hall of the contrasting a tour of the content of p.m. during a tour of the content of the	K 0	222	1. No Residents were harm by the alleged deficient practic. The Maintenance Director corrected the door at time of survey. 2. Any resident that reside the facility has the potential to affected by the alleged deficie practice. All other Secured Exwere check and no other concerns noted. 3. ED/Designee will compin service training with all Maintenance staff on the facili policy identified as Check all secured doors and Elevator. 4. ED/Designee will conduan audit of all exit doors week for 8 weeks monthly for 4 mor then Quarterly for 2 quarters. Executive Director will monitor through Faculty QUAPI meetin any issues noted will immedia be addressed to maintain compliance.	ce. es in be nt its blete ties ct ly nths,	04/07/2022
	nan exit was equipp	bed with magnetic lock with					i

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	OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING		(X3) DATE SURVEY COMPLETED
AND PLAN	155488	B. WING	01	03/21/2022
	155466			03/21/2022
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE	
5011116	NAME OF STREET		T JOSEPH RD	
ROLLING	HILLS HEALTHCARE CENTER	NEW A	LBANY, IN 47150	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	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 APPROPRIA	TE
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	15 second delayed egress and provided with			
	signage that read, PUSH UNTIL ALARM			
	SOUNDS DOOR CAN BE OPENED IN 15			
	SECONDS. This exit door was tested several			
	times during the tour and did not open in 15 seconds or even longer when attempting to			
	activate the delayed egress. The door did release			
	from the magnetic lock when the code on the			
	keypad was pressed. The Maintenance Director			
	did make an adjustment on the magnetic lock and			
	corrected the issue at the time of observation.			
	Based on interview at the time of observation,			
	the Maintenance Director agreed the 400 hall			
	exit door did not open when testing the delayed			
	egress for over 15 seconds several times, prior			
	to correcting the issue.			
	This finding was reviewed with the Executive			
	Director and Maintenance Director during the exit conference.			
	exit conference.			
	3.1-19(b)			
K 0281	NFPA 101			
SS=E	Illumination of Means of Egress			
Bldg. 01	Illumination of Means of Egress			
	Illumination of means of egress, including			
	exit discharge, is arranged in accordance			
	with 7.8 and shall be either continuously in			
	operation or capable of automatic operation			
	without manual intervention.			
	18.2.8, 19.2.8	TT 0001	b="">	0.4/0.7/0.000
	Based on observation and interview, the facility failed to ensure 1 of 11 exit means of egress was	K 0281	1. No Residents were	04/07/2022
	properly lighted and would not leave the area in		harmed by the alleged deficient	ont
	darkness. LSC 7.8.1.4 requires illumination		practice. The identified lighti	
	shall be arranged so that that the failure of any		was adjusted to illuminate th	_
	single lighting unit does not result in an		gate.	-
	illumination level of less than 0.2 foot-candle in		2. Any resident that resid	es
	any designated area. This deficient practice		in the facility has the potenti	
	· · · · · · · · · · · · · · · · · · ·		· · · · · ·	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155488	(X2) MUL A. BUIL B. WING	DING	NSTRUCTION 01	(X3) DATE SURVEY COMPLETED 03/21/2022
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE JOSEPH RD	
ROLLING	HILLS HEALTHCA	ARE CENTER		NEW AL	BANY, IN 47150	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PF	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	could affect up to 3- and visitors on the 1 Findings include:	4 residents as well as staff 00 hall.			to be affected by the alleged deficient practice. All other Exterior Lighting was checked and no other concerns noted	ed
	12:30 p.m. and 3:00 facility with the Ma hall exit was provid the exit door, hower light provided for the public way from the interview at the time Maintenance Direct the 100 hall exit doo light provided.	ons on 03/21/22 between 9 p.m. during a tour of the intenance Director, the 100 ed with light directly outside ver, there was no exterior the exit gate to get to the e 100 hall exit. Based on the of observation, the or agreed the exit gate from or needed to have exterior viewed with the Executive enance Director during the			 ED/Designee will complete in service training with all Maintenance staff on the facilities policy identified Operational test of Exit Lighting. ED/Designee will conduan audit of all exit door lighti weekly for 8 weeks monthly 14 months, then Quarterly for quarters 	uct ing for
K 0324 SS=E Bldg. 01	Ventilation Contro Commercial Cook * residential cooking appliances such a toasters) are used limited cooking in 18.3.2.5.2, 19.3.2. * cooking facilities smoke compartment patients comply w 18.3.2.5.3, 19.3.2.	IFPA 96, Standard for I and Fire Protection of ing Operations, unless: ng equipment (i.e., small s microwaves, hot plates, for food warming or accordance with 5.2 open to the corridor in ents with 30 or fewer ith the conditions under				

