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	04/22/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.73. Survey Date: 04/22/19 Facility Number: 000526 Provider Number: 155488 AIM Number: 100266970 At this Emergency Preparedness survey, Rolling Hills Health Care Center was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 115 certified beds. At the time of the survey, the census was 111. Quality Review completed on 04/25/19 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000	Preparation and or execution of this plan of correction in general or this corrective action in particular does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and or executed in compliance with state and federal laws. The facility is requesting a desk review of compliance for this plan of correction.	
E 0015 SS=C Bldg. --	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include at a minimum, (1) The provision of subsistence needs for staff and residents, whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical, and pharmaceutical supplies. (ii) Alternate sources of energy to maintain - (A) Temperatures to protect resident	E 0015	1. No resident were found to be affected. The Disaster Preparedness Manual was updated to address the (D) Sewage and Waste disposal in accordance with 42 CFR 483.73 (b) (1). The Maintenance Director has contacted Walker Mechanical Contractors to set up a contract	05/06/2019

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

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	health and safety and for the safe and sanitary storage of provisions; (B) Emergency lighting; (C) Fire detection, extinguishing, and alarm systems; and (D) Sewage and waste disposal in accordance with 42 CFR 483.73(b)(1). This deficient practice could affect all occupants. Findings include: Based on review of the Emergency Preparedness Manual on 04/22/19 between 2:30 p.m. and 3:30 p.m. with the Executive Director (ED) and Maintenance Director present, the plan provided did not address the loss of sewage and waste disposal in an emergency. Based on interview at the time of records review, the ED agreed the plan did not address the loss of sewage and waste disposal in an emergency.		for their services in case of an emergence resulting in the need for sewage and waste disposal. They have agreed to provide their services as needed. 2. All residents have the potential to be affected by this deficient practice. The Maintenance Director was inserviced on 5/3/19 on the requirements of E015. The Disaster Preparedness Manual was updated to address the (D) Sewage and Waste disposal with accordance with 42 CFR 483.73 (b) (1). 3. The facility disaster preparedness manual will be reviewed monthly for 6 months by the Administrator or designee, then annually by the Administrator. 4. The facility disaster preparedness manuals will be reviewed monthly by the QA committee to insure on going compliance	
E 0025 SS=C Bldg. --	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the development of arrangements with other LTC facilities and other providers to receive residents in the event of limitations or cessation of operations to maintain the continuity of services to LTC residents in	E 0025	1. No residents were found to have been affected. The Disaster Preparedness Manual was updated to address 42 CFR 483.73 (b) (7). Interfacility Transfer Agreement between Rolling Hills Healthcare Center	05/06/2019

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	accordance with 42 CFR 483.73(b)(7). This deficient practice could affect all occupants. Findings include: Based on review of the Emergency Preparedness Manual on 04/22/19 between 2:30 p.m. and 3:30 p.m. with the Executive Director (ED) and Maintenance Director present, documentation of emergency preparedness policies and procedures including the development of arrangements with other LTC facilities and other providers to receive residents in the event of limitations or cessation of operations was not available for review. Based on interview at the time of record review, the ED agreed documentation of arrangements with other facilities was not available for review at the time of the survey.		hereinafter the Evacuating Facility and Wedgewood hereinafter the Receiving Facility to provide assistance in the event an evacuation of either facility is required has been added to the facility Disaster Preparedness Manual. 2. All residents have the potential to be affected by this deficient practice. The facility Disaster Preparedness Manual was updated to contain the Interfacility Transfer Agreement between Rolling Hills Healthcare Center and Wedgewood. 3. The facility Disaster Preparedness Manual will be reviewed monthly x 6 months then annually by the administrator or designee to ensure it remains current. 4. The facility disaster preparedness manuals will be reviewed monthly by the QA committee to insure on going compliance	
E 0035 SS=C Bldg. --	Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes a method for sharing information from the emergency plan that the facility has determined is appropriate with	E 0035	1. No residents were found to be affected. The facility Disaster Preparedness Manual was updated to include a method for sharing information from the	05/22/2019

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	residents and their families or representatives in accordance with 42 CFR 483.73(c)(8). This deficient practice could affect all occupants. Findings include: Based on review of the Emergency Preparedness Manual on 04/22/19 between 2:30 p.m. and 3:30 p.m. with the Executive Director (ED) and Maintenance Director present, the communication plan failed to include a method for sharing information from the emergency plan that the facility has determined is appropriate with residents and their families or representatives in accordance with 42 CFR 483.73(c)(8). Based on interview at the time of record review, the ED said a method for sharing information from the emergency plan that the facility has determined is appropriate with residents and their families or representatives was not available for review.		Emergency Plan that the facility has determined is appropriate with residents and their families or representatives in accordance with 42 CFR 483.73 (c) (8). A letter will be added to admission packets stating the whereabouts of the facility Disaster Preparedness Manuals on each unit. The Admissions Director will provide information regarding the use and availability of the facility's Disaster Preparedness Manuals. 2. All the residents have the potential to be affected by this deficient practice. The Disaster Preparedness Manual was updated to address 42 CFR 483.73 (c) (8). 3. The facility Disaster Preparedness Manual will be reviewed monthly by the administrator or designee x 6 months then annually thereafter. 4. The facility disaster preparedness manuals will be reviewed monthly by the QA committee to insure on going compliance.	
E 0039 SS=C Bldg. --	Based on record review and interview, the facility failed to provide complete documentation of exercises to test the emergency plan at least annually, including unannounced staff drills using	E 0039	1. The disaster preparedness manual will be updated to include the after action report for each of the 2 documented exercises	05/22/2019

