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

FORM APPROVED
OMB NO. 0938-039

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	03/14/2023

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 Department of Health in accordance with 42 CFR 483.73. Survey Date: 03/14/23 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 104 at the time of this survey. Quality Review completed on 03/20/23	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: 03/14/23 Facility Number: 000526 Provider Number: 155488 AIM Number: 100266970 At this Life Safety Code survey, Rolling Hills Healthcare Center was found not in compliance	K 0000	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Donna	Jones	04/06/2023

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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	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 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 104 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 03/20/23			
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 1 of 7 exit means of egress were continuously maintained free of obstructions. This deficient practice could affect at least 10 residents, as well as staff and visitors.	K 0211	1) There were no negative effects as a result of this deficient practice with the residents/staff/visitors. 2) The items identified were removed and properly discarded	04/14/2023

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	Findings include: Based on observations on 03/14/23 between 1:45 p.m. and 4:00 p.m. during a tour of the facility with the Maintenance Director, there were at least three wood pallets, two bags of trash, and several other trash items on and next to the sidewalk outside the exit door near the laundry room. Based on interview at the time of observation, the Maintenance Director acknowledged the items in the path of egress from the exit outside the laundry room and said he would move them as soon as possible. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)		on 3/14/23. 3) All staff will be educated on proper disposal of debris and maintain exit means of egress should be free of obstructions. The education will be completed by 4/06/2023 4) All paths of egress will be checked for obstruction 3 times per week for 4 weeks, then 2 times per week for 2 weeks and random thereafter. 5) All findings will be reported to the QAPI committee for further recommendations	
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 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,			

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	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 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			

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	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 2 of 8 delayed egress locking arrangements were installed in accordance with LSC 7.2.1.6.1(3) which states an irreversible process shall release the lock in the direction of egress within 15 seconds, or 30 seconds where approved by the authority having jurisdiction, upon application of a force to the release device required in 7.2.1.5.10 under all of the following conditions: (a) The force shall not be required to exceed 15 lbf (67 N). (b) The force shall not be required to be continuously applied for more than 3 seconds. (c) The initiation of the release process shall activate an audible signal in the vicinity of the door opening. (d) Once the lock has been released by the application of force to the releasing device, relocking shall be by manual means only. This deficient practice could affect at least 40 residents, as well as staff and visitors. Findings include: Based on observations on 03/14/23 between 1:45 p.m. and 4:00 p.m. during a tour of the facility with the Maintenance Director, the following was noted: a. The 300 hall exit door was equipped with delayed egress. When the panic bar on the door was pushed for 15 seconds several times the door did not release from the magnetic hold located at the top of the door. Furthermore, the magnetic hold did not release the door when the code was	K 0222	1) There were no negative effects as a result of this deficient practice with the residents/staff/visitors. 2) Maintenance Director adjusted both doors – 300 hall exit door and main dining room door to ensure both doors are operating as designed on 3/14/23. Doors retested and operating as designed. 3) Maintenance Director and/or designee will be educated on the requirement/frequency to check egress doors to ensure the doors are operating as designed. The education will be completed by 4/6/2023 4) Maintenance Director or designee will check 300 hall exit door and main dining exit doors 3 times per week for 4 weeks, then 2 times per week for 2 weeks and random thereafter. 5) All findings will be reported to the QAPI committee for further recommendations	04/14/2023

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	pushed on the keypad located next to the door. The door did finally release from the magnetic hold when the fire alarm was tested using a near by pull station. b. The main dining room exit door to the courtyard was equipped with delayed egress. When the panic bar on the door was pushed for 15 seconds several times the door did not release from the magnetic hold located at the top of the door. The door did release when the code was pushed on the keypad located next to the door. Based on interview at the time of each observation, the Maintenance Director said all the exit doors are tested often to ensure they work properly and they all worked properly during the last test. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)			
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.)			
	Based on observation and interview, the facility failed to ensure 2 of over 10 exit signs were continuously illuminated. This deficient practice could affect at least 20 residents, as well as staff and visitors.	K 0293	1) There were no negative effects as a result of this deficient practice with the residents. 2) The exit signs located - at the 100 hall exit door and at the	04/14/2023

