

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155614	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 12/08/2014
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NAME OF PROVIDER OR SUPPLIER LINCOLN HILLS OF NEW ALBANY	STREET ADDRESS, CITY, STATE, ZIP CODE 326 COUNTRY CLUB DRIVE NEW ALBANY, IN 47150
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K010000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 12/08/14</p> <p>Facility Number: 000321 Provider Number: 155614 AIM Number: 100286130</p> <p>Surveyor: Lex Brashear, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Lincoln Hills of New Albany was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be Type II (000) construction and fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors and spaces open to the corridors, plus battery operated smoke detectors in all resident sleeping rooms.</p>	K010000	Preparation and execution of this response and plan of correction does not constitute an 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. For purpose of any allegation that the facility is not in substantial compliance with federal requirements of participation, the response and plan of correction constitutes Lincoln Hills Health Center's allegation of compliance in accordance with Section 7305 in the State Operations Manual.	

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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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K010029 SS=E	<p>The facility has a capacity of 152 and had a census of 147 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered, except a detached garage used for maintenance and an employee-only smoke shack.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 12/15/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure 2 of 4 shower rooms which contained soiled linen</p>	K010029	In compliance with NFPA 101, 19.3.2.1, the areas are separated from other spaces by smoke resisting partitions and doors. Doors	01/07/2015

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K010048 SS=F	<p>containers containers with a capacity over 32 gallons, were equipped with positive latching doors. This deficient practice could affect up to 63 residents, as well as staff and visitors while in and west wing.</p> <p>Findings include:</p> <p>Based on observations on 12/08/14 between 11:45 a.m. and 1:30 p.m. during a tour of the facility with the Maintenance Director, both the Men's and Women's west wing shower room doors were not equipped with positive latches. Both west wing shower rooms had one large soiled linen cart each with a capacity of over 32 gallons. Both soiled linen carts were empty at the time of each observation, however, the Maintenance Director said the carts do stay within the shower rooms and are emptied every two hours.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review and interview, the facility failed to provide a complete written fire safety plan for the protection of 147 of 147 residents to accurately</p>	K010048	<p>are self-closing and on-rated orfield-applied protective plates that do not exceed 48 inches from the bottom of the door are used. The doors on the Men's and Women's west wing shower roomshave been replaced with doors that have positive latches. All shower rooms throughout the facility have been checked toensure that all shower room doors are equipped with positive latches. During weekly rounds, Maintenance Director will monitorcompliance. Any inconsistencies will becorrected immediately. Results of theseaudits will be reported to the Quality Assessment and Assurance Committeequarterly.</p> <p>In compliance with NFPA 101, 19.7.1.1, there is a writtenplan for the protection of all patients and for their evacuation in the eventof any emergency.</p>	01/07/2015

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	<p>address all life safety systems such as staff response to battery operated smoke detectors in resident sleeping rooms, plus a system addressing all items required by NFPA 101, 2000 edition, Section 19.7.2.2. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following:</p> <ol style="list-style-type: none"> (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire <p>This deficient practice could affect all occupants in the event of an emergency.</p> <p>Findings include:</p> <p>Based on a review of the Disaster Preparedness Plan on 12/08/14 at 11:10 a.m. with the Maintenance Director present, the Fire Policy and Procedure within the Plan did not address staff response to battery operated smoke detectors in resident sleeping rooms. Based on interview at the time of record review, the Maintenance Director acknowledged the Fire Policy and Procedure did not include staff response</p>		<p>The facility Disaster Preparedness Plan has been updated to include a Policy and Procedure to address staff response to battery operated smoke detectors in resident sleeping rooms (see attached)</p> <p>All staff have been inserviced regarding the new Policy and Procedure regarding Battery Operated Smoke Detectors. This P & P will be reviewed for new hires during general orientation and annually with existing staff. Administrator will review the Disaster Preparedness Plan for accuracy quarterly. Quality Assessment and Assurance Committee to monitor.</p>	

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K010051 SS=F	<p>to battery operated smoke detectors in resident sleeping rooms.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>Based on record review and interview, the facility failed to ensure documentation for the testing of 1 of 1 fire alarm systems components and devices, such as, smoke detectors, horn/strobe devices, fire alarm boxes, and fire alarm control equipment was complete. LSC 9.6.2.10 refers to NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires fire alarm system devices, such as, smoke detectors, fire alarm</p>	K010051	<p>In compliance with NFPA 101, 19.3.4, 9.6, fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available.</p> <p>An itemized check list of all devices tested has been developed by the Maintenance Director. This listing includes all devices that are tested, including location and type of device. Meeting was held with FASSCO, our fire safety service, to</p>	01/07/2015

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K010052 SS=F	<p>boxes, horn/strobe devices, and fire alarm control equipment be tested annually. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's fire alarm system quarterly inspection reports in the inspection book on 12/08/14 at 10:30 a.m. with the Maintenance Director present, the four quarterly fire alarm system inspection reports over the past twelve months dated 10/28/14, 07/14/14, 04/25/14, and 01/21/14 did not include an itemized check list of all devices tested, including, location, type of device, visual/functional test, and pass/fail result. This was acknowledged by the Maintenance Director at the time of record review.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 Based on record review and interview,</p>	K010052	<p>review new procedures for documentation. During quarterly fire alarm system inspection tests, devices will be clearly listed on the report. Maintenance Director will review report thoroughly, compare to itemized check list and discuss any inconsistencies prior to exit of FASSCO.</p> <p>Administrator will monitor compliance quarterly at our quarterly Quality Assessment and Assurance Committee meeting.</p> <p>In compliance with NFPA 101,</p>	01/07/2015