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155488	l ,	ILDING	onstruction 01	(X3) DATE COMPL 03/21 /	ETED
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3625 ST JOSEPH RD NEW ALBANY, IN 47150				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES 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)	TE	(X5) COMPLETION DATE
K 0353 SS=E Bldg. 01	conditions under 1 Cooking facilities NFPA 96 per 9.2.3 enclosed as hazar be open to the cor 18.3.2.5.1 through through 19.3.2.5.5 Based on record rev facility failed to ens hood extinguishing proper working ord was not in a residen staff. Findings include: Based on record rev 9:15 a.m. and 12:30 Director present, ra dated 11/18/21, 05/ the facility's vendor shutting down on sy shutoff not working Maintenance Direct had been corrected, documentation or vi had been corrected. This finding was re Director and Mainte exit conference. 3.1-19(b) NFPA 101 Sprinkler System - Sprinkler System - Sprinkler System -	18.3.2.5.4, 19.3.2.5.1 i, 9.2.3, TIA 12-2 riew and interview, the cure 1 of 1 kitchen range system was maintained in er. This deficient practice t area but could affect kitchen riew on 03/21/22 between 1 p.m. with the Maintenance range hood suppression reports 14/21, and 11/02/20 from all stated "Electric oven not restem trip" or "Electric". When asked, the or said he thought the issue but could not find erify in any way that the issue wiewed with the Executive enance Director during the - Maintenance and Testing - Maintenance and Testing - Maintenance and Testing	K 03	324	1. No Staff were harmed by the alleged deficient practice. 2. Any resident that reside the facility has the potential to affected by the alleged deficie practice. Service company contacted to correct the concess. 3. ED/Designee will compain service training with all Maintenance staff on the facility policy identified as Have Hood cleaned by Certified Contracted Any inspection identified concerns will be reviewed with Maintenance Director or ED. 4. ED/Designee will conduct an audit of Kitchen Hood Fund weekly for 8 weeks monthly for months, then Quarterly for 2 quarters. Executive Director with meetings any issues noted will immediately be addressed to maintain compliance.	s in be nt ern. elete ties dor. or the etion or 4	04/07/2022
SS=E	NFPA 101 Sprinkler System Sprinkler System				таппаш сотпрпапсе.		