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	Findings include: Based on observations on 03/14/23 between 1:45 p.m. and 4:00 p.m. during a tour of the facility with the Maintenance Director, the following was noted: a. The exit sign above the 100 hall exit door to the outside was not illuminated. b. The exit sign above the west side of the set of smoke barrier in the center of the 100 hall had one of two bulbs not illuminated. Based on interview at the time of each observation, the Maintenance Director said he was not aware that the exit signs were not illuminated but would fix them as soon as possible. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1.19(b)		west side of the set of smoke barrier doors at center of 100 hall were both fixed to illuminate properly on March 20, 2023. 3) Maintenance Director and/or designee will be educated on the requirement to check exit signs to ensure the signs are illuminated. The education will be completed by 4/06/2023. 4) Maintenance Director or designee will check 100 hall exit door and west side of the set of smoke barrier doors at center of 100 hall to ensure both signs are illuminated 3 times per week for 4 weeks, then 2 times per week for 2 weeks and random thereafter. 5) All findings will be reported to the QAPI committee for further recommendations	
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			

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	* cooking facilities in smoke compartments 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 observation and interview, the facility failed to ensure the cook top in 1 of 1 Physical Therapy room was shut off at the switch when not in use. LSC 19.3.2.5.4 states within a smoke compartment, residential or commercial cooking equipment that is used to prepare meals for 30 or fewer persons shall be permitted, provided that the cooking facility complies with all the following conditions: (1) The space containing the cooking equipment is not a sleeping room. (2) The space containing the cooking equipment shall be separated from the corridor by partitions complying with 19.3.6.2 through 19.3.6.5. (3) The requirements of 19.3.2.5.3(1) through (10) and (13) are met. 19.3.2.5.3(9) states A switch meeting all the following is provided: (a) A locked switch, or a switch located in a restricted location, is provided within the cooking facility that deactivates the cooktop or range. (b) The switch is used to deactivate the cooktop or range whenever the kitchen is not under staff supervision. This deficient practice could affect at least 5 residents while in the Physical Therapy room. Findings include: Based on observations on 03/14/23 between 1:45 p.m. and 4:00 p.m. during a tour of the facility with	K 0324	1) There were no negative effects as a result of this deficient practice with the residents. 2) The cooktop stove was deactivated from the power source on 3/14/23. 3) Maintenance Director and/or designee will be educated on the expectation to deactivate the cooktop range when not in use. The education will be completed by 4/06/2023. 4) Maintenance Director or designee will check the cooktop stove 3 times per week for 4 weeks, then 2 times per week for 2 weeks and random thereafter 5) All findings will be reported to the QAPI committee for further recommendations	04/14/2023

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	the Maintenance Director, there was a cooktop stove in the Physical Therapy room. When checked, and not in use, this stove top appliance was not deactivated from the individual cooktop power source. Based on interview at the time of observation, the Maintenance Director confirmed the cooktop stove was not deactivated when not in use. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)			
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems 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 sprinkler heads in 1 of 7 smoke compartments covered with corrosion were replaced. NFPA 25, 2011 edition, at 5.2.1.1.1	K 0353	1) There were no negative effects as a result of this deficient practice. 2) The sprinkler heads were	04/14/2023

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	sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect laundry staff plus any resident while in the same smoke compartment. Findings include: Based on observations on 03/14/23 between 1:45 p.m. and 4:00 p.m. during a tour of the facility with the Maintenance Director, there were two sprinkler heads in the laundry room covered with green corrosion. Based on interview at the time of observation, the Maintenance Director agreed the two sprinkler heads in the laundry room were covered with green corrosion and should be replaced. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)		ordered from the SafeCare on 3/21/23. There is an 8-10 week lead time for the sprinkler heads 3) Maintenance Director and/or designee will be educated on the expectation of inspecting sprinkler heads. The education will be complete by 4/06/2023. 4) Maintenance Director or designee will inspect 10 sprinkler heads 3 times per week for 4 weeks, then 2 times per week for 2 weeks and random thereafter 5) All findings will be reported to the QAPI committee for further recommendations	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material			

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	capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 2 of 61 resident room corridor doors would close complete and latch into their door frames. This deficient practice could affect at least 30 residents, staff and visitors.	K 0363	1) There were no negative effects as a result of this deficient practice. 2) The corridor door to room 120 and 312 were fixed on	04/14/2023

