STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155614	A. BUILDING -- B. WING	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LINCOLN HILLS OF NEW ALBANY	326 COUNTRY CLUB DRIVE 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: 10/16/24 Facility Number: 000321 Provider Number: 155614 AIM Number: 100286130 At this Emergency Preparedness survey, Lincoln Hills of New Albany was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 156 certified beds, with a current census of 115. Quality Review completed on 10/22/24	E 0000	Nov 1st, 2024 Brenda Buroker, Director Long-Term Care Division Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204 Re: Allegation of Compliance Event ID: 2UHH21 Dear Mrs. Buroker: Please find enclosed the Plan of Correction for the State Licensure Survey conducted on October 16, 2024. This letter is to inform you that the plan of correction attached is to serve as Lincoln Hills of New Albany credible allegation of compliance. We allege substantial compliance on October 31, 2024. We are requesting paper compliance for this plan of correction. If you have any further questions, please do not hesitate to contact me at 765-778-7501. Sincerely, Kim Povinelli, HFA	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kimberly Povinelli	Administrator	11/01/2024

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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			Administrator Lincoln Hills Submission of this plan of correction in no way constitutes an admission by Lincoln Hills of New Albany or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care or other services provided in this facility. The Plan of Correction is prepared and executed solely because it is required by Federal and State Law. This statement of deficiencies and plan of correction will be reviewed at the Monthly Quality Assurance/Assessment Committee meeting.	
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.542(e), 485.62 Hospital CAH and LTC Emergency Power Based on record review and interview, the facility failed to implement the emergency power system inspection, testing, and maintenance requirements	E 0041	**E041** **I. The corrective actions to be**	10/31/2024

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	found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all occupants. Findings include: Based on observation and interview on 10/16/2024 between 11:45 AM and 2:30 PM with the Maintenance Director, the digital panel on the generator indicated "low coolant temp." Based on interview at the time of observation, the Maintenance Director stated the generator was serviced on 10/11/24 and he believed that if the generator had shown that message at the time of service, the contractor would have addressed the issue. This finding was reviewed with the Maintenance Director at the exit conference.		**accomplished for those residents found to have been affected by the deficient practice.** Observation - The community failed to ensure that the Emergency Generator was functioning properly at the time of survey. The “low Coolant Temp” light was illuminated at the digital panel at the nurse station. The Maintenance Supervisor called out to Cummins Crosspoint Generators to make the repair and top off the coolant. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** This is a permanent fix to the deficiency as Cummins Crosspoint Generators made repairs to the generator. **IV The facility will monitor the corrective action by**	

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			implementing the following measures. CarDon Corporate facilities will inspect the generator, sub panel, and outside contractor paperwork during their quarterly site visits. **V. Plan of Correction completion date.** Plan of Completion date is October 31st, 2024.	
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: 10/16/24 Facility Number: 000321 Provider Number: 155614 AIM Number: 100286130 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 483.90(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 Type	K 0000	Nov 1st, 2024 Brenda Buroker, Director Long-Term Care Division Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204 Re: Allegation of Compliance Event ID: 2UHH21 Dear Mrs. Buroker: Please find enclosed the Plan of Correction for the State Licensure Survey conducted on October 16, 2024. This letter is to inform you that the plan of correction	

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	II (111) construction and was 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 alarms in all resident sleeping rooms. The facility has a capacity of 156 and had a census of 115 at the time of this survey. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. The facility has a detached wooden storage garage and a wooden storage shed which were not sprinkled. Quality Review completed on 10/22/24		attached is to serve as Lincoln Hills of New Albany credible allegation of compliance. We allege substantial compliance on October 31, 2024. We are requesting paper compliance for this plan of correction. If you have any further questions, please do not hesitate to contact me at 765-778-7501. Sincerely, Kim Povinelli, HFA Administrator Lincoln Hills Submission of this plan of correction in no way constitutes an admission by Lincoln Hills of New Albany or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care or other services provided in this facility. The Plan of Correction is prepared and executed solely because it is required by Federal and State Law.	

