CENTERS FO	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155614		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/16/2024	
	PROVIDER OR SUPPLIER		326 C	ADDRESS, CITY, STATE, ZIP COD DUNTRY CLUB DRIVE ALBANY, IN 47150	
(X4) ID PREFIX TAG E 0000	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
Bldg	conducted by the Ir accordance with 42 Survey Date: 10/16 Facility Number: 0 Provider Number: AIM Number: 100 At this Emergency Hills of New Alban with Emergency Pr Medicare and Mediand Suppliers, 42 C The facility has 156 census of 115.	5/24 000321 155614 286130 Preparedness survey, Lincoln by was found not in compliance eparedness Requirements for icaid Participating Providers	E 0000	Brenda Buroker, Director Long-Term Care Division Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204 Re: Allegation of Complian Event ID: 2UHH21 Dear Mrs. Buroker: Please find enclosed the Plane Correction for the State Licens Survey conducted on October 2024. This letter is to inform yethat the plan of correction attached is to serve as Lincoln Hills of New Albany credible allegation of compliance. We allege substantial compliance of October 31, 2024. We are requesting paper compliance for this plan of correction. If you have any further question please do not hesitate to contain me at 765-778-7501. Sincerely, Kim Povinelli, HFA	of sure 16, ou on for

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

Kimberly Povinelli

TITLE

(X6) DATE 11/01/2024

Any defiency statement 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 disclodays 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

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155614		X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING X3) DATE SURVEY COMPLETED 10/16/2024			
	PROVIDER OR SUPPLIE N HILLS OF NEW A		326 C	ADDRESS, CITY, STATE, ZIP COD OUNTRY CLUB DRIVE ALBANY, IN 47150	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				Administrator Lincoln Hills Submission of this plan of correction in no way constitute an admission by Lincoln Hills New Albany or its manageme company that the allegations contained in the survey report true and accurate portrayal of provision of nursing care or of services provided in this facilit The Plan of Correction is prep and executed solely because required by Federal and State Law. This statement of deficiencies plan of correction will be revie at the Monthly Quality Assurance/Assessment Committee meeting.	es of nt t is a the ther ty. pared it is
E 0041 SS=F Bldg	Hospital CAH and	8(e), 485.542(e), 485.62 d LTC Emergency Power			
	failed to implemen	view and interview, the facility t the emergency power system and maintenance requirements	E 0041	I. The corrective actions to l	10/31/2024 be