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	Findings include: Based on observations on 03/14/23 between 1:45 p.m. and 4:00 p.m. during a tour of the facility with the Maintenance Director, the following was noted: a. The corridor door to room 120 did not latch when tested several times. The door would swing back open each time it was closed. b. The corridor door to room 312 did not latch when tested several times. Based on interview at the time of each observation, the Maintenance Director acknowledged the corridor doors to rooms 120 and 312 failed to close complete 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)		3/14/23. The doors were checked and confirmed to operate as designed. This was corrected on 3/14/2023. 3) Maintenance Director and/or designee will be educated on the expectation of inspecting corridor doors to ensure the doors operate as designed. The education will be completed by 4/06/2023. 4) Maintenance Director or designee will inspect 10 corridor doors 4 times per week for 4 weeks, then 2 times per week for 2 weeks and random thereafter 5) All findings will be reported to the QAPI committee for further recommendations	
K 0374 SS=F 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			

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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
	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 3 of 6 sets of 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 03/14/23 between 1:45 p.m. and 4:00 p.m. during a tour of the facility with the Maintenance Director, the following was noted: a. The set of smoke barrier doors leading into the 200 hall did not close completely when tested. There was a 1/2 inch gap between the doors when closed fully. b. One door of the set of smoke barrier doors leading into the 400 hall would not close on its own when released from the magnetic holder because it was dragging on the floor. c. One door of the set of smoke barrier doors leading into the Center hall and main dining room area would not close on its own when released from the magnetic holder because it was dragging on the floor. Based on interview at the time of each observation, the Maintenance Director agreed each set of smoke barrier doors observed did not close completely when tested. This finding was reviewed with the Executive Director and Maintenance Director during the exit	K 0374	1) There were no negative effects as a result of this deficient practice. 2) The smoke barrier door leading into the 200 hall, leading into 400 hall and doors leading into center hall all have were fixed and now operating as designed (need to confirm). This was corrected on 3/15/2023 3) Maintenance Director and/or designee will be educated on the expectation of inspecting corridor doors to ensure the doors operate as designed. The education will be completed by 4/06/2023. 4) Maintenance Director or designee will inspect 10 corridor doors 4 times per week for 4 weeks, then 2 times per week for 2 weeks and random thereafter 5) All findings will be reported to the QAPI committee for further recommendations	04/14/2023

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	conference. 3.1-19(b)			
K 0511 SS=D Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 2 of over 30 wet locations, were provided with ground fault circuit interrupter (GFCI) protection against electric shock. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily accessible location. Informational Note: See 215.9 for ground-fault circuit interrupter protection for personnel on feeders. (B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in 210.8(B)(1) through (8) shall have ground-fault circuit-interrupter protection for personnel. (1) Bathrooms (2) Kitchens (3) Rooftops (4) Outdoors Exception No. 1 to (3) and (4): Receptacles that are not readily accessible and are supplied by a branch circuit dedicated to electric snow-melting,	K 0511	1) There were no negative effects as a result of this deficient practice. 2) The outlets identified have been corrected and inspected, now operating as designed – GFCI protected. The outlets were changed on 3/15/2023. 3) Maintenance Director and/or designee will be educated on the expectation of inspecting electrical outlets that require GFCI protection, we have in place. The education will be completed by 4/06/2023. 4) Maintenance Director or designee will inspect 10 outlets 4 times per week for 4 weeks, then 2 times per week for 2 weeks and random thereafter 5) All findings will be reported to the QAPI committee for further recommendations	04/14/2023

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	deicing, or pipeline and vessel heating equipment shall be permitted to be installed in accordance with 426.28 or 427.22, as applicable. Exception No. 2 to (4): In industrial establishments only, where the conditions of maintenance and supervision ensure that only qualified personnel are involved, an assured equipment grounding conductor program as specified in 590.6(B)(2) shall be permitted for only those receptacle outlets used to supply equipment that would create a greater hazard if power is interrupted or having a design that is not compatible with GFCI protection. (5) Sinks - where receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink. Exception No. 1 to (5): In industrial laboratories, receptacles used to supply equipment where removal of power would introduce a greater hazard shall be permitted to be installed without GFCI protection. Exception No. 2 to (5): For receptacles located in patient bed locations of general care or critical care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection shall not be required. (6) Indoor wet locations (7) Locker rooms with associated showering facilities (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect staff only. Findings include:			