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			This statement of deficiencies and plan of correction will be reviewed at the Monthly Quality Assurance/Assessment Committee meeting.	
K 0100 SS=E Bldg. 01	NFPA 101 General Requirements - Other Based on observation and interview, the facility failed to maintain latching hardware on 1 of 1 E hall smoke barrier doors per 4.6.12.3. LSC 4.6.12.3 requires existing life safety features obvious to the public if not required by the Code, shall be either maintained or removed. This deficient practice could affect at least 10 residents, staff, and visitors. Findings include: Based on observation during a tour of the facility on 10/16/24 between 11:45 AM and 2:30 PM with the Maintenance Director, the E hall smoke barrier doors were equipped with latching hardware but was unable to latch into the frame. Based on interview at the time of observation, the Maintenance Director agreed the E hall smoke barrier doors were unable to latch. This finding was reviewed with the Maintenance Director at the exit conference. 3.1-19(b)	K 0100	**K 100** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation - The Community failed to ensure the E Hall fire doors would shut properly. The Maintenance Supervisor has adjusted the doors so they close and latch properly. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents of the E Hall have the potential to be affected by this deficient practice. **III. The facility will put into**	10/31/2024

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			place the following systematic changes to ensure that the deficient practice does not recur. There is a current monthly TELS task to inspect all fire doors to ensure they close and latch properly. See attached TELS task labeled “Lincoln Hills Fire Door Inspection Task.” **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate facilities will inspect all fire doors to ensure they shut and latch during their quarterly site visits. **V. Plan of Correction completion date.** Plan of Completion date is October 31st, 2024.	

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			11/1/24, 1:25 PM TELS Check Fire, Resident Room Entrance and Restroom Doors for proper closing and latching. Maintenance **Recurrence:** Every 1 ¿ Months **Next Due:** **Assigned To:** **Category:** In December 2024 Change ¿ Nobody Facility Inspection No assets linked to this task	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Based on observation and interview, the facility failed to ensure staff had access to the shutoff switch for 1 of 1 stove/oven in the memroy care activities room. 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 of the following conditions:	K 0324	**K 324** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation - The Community	10/31/2024

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	(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 of 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. (c) The switch is on a timer, not exceeding a 120-minute capacity, that automatically deactivates the cooktop or range, independent of staff action. This deficient practice could impact at least 10 residents and staff. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 10/16/24 between 11:45 AM and 2:30 PM, there was a cooktop stove/oven in the memory care activities room. Based on interview at the time of observation, the Maintenance Director stated the disconnect for the appliance was located in a different room than the appliance. The finding was reviewed with the Maintenance Director at the exit conference. 3.1-19(b)		failed to ensure that the memory care oven shut off switch was behind a locked door not in the cooking area. The Maintenance Supervisor had an electrical contractor re locate the oven timer so it is in the cooking area. See attached picture labeled “Lincoln Hills Oven Timer” **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All residents and staff have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** This is a permanent fixt to the deficiency and no more follow up is needed. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate facilities will inspect the oven timer on their site visits to ensure it is shutting off the oven properly.	

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			V. Plan of Correction completion date. Plan of Completion date is October 31st, 2024.	
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Based on observation and interview, the facility failed to ensure the spray pattern for sprinkler heads were not obstructed in 1 of 1 therapy closets in the hallway next to the salon in accordance with LSC 19.3.5.1. NFPA 13, 2010 edition, Section 8.5.5.1 states sprinklers shall be located so as to minimize obstructions to discharge as defined in Section 8.5.5.2 and Section 8.5.5.3 or additional sprinklers shall be provided to ensure adequate coverage of the hazard. Sections 8.5.5.2 and 8.5.5.3 do not permit continuous or noncontinuous obstructions less than or equal to 18 inches below the sprinkler deflector or in a horizontal plane more than 18 inches below the sprinkler deflector that prevent the spray pattern from fully developing. This deficient practice could affect at least 10 staff and residents. Findings include: Based on observation with the Maintenance Director on 10/16/24 between11:45 AM and 2:30 PM, the therapy closet in the hallway next to the salon had storage less than 18 inches from the ceiling. Based on interview at the time of observation, the Maintenance Director agreed the storage in the aforementioned area was less than 18 inches from the ceiling.	K 0351	**K 351** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation - The community failed to keep the items in the Therapy Supply closet lower that 18 inches from the ceiling. The Maintenance Supervisor has removed those items from the top shelf and has re educated the staff that they cannot store items within 18" of a any ceiling. See attached Picture labeled " Lincoln Hills Storage" showing these items removed and red tap installed showing the 18" line. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents have the	10/31/2024