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	01	COMPL	ETED
		155488	B. WI	NG		03/21/	/2022
				CED FEE	ADDRESS CITY STATE TIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP CODE		
501111		ADE OFNITED			T JOSEPH RD		
ROLLING	HILLS HEALTHC	ARE CENTER		NEW A	LBANY, IN 47150		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX			COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	are inspected, tes	ted, and maintained in					
	accordance with N	NFPA 25, Standard for the					
	Inspection, Testin	nspection, Testing, and Maintaining of					
	Water-based Fire	Protection Systems.					
	Records of system	n design, maintenance,					
	inspection and tes	sting are maintained in a					
	secure location ar	nd readily available.					
	a) Date sprinkler	system last checked					
	b) Who provided	system test					
	c) Water system	supply source					
	Provide in REMARKS information on						
	coverage for any	non-required or partial					
	automatic sprinkle	er system.					
	9.7.5, 9.7.7, 9.7.8	, and NFPA 25					
	Based on observation	on and interview, the facility	K 03	353			04/07/2022
	failed to ensure the	ceiling in 1 of 7 sprinklered			No Residents were harn	ned	
	smoke compartmen	ts was maintained to allow			by the alleged deficient praction	ce.	
	sprinkler heads to f	unction to their full			The identified area was correct	cted	
	capability. This de	ficient practice could affect			the day of survey.		
	up to 23 residents in	n the 200 hall.			Any resident that reside		
					the facility has the potential to		
	Findings include:				affected by the alleged deficie		
					practice. All other Mechanical		
		ons on 03/21/22 between			Rooms were inspected and no	0	
	_	p.m. during a tour of the			further concerns were noted.		
	facility with the Ma	intenance Director, there was					
		and a conduit through the			3. ED/Designee will comp	olete	
	_	all Mechanical Room that			in service training with all		
		re stopped. Based on			Maintenance staff on the facil		
		e of observation, the			policy identified as Inspect Att	ic	
		tor agreed the hole around the			Fire/Smoke wall barriers		
		om conduit was not properly					
	fire stopped.				4. ED/Designee will condu		
					an audit of all Mechanical Roo		
	This finding was re	viewed with the Executive			weekly for 8 weeks monthly for	or 4	
	Director and Mainte	enance Director during the			months, then Quarterly for 2		
	exit conference.				quarters. Executive Director w	/ill	

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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 01	(X3) DATE SURVEY COMPLETED 03/21/2022
	PROVIDER OR SUPPLIER G HILLS HEALTHCARE CENTER	3625 S	ADDRESS, CITY, STATE, ZIP CODE IT JOSEPH RD ALBANY, IN 47150	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	3.1-19(b)		monitor through Faculty QUAF meetings any issues noted wil immediately be addressed to maintain compliance.	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility failed to ensure 2 of 6 sets of fire/smoke barrier doors would close to form a smoke resistant barrier. LSC, Section 19.3.7.8 requires that doors in smoke barriers shall comply with LSC, Section 8.5.4. LSC, Section 8.5.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice could affect all residents, as well as staff and visitors. Findings include: Based on observations on 03/21/22 between	K 0374	1. No Residents were harm by the alleged deficient practic The Smoke Barrier Doors goir into the main Dining Area and 100 hall were adjusted and arfunctioning. 2. Any resident that reside the facility has the potential to affected by the alleged deficie practice. All other Smoke Barr Doors were tested and no furt concerns noted. 3. ED/Designee will compin service training with all Maintenance staff on the facility.	ce. ng the e s in be nt ier her

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	01	COMPL	ETED
		155488	B. W	NG		03/21/	2022
				CTDEET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER						
BOLLING		ADE OFNITED			T JOSEPH RD		
ROLLING	HILLS HEALTHCA	ARE CENTER		NEW A	LBANY, IN 47150		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		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		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	'	DATE
	12:30 p.m. and 3:00	p.m. during a tour of the			policy identified as Conducting		
	facility with the Ma	intenance Director, the			the Fire Drills.		
	following was noted						
	-	barrier doors in the corridor			4. ED/Designee will condu	ct	
		n Dining Room area did not			an audit of all Smoke Barrier		
	_	nen tested. There was a six			doors weekly for 8 weeks mon	thly	
		e set of doors when closed			for 4 months, then Quarterly fo	-	
	fully.				quarters. Executive Director w		
	•	noke barrier doors within the			monitor through Faculty QUAF		
		ning Room/Lounge area did			meetings any issues noted will		
		and latch when tested. This			immediately be addressed to		
	•	rrier doors was equipped			maintain compliance.		
		are. There was a one inch gap					
	_	oors when closed fully.					
	Based on interview	-					
		intenance Director agreed					
		ioned sets of fire/smoke					
		t close completely and latch					
	into their door frame						
	into their door frum	es when tested.					
	This finding was rev	viewed with the Executive					
	_	enance Director during the					
	exit conference.	mance Director during the					
	can conference.						
	3.1-19(b)						
	3.1-17(0)						
K 0754	NFPA 101						l l
SS=E	Soiled Linen and 1	Frash Containers					
Bldg. 01	Soiled Linen and 1						
Blag. 01		sh collection receptacles					
		2 gallons in capacity. The					
		f container capacity in a					
	room or space sha	· · · · · · · · · · · · · · · · · · ·					
		et. A total container					
		ons shall not be exceeded					
		are feet area. Mobile soiled					
		ection receptacles with					
		than 32 gallons shall be					
		protected as a hazardous					
	area when not atte						
	area wrien not alle	anucu.	1				