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	the emergency procedures. The LTC facility must do all of the following: (i) participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event; (ii) conduct an additional exercise that may include, but is not limited to the following: (A) a second full-scale exercise that is community-based or individual, facility-based. (B) a tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan; (iii) analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants. Findings include: Based on review of the Emergency Preparedness Manual on 04/22/19 between 2:30 p.m. and 3:30 p.m. with the Executive Director (ED) and Maintenance Director present, the facility was able to provide documentation of two exercises within the past twelve months, however, the two documented exercises did not have an After Action Report attached. Based on interview at the time of review, the ED said the facility did conduct at least two community based emergency preparedness exercises during the past twelve		within the past 12 month. All table top and community drills will be followed by an after action report. 2. All residents have the potential to be affected by this deficient practice. The Maintenance Director is aware of the requirements of the E 0039 in accordance with 42 CFR 483.73 (d) (2). The Disaster Preparedness Manual will be updated to include the After Action Reports available for each exercise conducted. 3. The facility Disaster Preparedness Manual will be reviewed monthly by the administrator or designee x 6 months then annually thereafter to ensure it remains current. 4. The facility disaster preparedness manuals will be reviewed monthly by the QA committee to insure on going compliance.	

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	months, but there was no After Action Report available for either exercise conducted.			
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 04/22/19 Facility Number: 000526 Provider Number: 155488 AIM Number: 100266970 At this Life Safety Code survey, Rolling Hills Health Care Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and nine resident sleeping rooms in the 100B hall. The facility has a capacity of 115 and had a census of 111 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 04/25/19	K 0000	Preparation and or execution of this plan of correction in general or this corrective action in particular does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and or executed in compliance with state and federal laws. The facility is requesting a desk review of compliance for this plan of correction.	

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K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) Based on observation and interview, the facility failed to ensure the corridor doors to 2 of over 10 hazardous area doors, such as a Bio Hazard room and fuel fired water heater room, were provided with properly functioning self closing devices.	K 0321	1. No residents were found to have been affected. The Maintenance Director aware of the issues with the doors. Contracted with R. Underwood Construction,	05/22/2019

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	This deficient practice could affect at least 24 residents, as well as staff and visitors in the 400 hall. Findings include: Based on observation on 04/22/19 between 1:00 p.m. to 2:30 p.m. during a tour of the facility with the Maintenance Director, the corridor doors to the 400 hall Bio Hazard Room and the Mechanical Room which contained a fuel fired water heater, did not self close completely when tested several times. Based on interview at the time of observations, the Maintenance Director acknowledged the doors did not close completely and latch when tested and said he was aware of the issues with the doors, and further said two doors have already been ordered to replace the current doors. 3.1-19(b)		Inc. from Franklin, IN to provide and install prefinished steel doors and frames for the biohazard room and fuel fired water heater room on the 400 Hall. 2. All residents have the potential to be affected. The Maintenance Director will perform a house wide audit of the same issue. 3. The Maintenance Director will be educated on the deficiency. 4. Maintenance Director or designee will inspect the Hazard area doors quarterly per TELS PM program. QA Committee will review quarterly TELS PM documentation for continued compliance.	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on record review and interview, the facility failed to ensure 3 of 60 smoke detectors were tested for sensitivity within the past 24 months.	K 0345	1. No residents were found to be affected. The Maintenance Director contacted FESCO in	05/06/2019

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	NFPA 72, National Fire Alarm Code, 2010 Edition, Section 14.4.5.3.1 states detector sensitivity shall be checked within 1 year of installation, and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range, the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or areas where nuisance alarms show an increase over the previous year, calibration tests shall be performed. To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the methods: (1) Calibrated test method. (2) Manufacturer's calibrated sensitivity test instrument. (3) Listed control equipment arranged for the purpose. (4) Smoke detector/fire alarm control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range. (5) Other calibrated sensitivity method acceptable to the authority having jurisdiction. Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated, or replaced. The detector sensitivity cannot be tested or measured using any spray device that administers an unmeasured concentration of aerosol into the detector. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include:		regards to the testing of all hardwired smoke detectors in the facility. A 102 page report was received at the facility verifying that all hardwired smoke detectors were tested for sensitivity. 2. All the residents have the potential for be affected by this deficient practice. The Maintenance Director will review all documentation received from FESCO each visit. Any discrepancies will be addressed promptly. 3. The Maintenance Director will bed inserviced by the Administrator on 5/6/19. 4. Fire alarm documentation and sensitivity testing will be monitored by Maintenance Director for continue compliance. Administrator and Maintenance Director will immediately address any issues with the fire alarm inspection company.	

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	Based on record review on 04/22/19 between 10:30 a.m. and 1:00 p.m. with the Maintenance Director present, the most recent smoke detector sensitivity test documentation dated 07/23/18 indicated there were 60 hard wired smoke detectors in the facility. The 07/23/18 inspection report noted that only 57 of the 60 hard wired smoke detectors were tested for sensitivity. Based on interview at the time of record review, the Maintenance Director said there was no other documentation or information available to show the three remaining smoke detector had been tested for sensitivity during the past 24 months. 3.1-19(b)			