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	This finding was reviewed with the Maintenance Director at the exit conference. 3.1-19(b)		potential to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** There is a current quarterly TELS task to inspect all closets to ensure there is no storage within 18" of the ceiling. See attached TELS task labeled "Lincoln Hills Storage Room Audit Task" **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate facilities will inspect all closets during their annual CQR to ensure that there is not items being stored within 18" of the ceiling. **V. Plan of Correction completion date.** Plan of Completion date is October 31st, 2024. 11/1/24, 1:49 PM	

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			TELS Inspect all storage closets to ensure nothing is stored within 18" of the ceiling Maintenance **Recurrence:** Every 3 ¿ Months **Next Due:** **Assigned To:** **Category:** This month Change ¿ Nobody Facility Inspection No assets linked to this task **Resources** ¿ **Instructions** Inspect all storage closets to ensure nothing is stored within 18" of the ceiling. If found please remove and educate the sta that is using this area that you are not permitted to store items within 18" of the ceiling.	
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing 1. Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 1 MDS offices, 1 of 1 areas behind the dryer, 1 of 1 kitchen dishroom areas, 1 of 1 west wing mechanical rooms, 1 of 1 west wing water tank rooms, and 1 of 1 HR offices. NFPA 13, 2010 edition, Section 3.3.5.4 defines a smooth ceiling as a continuous ceiling free from significant irregularities, lumps, or indentations. The ceiling traps hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. Section 8.5.4.1.1 states the distance between the sprinkler deflector and the ceiling	K 0353	**K 353** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation 1 - The community failed to ensure that multiple sprinkler head and escutcheon plates were tight to the ceiling or had proper fire caulking around	10/31/2024

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	above shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect at least 5 staff in the aforementioned areas. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 10/16/24 between 11:45 AM and 2:30 PM, the following was observed in the ceilings: a. MDS office was observed to have a 0.5 inch penetration around the sprinkler head b. a 2 inch penetration was observed behind the left most dryer around the pipe leading to the dryer c. 20 penetrations of 0.5 inches each around pipes leading to the panels in the kitchen dishroom area d. a 0.5 inch penetration around the sprinkler head in the west wing mechanical room e. a 2 inch penetration around the light in the west wing mechanical room f. a 1.5 inch penetration in the ceiling above 1 of 2 boilers in the west wing water tank room g. a 2 inch penetration around the sprinkler riser in the west wing water tank room h. a 0.5 inch penetration around the sprinkler head in the HR office Based on interview at the time of record review, the Maintenance Director agreed there was a penetration in the aforementioned locations and provided the measurements. This finding was reviewed with the Maintenance Director at the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility		them. The Maintenance Supervisor has gone to multiple locations and fixed the deficient practice. See a few examples of pictures labeled "Lincoln Hills fire block 1 and Fire block 2." Observation 2- The community failed to ensure that the spare sprinkler heads were secured in a spare head box. The Maintenance Supervisor has purchased another spare head box and installed. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** There is a current quarterly TELS task to inspect all fire sprinkler heads, escutcheon plates, ceiling penetrations to ensure they are compliant. There is a current quarterly TELS task in place to inspect these types of areas. See attached TELS task labeled "Lincoln Hills Storage Room Audit Task"	

