STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155488	A. BUILDING -- B. WING	03/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING HILLS HEALTHCARE CENTER	3625 ST JOSEPH RD NEW 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 03/21/22 Facility Number: 000526 Provider Number: 155488 AIM Number: 100266970 At this Emergency Preparedness survey, Rolling Hills Healthcare 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 102 at the time of this survey. Quality Review completed on 03/24/22	E 0000	***This Plan of Correction is the center's credible allegation of compliance.*** ***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. Rolling Hills would like to request a DESK REVIEW in lieu of Follow-Up Revisit to the facility.***	
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: 03/21/22 Facility Number: 000526 Provider Number: 155488 AIM Number: 100266970 At this Life Safety Code survey, Rolling Hills Healthcare Center was found not in compliance with Requirements for Participation in	K 0000	***This Plan of Correction is the center's credible allegation of compliance.*** ***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. Rolling***	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement 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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	Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors, spaces open to the corridors, and nine resident sleeping rooms in the 100B hall. All other resident rooms are equipped with battery operated smoke alarms. The facility has a capacity of 115 and had a census of 102 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 03/24/22		***Hills would like to request a DESK REVIEW in lieu of Follow-Up Revisit to the facility.***	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all			

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	locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS			

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	LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility failed to ensure the means of egress through 1 of 11 delayed egress locks were readily accessible for residents, staff, and visitors. LSC 7.2.1.6.1, Delayed Egress Locking Systems, says approved, listed, delayed-egress locking systems shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system installed in accordance with Section 9.6, or an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, and where permitted in Chapters 11 through 43, provided: (4*) A readily visible, durable sign in letters not less than 1 inch high and not less than 1/8 inch in stroke width on a contrasting background that reads as follows shall be located on the door leaf adjacent to the release device in the direction of egress: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS. This deficient practice could affect up to 22 residents, staff and visitors in the 400 hall of the facility. Findings include: Based on observations on 03/21/22 between 12:30 p.m. and 3:00 p.m. during a tour of the facility with the Maintenance Director, the 400 hall exit was equipped with magnetic lock with	K 0222	1. No Residents were harmed by the alleged deficient practice. The Maintenance Director corrected the door at time of survey. 2. Any resident that resides in the facility has the potential to be affected by the alleged deficient practice. All other Secured Exits were check and no other concerns noted. 3. ED/Designee will complete in service training with all Maintenance staff on the facilities policy identified as Check all secured doors and Elevator. 4. ED/Designee will conduct an audit of all exit doors weekly for 8 weeks monthly for 4 months, then Quarterly for 2 quarters. Executive Director will monitor through Faculty QUAPI meetings any issues noted will immediately be addressed to maintain compliance.	04/07/2022

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	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. 3.1-19(b)			
K 0281 SS=E Bldg. 01	NFPA 101 Illumination of Means of Egress 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 Based on observation and interview, the facility failed to ensure 1 of 11 exit means of egress was properly lighted and would not leave the area in darkness. LSC 7.8.1.4 requires illumination shall be arranged so that that the failure of any single lighting unit does not result in an illumination level of less than 0.2 foot-candle in any designated area. This deficient practice	K 0281	**b="">** **1. No Residents were harmed by the alleged deficient practice. The identified lighting was adjusted to illuminate the gate.** **2. Any resident that resides in the facility has the potential**	04/07/2022

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	could affect up to 34 residents as well as staff and visitors on the 100 hall. Findings include: Based on observations on 03/21/22 between 12:30 p.m. and 3:00 p.m. during a tour of the facility with the Maintenance Director, the 100 hall exit was provided with light directly outside the exit door, however, there was no exterior light provided for the exit gate to get to the public way from the 100 hall exit. Based on interview at the time of observation, the Maintenance Director agreed the exit gate from the 100 hall exit door needed to have exterior light provided. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)		**to be affected by the alleged deficient practice. All other Exterior Lighting was checked and no other concerns noted.** **3. ED/Designee will complete in service training with all Maintenance staff on the facilities policy identified as Operational test of Exit Lighting.** **4. ED/Designee will conduct an audit of all exit door lighting weekly for 8 weeks monthly for 4 months, then Quarterly for 2 quarters**	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments			

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	with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on record review and interview, the facility failed to ensure 1 of 1 kitchen range hood extinguishing system was maintained in proper working order. This deficient practice was not in a resident area but could affect kitchen staff. Findings include: Based on record review on 03/21/22 between 9:15 a.m. and 12:30 p.m. with the Maintenance Director present, range hood suppression reports dated 11/18/21, 05/14/21, and 11/02/20 from the facility's vendor all stated "Electric oven not shutting down on system trip" or "Electric shutoff not working". When asked, the Maintenance Director said he thought the issue had been corrected, but could not find documentation or verify in any way that the issue had been corrected. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)	K 0324	1. No Staff were harmed by the alleged deficient practice. 2. Any resident that resides in the facility has the potential to be affected by the alleged deficient practice. Service company contacted to correct the concern. 3. ED/Designee will complete in service training with all Maintenance staff on the facilities policy identified as Have Hood cleaned by Certified Contractor. Any inspection identified concerns will be reviewed with the Maintenance Director or ED. 4. ED/Designee will conduct an audit of Kitchen Hood Function weekly for 8 weeks monthly for 4 months, then Quarterly for 2 quarters. Executive Director will monitor through Faculty QUAPI meetings any issues noted will immediately be addressed to maintain compliance.	04/07/2022
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems			