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	Based on observations on 03/14/23 between 1:45 p.m. and 4:00 p.m. during a tour of the facility with the Maintenance Director, the following was noted: a. There was one electric receptacle within three feet of the sink in the 100 hall kitchenette that was not provided with GFCI protection. When tested with a GFCI testing device, the electric circuit was not broken. b. There was one electric receptacle within three feet of the sink in the 400 hall Nourishment room with a GFCI receptacle provided, however, when tested with a GFCI tester, the receptacle seemed to be wired correctly, but, the electric circuit was not broken. The circuit was also not broken when pushing the test button on the GFCI receptacle. Based on interview at the time of each observation, the Maintenance Director agreed both receptacles were not properly GFCI protected. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)			
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded			

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	announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 1. Based on record review and interview, the facility failed to provide quarterly fire drill documentation for 2 of 3 shifts during 2 of 4 quarters. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on review of the facility's fire drill reports on 03/14/23 between 9:30 a.m. and 1:45 p.m. with the Maintenance Director present, the facility lacked fire drill documentation for the following shifts and quarters during the past 12 month period: a. First shift (day) of the third quarter (July, August, and September) of 2022 b. Second shift (evening) of the second quarter (April, May, and June) of 2022 Based on interview at the time of record review, the Maintenance Director confirmed the lack of fire drill reports during the previously mentioned shifts and quarters. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to provide complete fire drill documentation for 2 of 10 fire drills performed during the past 12 month period. This deficient practice could affect all residents in the facility. Findings include:	K 0712	1) There were no negative effects as a result of this deficient practice with the residents/staff/visitors. 2) Maintenance Director completed fire drills on 2 of the 3 shifts that were missing on 4/7/2023. 3) Maintenance Director and/or designee will be educated on NFPA 101 regarding the frequency/sequence of Fire Drills. The education will be completed by 4/06/2023. 4) Executive Director will validate fire drills are occurring as outlined in NFPA 101 monthly for 3 months. 5) All findings will be reported to the QAPI committee for further recommendations	04/14/2023

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	Based on review of the facility's fire drill reports on 03/14/23 between 9:30 a.m. and 1:45 p.m. with the Maintenance Director present, 2 of 10 documented fire drills performed during the past 12 month period (06/29/22 at 4:30 a.m. and 08/28/22 at 7:00 p.m.) did not include the names and signatures of staff that participated in the fire drills. Based on interview at the time of record review, the Maintenance Director confirmed the lack of staff signatures on 2 of 10 fire drill reports during the past 12 month period. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)			
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited.			

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	(4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4			
	1. Based on observation and interview, the facility failed to ensure cigarette butts were properly disposed of at 1 of 1 area where cigarettes were allowed to be smoked by residents. This deficient practice could affect at least 5 residents and staff. Findings include: Based on observations on 03/14/23 between 1:45 p.m. and 4:00 p.m. during a tour of the facility with the Maintenance Director, the resident smoking area in the courtyard gazebo had several cigarette disposal towers and a cigarette butt can, however, there were thousands of cigarette butts on the floor of the gazebo and on the ground in a large area around the gazebo. Based on interview at the time of observation, the Maintenance Director agreed there were thousands of cigarette butts on the ground in and around the gazebo. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b) 2. Based on observation, records review, and interview; the facility failed to ensure cigarettes	K 0741	1) There were no negative effects as a result of this deficient practice with the residents/staff. 2) The cigarettes butts and debris were cleaned up on 3/14/23 in the areas identified – outside of 100 exit door and outside of exit door near laundry room. 1) All staff will be educated on proper disposal of cigarette butts and approved smoking locations outside the building. The education will be completed by 4/06/2023. 3) Maintenance Director or designee will inspect facility grounds 3 days per week for 4 weeks, then 2 days per week for 2 weeks and random thereafter 4) All findings will be reported to the QAPI committee for further recommendations	04/14/2023

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	were not smoked at 2 of 2 non-smoking areas according to the facility's smoking policy. This deficient practice could affect at least 20 residents, staff and visitors while exiting two areas of the facility. Findings include: Based on observations on 03/14/23 between 1:45 p.m. and 4:00 p.m. during a tour of the facility with Maintenance Director,the following was noted: a. There were hundreds of cigarette butts on the ground outside the 100 hall exit door. b. There were hundreds of cigarette butts on the ground outside the exit near the laundry room. There were also at least three wood pallets, two bags of trash, and other trash items on the ground near the cigarette butts. Based on interview at the time of each observation, the Maintenance Director acknowledged the cigarette butts on the ground and the cigarette butts mixed with combustible items outside the exit doors. Based on review of the facility's Smoking Policy between 9:30 a.m. and 1:45 p.m., the smoking policy did not include the 100 hall exit and the exit near the laundry room as smoking areas. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)			
K 0754 SS=F 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			