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	failed to maintain the ceiling construction in rooms C8 and B12 in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, Section 6.2.7.1 states plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic, or shall be listed for use around a sprinkler. This deficient practice could affect at least 4 staff, residents, and visitors in this area. Findings include: Based on observation during a tour of the facility on 10/16/2024 between 11:45 AM and 2:30 PM with the Maintenance Director, rooms C8 and B12 were both missing an escutcheon around 1 of 2 sprinkler heads located in each of the aforementioned rooms. Based on interview at the time of observation, the Maintenance Director agreed there was a missing escutcheon in the aforementioned location. This finding was reviewed with the Maintenance Director at the exit conference. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems was maintained with spare sprinklers, a spare sprinkler cabinet and a sprinkler wrench on the premises. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.4.1.4 states a supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have been operated or damaged in any way can be promptly replaced. The sprinklers shall correspond to the types and temperature ratings of the sprinklers on the property. The		**IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate facilities will inspect the community during their annual CQR to ensure that the sprinkler system and sprinkler heads are compliant. **V. Plan of Correction completion date.** Plan of Completion date is October 31, 2024. 11/1/24, 1:45 PM TELS Inspect attic, ceilings, sprinkler heads, re barrier walls for penetrations, seal with UL listed caulk if needed. Maintenance **Recurrence:** Every 3 ¿ Months **Next Due:** **Assigned To:** **Category:** This month Change ¿ Nobody Facility Inspection No assets linked to this task **Resources** ¿ **Instructions**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155614	A. BUILDING 01 B. WING	10/16/2024

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	sprinklers shall be kept in a cabinet located where the temperature in which they are subjected will at no time exceed 100 degrees Fahrenheit. A special sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. This deficient practice could affect all residents and staff in the facility. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 10/16/24 between 11:45 AM and 2:30 PM, 5 of 17 spare sprinkler heads were not supported in the spare sprinkler cabinet and were resting on the bottom edge of the spare sprinkler cabinet. Based on interview at the time of observation, the Maintenance Director agreed 5 of the sprinkler heads were not supported. This finding was reviewed with the Maintenance Director at the exit conference. 3.1-19(b)		Inspect attic, ceilings, sprinkler heads, re barrier walls for penetrations, seal with UL listed caulk if needed.	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors 1. Based on observation and interview, the facility failed to ensure 1 of 1 bio med rooms had no impediment to closing and would resist the passage of smoke. This deficient practice could affect at least 2 residents and staff. Findings include: Based on observation during a tour of the facility on 10/16/24 between 11:45 AM and 2:30 PM with the Maintenance Director, the bio med room was observed to be propped open using the wheel of a	K 0363	**K 363** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation - The community failed to ensure that reception area door and the bio med door would latch into the door frame. The	10/31/2024

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	155614	A. BUILDING 01 B. WING	10/16/2024

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	dialysis filter tool box. Based on interview at the time of observation, the Maintenance Director agreed the aforementioned door was propped open. This finding was reviewed with the Executive Director, and Maintenance Director at the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 reception doors to the office hallway and 1 of 1 bio med rooms were able to latch into the frame. This deficient practice could affect at least 10 residents, staff, and visitors. Findings include: Based on observation during a tour of the facility on 10/16/24 between 11:45 AM and 2:30 PM with the Maintenance Director, the reception door to the office hallway was unable to latch into the frame and the bio med room was unable to latch into the frame. Based on interview at the time of observation, the Maintenance Director agreed the doors in the aforementioned locations were unable to latch. This finding was reviewed with the Maintenance Director at the exit conference.		Maintenance Supervisor has repaired the doors so they latch properly into the door frame. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All residents and staff have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** There is a current monthly TELS task to inspect all corridor doors and fire doors to ensure they close and latch properly. See attached TELS task labeled “Lincoln Hills Fire Door Inspection Task.” ” **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate facilities will inspect all fire doors, office door, corridor doors to ensure they shut and latch during their quarterly site visits **V. Plan of Correction**	