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	<p>the facility failed to ensure 4 of 72 smoke detectors had been tested for sensitivity. LSC Section 9.6.1.3 says the provisions of 9.6 cover the basic functions of the fire alarm system, including fire detection systems. LSC 9.6.1.4 refers to NFPA 72, National Fire Alarm Code. NFPA 72, at 7-3.2.1 states, "Detector sensitivity shall be checked within one year after installation and every alternative year thereafter. After the second required calibration test, if sensitivity tests indicate the detectors have remained within their listed and marked sensitivity ranges, the length of time between calibration tests may be extended to a maximum of five years. If the frequency is extended, records of detector caused nuisance alarms shall be maintained. In zones or areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed. To ensure each smoke detector is within its listed and marked sensitivity range it shall be tested using the following methods:</p> <ol style="list-style-type: none"> (1) Calibrated test method. (2) Manufacturer's calibrated sensitivity test instrument. (3) Listed control equipment arranged for the purpose. (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its 		<p>9.6.1.4, our fire alarm system is installed, tested and maintained in accordance with NFPA 70.</p> <p>An itemized check list of all devices tested has been developed by the Maintenance Director. This listing includes all smoke detectors that are tested, including location and type of device. Maintenance Director did verify the location of 68 smoke detectors throughout the facility which matched the number on our most recent sensitivity test dated 01/21/14.</p> <p>After completion of each sensitivity test, the Maintenance Director will check the number and location of all smoke detectors tested against our itemized check list and discuss any inconsistencies prior to exit of FASSCO. Meeting was held with FASSCO, our fire safety service, to review new procedures for documentation.</p> <p>Administrator will monitor compliance quarterly at our quarterly Quality Assessment and Assurance Committee meeting.</p>	

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	<p>sensitivity is outside its acceptable sensitivity range.</p> <p>(5) Other calibrated sensitivity test method acceptable to the authority having jurisdiction.</p> <p>Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or replaced.</p> <p>The detector sensitivity shall not be tested or measured using any device that administers an unmeasured concentration of aerosol into the detector. NFPA 72, 7-5.2 requires inspection, testing and maintenance reports be provided for the owner or a designated representative. It shall be the responsibility of the owner to maintain these records for the life of the system and to keep them available for examination by the authority having jurisdiction. Paper or electronic media shall be acceptable. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of the smoke detector sensitivity records and quarter fire alarm system inspection reports in the inspection book on 12/08/14 at 10:30 a.m. with the Maintenance Director present, the most recent sensitivity test documentation available was dated</p>			

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K010147 SS=E	<p>01/21/14 for 68 smoke detectors. The four most recent quarterly fire alarm system inspection reports dated 10/28/14, 07/14/14, 04/25/14, and 01/21/14 showed that 72 smoke detectors were inspected and tested for visual/functional condition. Based on interview at the time of record review, the Maintenance Director acknowledged four smoke detectors were not accounted for during the sensitivity test on 01/21/14.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure power strips and multi plug adaptors were not used as a substitute for fixed wiring in 10 of 95 residents and one staff room. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, Article 400-8 requires, 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 17 residents in rooms A-5, B-15, C-8, D-9, E-2, E-8,</p>	K010147	<p>In compliance with NFPA 70, National Electrical Code 9.1.2, the facility has ensured that power strips and multi plug adaptors are not used as a substitute for fixed wiring. Additional fixed wiring has been installed in rooms A-5, B-15, C-8, D-9, E-2, E-8, G-3, G-9, G-11, G-13 and the west wing Clean Utility Room. All other resident rooms and utility rooms have been checked with additional fixed wiring installed as necessary.</p> <p>All staff have been inserviced regarding the need to utilize fixed wiring instead of power strips and multi plug adaptors when necessary. Maintenance Director will complete</p>	01/07/2015

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	<p>G-3, G-9, G-11, and G-13, as well as staff while in the west wing Clean Utility room.</p> <p>Findings include:</p> <p>Based on observations on 12/08/14 between 11:45 a.m. and 1:30 p.m. during a tour of the facility with the Maintenance Director, the following was noted:</p> <ol style="list-style-type: none"> 1. Room E-8 had a refrigerator plugged into a power strip 2. Room E-2 had a refrigerator plugged into a power strip 3. Room G-3 had a power strip plugged into another power strip 4. Room G-9 had a refrigerator plugged into a power strip 5. Room G-11 had a nebulizer and oxygen concentrator plugged into a power strip 6. Room G-13 had a refrigerator plugged into a power strip 7. Room A-5 had a refrigerator plugged into a power strip and also had a multi adapter plugged into the wall outlet 8. Room C-8 had a multi adapter plugged into the wall outlet 9. Room D-9 had a refrigerator plugged into a power strip which was plugged into another power strip 10. Room B-15 had a microwave over and refrigerator plugged into a power 		<p>an audit of everyresident room and utility rooms weekly times four weeks and then monthly toensure that power strips and multi plug adaptors are not used as a substitutefor fixed wiring. Any inconsistencieswill be corrected with additional training or counseling completed asnecessary. Results of above audits will be reported to the QualityAssessment and Assurance Committee quarterly. Administrator to monitor.</p>	

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	strip 11. The west wing Clean Utility room had a microwave oven and large refrigerator plugged into a power strip. At the time of each observation, the Maintenance Director acknowledged the use of the power strips in the previously mentioned rooms. 3.1-19(b)						