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	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. 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 all four resident room 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 all residents, as well as staff and visitors in the facility. Findings include: Based on observations on 03/14/23 between 1:45 p.m. and 4:00 p.m. during a tour of the facility with the Maintenance Director, there were four double carts with soiled linen with at least a 32 gallon capacity each stored in all four resident room corridors. Based on interview at the time of each observation, the Maintenance Director agreed the double carts exceeded the 32 gallon 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	K 0754	1) There were no negative effects as a result of this deficient practice with the residents/staff/visitors. 2) The soiled linen and trash receptacles identified were emptied on 3/14/23. 1) All staff utilizing soiled linen carts and trash receptacles will be educated on the expectation of properly storing soiled linen carts and trash receptacles that are approaching or at 32 gallons. The education will be completed by 4/07/2023. 3) Executive Director or designee will check halls 4 times per week for 4 weeks, then 2 times per week for 2 weeks and random thereafter All findings will be reported to the QAPI committee for further recommendations	04/14/2023

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	conference. 3.1-19(b)			
K 0761 SS=E Bldg. 01	Based on observation, record review, and interview; the facility failed to ensure an annual inspection and testing of 1 of 1 oxygen room fire door assembly was completed in accordance with LSC 19.1.1.4.1.1. Communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped.	K 0761	1) There were no negative effects as a result of this deficient practice with the residents/staff/visitors. 2) The oxygen transfillng fire door was inspected on 3/14/23, no issues noted. 1) Maintenance Director and/or designee will be educated on the frequency of inspection for the oxygen transfilling room fire door. The education will be completed by 4/06/2023. 3) Maintenance Director or designee will check the oxygen transfilling room fire door monthly for three months, then annually thereafter 4) All findings will be reported to the QAPI committee for further recommendations	04/14/2023

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	(3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect up to 23 residents, as well as staff, and visitors in the 400 hall. Findings include: Based on record review on 03/14/23 between 9:30 a.m. and 1:45 p.m. with the Maintenance Director present, the facility was unable to provide documentation for an annual inspection of the oxygen transfilling room fire door assembly. Based on interview at the time of record review, the Maintenance Director said there was no documentation of an annual inspection of the oxygen transfilling room fire door assembly. Based on observations during a tour of the facility with the Maintenance Director between 1:45 p.m. and 4:00 p.m., there was one oxygen transfilling room fire door assembly noted in the facility.			

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	This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)			
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 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 power strips and adapters were not used as a substitute for fixed wiring in 1 of 61 resident rooms and one staff office. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC	K 0920	1) There was no negative outcome as a result of this deficient practice with the residents and/or staff.	04/14/2023

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	155488	A. BUILDING 01 B. WING	03/14/2023

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
	9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, 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 could affect two residents and staff. Findings include: Based on observations on 03/14/23 between 1:45 p.m. and 4:00 p.m. during a tour of the facility with the Maintenance Director, the following was noted: a. There was a small refrigerator plugged into a power strip in the Admission's Office. b. Room 314 had small refrigerator plugged into a power strip near bed 1. There was also a double adapter plugged into the power strip. Furthermore, there was a second small refrigerator plugged into a power strip near bed 2. There was also a triple adapter plugged into the power strip with a fan and TV plugged into the triple adapter. Based on interview at the time of each observation, the Maintenance Director acknowledged the use of the power strips and adapters in the Admission's Office and resident room 314. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)		2) The refrigerator in the Admission's office is no longer plugged into an unapproved power strip. The unapproved power strips and triple adapter have been removed from room 314. This deficient practice was corrected on 3/14/23. 3) Maintenance Director and/or designee will be educated on the proper use of approved power strips in a patient care and other areas in a long term care facility. The education will be completed by 4/06/2023. 4) Maintenance Director or designee will inspect 5 areas 4 days per week, then 2 areas 2 days per week and random thereafter 5) All findings will be reported to the QAPI committee for further recommendations	