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			completion date. Plan of Completion date is October 31st, 2024. 11/1/24, 1:25 PM TELS Check Fire, Resident Room Entrance and Restroom Doors for proper closing and latching. Maintenance **Recurrence:** Every 1 ¿ Months	

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			Next Due: **Assigned To:** **Category:** In December 2024 Change ¿ Nobody Facility Inspection No assets linked to this task	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions on the 3 of 4 third shift fire drills. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on record review on 10/16/24 between 10:00 AM and 11:45 AM with the Maintenance Director, the third shift fire drills were conducted at 11:00 PM, 1:00 AM, 3:00 AM, and 1:00 AM. Based on interview at the time of record review, the Maintenance Director agreed that quarters 2, 3, and 4 were within 2 hours of each other. This finding was reviewed with the Maintenance Director at the exit conference. 3.1-19(b) 3.1-51(c)	K 0712	**K 712** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation - The community failed to ensure that the community-based fire drills were for each quarter were not more that 2 hours apart and at they were at different times of the month. The Maintenance Supervisor was re educated by CarDon Corporate Facilities on the frequency and timing of these fire drills. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents have the potential to be affected by this deficient practice.	10/31/2024

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			III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur. The Maintenance Supervisor was reeducated by CarDon Corporate Facilities on the frequency and timing of these fire drills. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will audit the fire drills time and frequency during their quarterly site visits to ensure the are compliant. **V. Plan of Correction completion date.** Plan of Completion date is October 31st, 2024.	

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K 0753 SS=E Bldg. 01	NFPA 101 Combustible Decorations Based on observation and interview, the facility failed to ensure the corridor door to room H12 was maintained in accordance with 19.7.5.6. 19.7.5.6 states combustible decorations shall be prohibited in any health care occupancy, unless one of the following criteria is met: (1) They are flame-retardant or are treated with approved fire-retardant coating that is listed and labeled for application to the material to which it is applied. (2) The decorations meet the requirements of NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films. (3) The decorations exhibit a heat release rate not exceeding 100 kW when tested in accordance with NFPA 289, Standard Method of Fire Test for Individual Fuel Packages, using the 20 kW ignition source. (4)*The decorations, such as photographs, paintings, and other art, are attached directly to the walls, ceiling, and non-fire-rated doors in accordance with the following: (a) Decorations on non-fire-rated doors do not interfere with the operation or any required latching of the door and do not exceed the area limitations of 19.7.5.6(b), (c), or (d). (b) Decorations do not exceed 20 percent of the	K 0753	**K 753** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation 1– The community failed to ensure that resident room door H12 was decoration and free of combustible materials. The Maintenance Supervisor had a fellow staff member remove the decorations from the door. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents on the H Hall have the potential to be affected by this deficient practice.	10/31/2024

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	wall, ceiling, and door areas inside any room or space of a smoke compartment that is not protected throughout by an approved automatic sprinkler system in accordance with Section 9.7. (c) Decorations do not exceed 30 percent of the wall, ceiling, and door areas inside any room or space of a smoke compartment that is protected throughout by an approved supervised automatic sprinkler system in accordance with Section 9.7. (d) Decorations do not exceed 50 percent of the wall, ceiling, and door areas inside patient sleeping rooms having a capacity not exceeding four persons, in a smoke compartment that is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. (5)*They are decorations, such as photographs and paintings, in such limited quantities that a hazard of fire development or spread is not present. This deficient practice could affect over 5 residents, staff and visitors in the vicinity of room H12 Findings include: Based on observation with the Maintenance Director during a tour of the facility from 11:45 AM to 2:30 PM, the door to room H12 was fully covered with a Halloween themed plastic appearing covering. When asked if the material had been treated with a flame retardant, the Maintenance Director stated he was not sure, but that it was unlikely to have been. At the time of observation, the Maintenance Director had a staff member remove the covering. These finding were reviewed with the Maintenance Director during the exit conference.		**III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** Observation 1- The Maintenance Supervisor was reeducated that nothing is to be attached to and corridor or fire doors within the community. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will audit all resident room doors to ensure they are compliant during their quarterly site visits. **V. Plan of Correction completion date.** Plan of Completion date is October 31st, 2024.	