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	are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to ensure the ceiling in 1 of 7 sprinklered smoke compartments was maintained to allow sprinkler heads to function to their full capability. This deficient practice could affect up to 23 residents in the 200 hall. Findings include: Based on observations on 03/21/22 between 12:30 p.m. and 3:00 p.m. during a tour of the facility with the Maintenance Director, there was a one inch hole around a conduit through the ceiling of the 200 hall Mechanical Room that was not properly fire stopped. Based on interview at the time of observation, the Maintenance Director agreed the hole around the 200 Mechanical Room conduit was not properly fire stopped. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference.	K 0353	1. No Residents were harmed by the alleged deficient practice. The identified area was corrected the day of survey. 2. Any resident that resides in the facility has the potential to be affected by the alleged deficient practice. All other Mechanical Rooms were inspected and no further concerns were noted. 3. ED/Designee will complete in service training with all Maintenance staff on the facilities policy identified as Inspect Attic Fire/Smoke wall barriers 4. ED/Designee will conduct an audit of all Mechanical Rooms weekly for 8 weeks monthly for 4 months, then Quarterly for 2 quarters. Executive Director will	04/07/2022

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	3.1-19(b)		monitor through Faculty QUAPI meetings any issues noted will 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 harmed by the alleged deficient practice. The Smoke Barrier Doors going into the main Dining Area and the 100 hall were adjusted and are functioning. 2. Any resident that resides in the facility has the potential to be affected by the alleged deficient practice. All other Smoke Barrier Doors were tested and no further concerns noted. 3. ED/Designee will complete in service training with all Maintenance staff on the facilities	04/07/2022

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	12:30 p.m. and 3:00 p.m. during a tour of the facility with the Maintenance Director, the following was noted: a. The set of smoke barrier doors in the corridor leading into the main Dining Room area did not close completely when tested. There was a six inch gap between the set of doors when closed fully. b. The set of fire/smoke barrier doors within the 100 hall near the Dining Room/Lounge area did not close complete and latch when tested. This set of fire/smoke barrier doors was equipped with latching hardware. There was a one inch gap between the set of doors when closed fully. Based on interview at the time of each observation, the Maintenance Director agreed the previously mentioned sets of fire/smoke barrier doors did not close completely and latch into their door frames when tested. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)		policy identified as Conducting the Fire Drills. 4. ED/Designee will conduct an audit of all Smoke Barrier doors weekly for 8 weeks monthly for 4 months, then Quarterly for 2 quarters. Executive Director will monitor through Faculty QUAPI meetings any issues noted will immediately be addressed to maintain compliance.	
K 0754 SS=E Bldg. 01	NFPA 101 Soiled Linen and Trash Containers Soiled Linen and Trash Containers Soiled linen or trash collection receptacles shall not exceed 32 gallons in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gallons/square feet. A total container capacity of 32 gallons shall not be exceeded within any 64 square feet area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gallons shall be located in a room protected as a hazardous area when not attended.			

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	Containers used solely for recycling are permitted to be excluded from the above requirements where each container is less than or equal to 96 gallons unless attended, and containers for combustibles are labeled and listed as meeting FM Approval Standard 6921 or equivalent. 18.7.5.7, 19.7.5.7 Based on observation and interview, the facility failed to ensure soiled linen and trash receptacles in 3 of 5 corridors were maintained in accordance with 19.7.5.7. Section 19.7.5.7(2) states that a capacity of 32 gallons shall not be exceeded within any 64 square foot area. This deficient practice could affect at least 50 residents, as well as staff and visitors in the facility. Findings include: Based on observation on 03/21/22 between 12:30 p.m. and 3:00 p.m. during a tour of the facility with the Maintenance Director, the following was noted: a. There was a soiled linen container and trash container with at least 32 gallon capacity each being stored in the 300 hall outside resident room 310. Each container was at least half full and was not being used at the time of observation. a. There was a soiled linen container and trash container with at least 32 gallon capacity each being stored in the 200 hall outside resident room 213. Each container was at least half full and was not being used at the time of observation. a. There was a soiled linen container and trash container with at least 32 gallon capacity each being stored in the 100 hall outside resident room 109. Each container was at least half full	K 0754	1. No Residents were harmed by the alleged deficient practice. The Soiled Linen and Trash Containers were removed from the unit. 2. Any resident that resides in the facility has the potential to be affected by the alleged deficient practice. All other Soiled Linen and Trash Containers were removed from the other units. 3. ED/Designee will complete in service training with all staff on the facilities policy identified as Infection Control Practice for Laundry and Linen Policy and Procedure. 4. ED/Designee will conduct an audit of Soiled and Linen Containers being off the unit when not in use weekly for 8 weeks monthly for 4 months, then Quarterly for 2 quarters. Executive Director will monitor through Faculty QUAPI meetings any issues noted will immediately be addressed to maintain compliance.	04/07/2022

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	and was not being used at the time of observation. Based on interview at the time of each observation, the Maintenance Director agreed each container was at least 32 gallons in capacity and should be stored in a room protected as a hazardous area when not in use. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)			