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	01	COMPLET	ΓED
		155488	B. W	ING		03/21/2022	
				CTREET	ADDRESS SITU STATE ZIR SODE		
NAME OF F	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
DOLL N.		ADE OFNITED			T JOSEPH RD		
ROLLING	HILLS HEALTHC	AKE CENTEK		NEW A	LBANY, IN 47150		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		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 APPROPRIA	ATE (COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	(1)	DATE
	Containers used s	solely for recycling are					
	permitted to be ex	cluded from the above					
	requirements whe	ere each container is less					
	than or equal to 9	6 gallons unless attended,					
	and containers for	r combustibles are labeled					
	and listed as mee	ting FM Approval Standard					
	6921 or equivalen	ıt.					
	18.7.5.7, 19.7.5.7						
	Based on observation	on and interview, the facility	K 0	754	1. No Residents were harn	ned (04/07/2022
	failed to ensure soil	led linen and trash			by the alleged deficient praction	ce.	
	receptacles in 3 of 3	5 corridors were maintained			The Soiled Linen and Trash		
	in accordance with	19.7.5.7. Section 19.7.5.7(2)			Containers were removed from	m	
	states that a capacit	y of 32 gallons shall not be			the unit.		
	exceeded within an	y 64 square foot area. This			Any resident that reside	es in	
	deficient practice co	ould affect at least 50			the facility has the potential to	be	
	residents, as well as	s staff and visitors in the			affected by the alleged deficie	ent	
	facility.				practice. All other Soiled Lines	n	
					and Trash Containers were		
	Findings include:				removed from the other units.		
	Based on observation	on on 03/21/22 between			ED/Designee will comp	olete	
	12:30 p.m. and 3:00	p.m. during a tour of the			in service training with all staff	f on	
	facility with the Ma	nintenance Director, the			the facilities policy identified a	s	
	following was note	d:			Infection Control Practice for		
	a. There was a soil	ed linen container and trash			Laundry and Linen Policy and		
	container with at le	ast 32 gallon capacity each			Procedure.		
	_	300 hall outside resident					
	room 310. Each co	ntainer was at least half full			4. ED/Designee will condu	ıct	
	and was not being t	used at the time of			an audit of Soiled and Linen		
	observation.				Containers being off the unit v	vhen	
		ed linen container and trash			not in use weekly for 8 weeks		
	container with at le	ast 32 gallon capacity each			monthly for 4 months, then		
		200 hall outside resident			Quarterly for 2 quarters. Exec	utive	
		ntainer was at least half full			Director will monitor through		
	and was not being t	used at the time of			Faculty QUAPI meetings any		
	observation.				issues noted will immediately	be	
		ed linen container and trash			addressed to maintain		
		ast 32 gallon capacity each			compliance.		
	being stored in the	100 hall outside resident					
	room 109. Each co	ntainer was at least half full					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	01	COMPL	ETED
		155488	B. WI	NG		03/21	/2022
NAME OF PROVIDER OR SUPPLIER ROLLING HILLS HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3625 ST JOSEPH RD NEW ALBANY, IN 47150				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		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	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	each container was and should be store hazardous area whe This finding was re	at the time of each sintenance Director agreed at least 32 gallons in capacity d in a room protected as a					

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