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	3.1-19(b)		**K 918**	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste 1. Based on record review and interview, the facility failed to maintain 1 of 1 Emergency Power Standby System in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Section 8.4.9, as required by NFPA 99 Health Care Facilities Code, Section 6.4.1.1.6.1. This deficient practice could affect all building occupants. Findings include: Based on observation and interview on 10/16/2024 between 11:45 AM and 2:30 PM with the Maintenance Director, the digital panel on the generator indicated "low coolant temp." Based on interview at the time of observation, the Maintenance Director stated the generator was serviced on 10/11/24 and he believed that if the generator had shown that message at the time of service, the contractor would have addressed the issue. This finding was reviewed with the Maintenance Director at the exit conference. 3.1-19(b)	K 0918	**K 918** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation 1- The community failed to ensure that the Emergency Generator was functioning properly at the time of survey. The “low Coolant Temp” light was illuminated at the digital panel at the nurse station. The Maintenance Supervisor called out to Cummins Crosspoint Generators to make the repair and top off the coolant. Observation 2- The community failed to conduct the 36-month 4 hour generator run test. The Maintenance Supervisor completed this run test on October 29th. See attached	10/31/2024

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	2. Based on record review, observation, and interview; the facility failed to document 36-month period emergency generator testing for 1 of 1 emergency generators in accordance with NFPA 99 and NFPA 110. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.4.1.1.6.1 states Type 1 and Type 2 essential electrical system power sources (EPSS) shall be classified as Type 10, Class X, Level 1 generator sets per NFPA 110. NFPA 110, the Standard for Emergency and Standby Powers Systems, 2010 Edition, Section 8.4.9 states Level 1 EPSS shall be tested at least once within every 36 months. Section 8.4.9.1 states Level 1 EPSS shall be tested continuously for the duration of its assigned class (See Section 4.2). Section 8.4.9.2 states where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 continuous hours. Section 8.4.9.5 states the minimum load for this test shall be specified in 8.4.9.5.1, 8.4.9.5.2, or 8.4.9.5.3. Section 8.4.9.5.3 states for spark-ignited EPS's, loading shall be the available EPSS load. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on record review with the Maintenance Director on 10/16/24 between 10:00 and 11:45 AM, thirty-six-month period emergency generator testing documentation for four continuous hours for the fuel-fired emergency generator was not available for review. Based on interview at the time of record review, the Maintenance Director stated he was did not have the documentation at this time. This finding was reviewed with the Maintenance Director during the exit conference.		picture labeled “Lincoln Hills 4 Hour Run. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** Observation 1-This is a permanent fix to the deficiency as Cummins Crosspoint Generators made repairs to the generator. Observation 2- There is a 36-month 4 hour run test TELS task. See attached TELS task labeled “Lincoln Hills 36 Month run Test” **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate facilities will inspect the generator, sub panel, and outside contractor paperwork during their quarterly site visits. **V. Plan of Correction**	

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	3.1-19(b)		**completion date.** Plan of Completion date is October 31st, 2024. 11/1/24, 2:19 PM TELS **Run generator for 4 hours with building load** Regulatory Maintenance **Recurrence:** Every 36 ¿ Months **Next Due:** **Assigned To:** **Category:** In October 2027 Change ¿ Nobody Emergency Generators No assets linked to this task **Resources** ¿ **Instructions** This is a task that you can perform yourself. Just turn on your generator manually and run for 4 hours with the building load	

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			on it. Make sure to document this and put in your life safety book under generators. If you Have questions on this task call Jason Oskay.	