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155614		(X2) MULTIPLE C A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/16/2024		
	ROVIDER OR SUPPLIER I HILLS OF NEW A		STREET ADDRESS, CITY, STATE, ZIP COD 326 COUNTRY CLUB DRIVE NEW ALBANY, IN 47150		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	(X5) COMPLETION DATE	
0	found in the Health 110, and Life Safety	Care Facilities Code, NFPA y Code in accordance with 42 This deficient practice could		accomplished for those residents found to have bee affected by the deficient practice.	
	Findings include: Based on observation between 11:45 AM Maintenance Direct generator indicated interview at the tim Maintenance Direct serviced on 10/11/2 generator had show service, the contract issue.	on and interview on 10/16/2024 and 2:30 PM with the cor, the digital panel on the "low coolant temp." Based on e of observation, the cor stated the generator was 4 and he believed that if the n that message at the time of tor would have addressed the viewed with the Maintenance		Observation - The community failed to ensure that the Emergency Generator was functioning properly at the time survey. The "low Coolant Tellight was illuminated at the digpanel at the nurse station. The Maintenance Supervisor called to Cummins Crosspoint Generators to make the repair 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.	e of mp" gital ne ed out r and e
				IV The facility will monitor the corrective action by	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155614		A. BUILDING COM		(X3) DATE SURVEY COMPLETED 10/16/2024			
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 326 COUNTRY CLUB DRIVE NEW ALBANY, IN 47150				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL . LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			
				implementing the following measures. CarDon Corporate facilities winspect the generator, sub particular and outside contractor paper during their quarterly site visit. V. Plan of Correction	inel, work		
K 0000				completion date. Plan of Completion date is October 31st, 2024.			
Bldg. 01	Licensure Survey w Department of Heal 483.90(a). Survey Date: 10/16 Facility Number: 0 Provider Number: 100 At this Life Safety of New Albany was for Requirements for P Medicare/Medicaid Life Safety from Fi National Fire Protect Life Safety Code (I Health Care Occupa	00321 155614 286130 Code survey, Lincoln Hills of und not in compliance with	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 Complia Event ID: 2UHH21 Dear Mrs. Buroker: Please find enclosed the Plar Correction for the State Licer Survey conducted on Octobe 2024. This letter is to inform that the plan of correction	n of nsure er 16,		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155614		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/16/2024			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 326 COUNTRY CLUB DRIVE NEW ALBANY, IN 47150				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
	The facility has a fi smoke detectors in to the corridors, plu alarms in all residen has a capacity of 15 the time of this surv All areas where res were sprinkled and services were sprin detached wooden st storage shed which	n and was fully sprinklered. re alarm system with hard wired the corridors and spaces open as battery operated smoke at sleeping rooms. The facility 66 and had a census of 115 at vey. idents have customary access all areas providing facility kled. The facility has a torage garage and a wooden were not sprinkled.			attached is to serve as Lincoln Hills of New Albany credible allegation of compliance. We allege substantial compliance October 31, 2024. We are requesting paper compliance this plan of correction. If you have any further questic please do not hesitate to contame at 765-778-7501. Sincerely, Kim Povinelli, HFA Administrator	on or	
					Submission of this plan of correction in no way constitute an admission by Lincoln Hills on New Albany or its management company that the allegations contained in the survey report true and accurate portrayal of provision of nursing care or ot services provided in this facilit. The Plan of Correction is prepand executed solely because required by Federal and State Law.	of nt is a the ner y. ared	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155614		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 10/16/2024	
	ROVIDER OR SUPPLIER		326 CC	ADDRESS, CITY, STATE, ZIP COD DUNTRY CLUB DRIVE ALBANY, IN 47150	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
				This statement of deficiencies plan of correction will be review at the Monthly Quality Assurance/Assessment Committee meeting.	
K 0100 SS=E Bldg. 01	failed to maintain la hall smoke barrier or requires existing lift the public if not requires either maintained or practice could affect and visitors. Findings include: Based on observation 10/16/24 betwee the Maintenance Didoors were equippe was unable to latch interview at the tim Maintenance Direct barrier doors were unable to latch interview at the tim Maintenance Direct barrier doors were unable to latch interview at the tim Maintenance Direct barrier doors were unable to latch interview at the tim Maintenance Direct barrier doors were unable to latch interview at the tim Maintenance Direct barrier doors were unable to latch interview at the tim Maintenance Direct barrier doors were unable to latch interview at the tim Maintenance Direct barrier doors were unable to latch interview at the tim Maintenance Direct barrier doors were unable to latch interview at the tim Maintenance Direct barrier doors were unable to latch interview at the tim Maintenance Direct barrier doors were unable to latch interview at the tim Maintenance Direct barrier doors were unable to latch interview at the tim Maintenance Direct barrier doors were unable to latch interview at the tim Maintenance Direct barrier doors were unable to latch interview at the tim Maintenance Direct barrier doors were unable to latch interview at the tim Maintenance Direct barrier doors were unable to latch interview at the tim Maintenance Direct barrier doors were unable to latch interview at the tim Maintenance Direct barrier doors were unable to latch interview at the tim Maintenance Direct barrier doors were unable to latch interview at the tim Maintenance Direct barrier doors were unable to latch interview at the tim Maintenance Direct barrier doors were unable to latch interview at the tim Maintenance Direct barrier doors were unable to latch interview at the tim Maintenance Direct barrier doors were unable to latch interview at the tim Maintenance Direct barrier doors were unable to latch interview at the tim Maintenance Direct barrier doors we	on and interview, the facility atching hardware on 1 of 1 E doors per 4.6.12.3. LSC 4.6.12.3 is easiety features obvious to uired by the Code, shall be a removed. This deficient is at least 10 residents, staff, on during a tour of the facility in 11:45 AM and 2:30 PM with rector, the E hall smoke barrier did with latching hardware but into the frame. Based on its of observation, the or agreed the E hall smoke inable to latch.	K 0100	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 cloand 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.	nee see
				III. The facility will put into	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION (X3) DATE A. BUILDING 01 COMP					
		155614	B. WING			10/16/2024	
	PROVIDER OR SUPPLIER		<u> </u>	326 CO	ADDRESS, CITY, STATE, ZIP COD OUNTRY CLUB DRIVE LBANY, IN 47150		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
	(EACH DEFICIEN				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) place the following systemat changes to ensure that the deficient practice does not recur. There is a current monthly TEI task to inspect all fire doors to ensure they close and latch properly. See attached TELS labeled "Lincoln Hills Fire Doo Inspection Task." IV The facility will monitor the corrective action by implementing the following measures. CarDon Corporate facilities wi inspect all fire doors to ensure they shut and latch during thei quarterly site visits. V. Plan of Correction completion date. Plan of Completion date is October 31st, 2024.	ic LS task r	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155614		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 10/16/2024			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
K 0324 SS=E	NFPA 101 Cooking Facilities			TELS Check Fire, Resident Room Entrance and Restroom Door proper closing and latching. Maintenance Recurrence: Every 1	's for		
Bldg. 01	Based on observation failed to ensure staff switch for 1 of 1 state activities room. LSG smoke compartment cooking equipment for 30 or fewer personal failed to ensure the staff of the sta	on and interview, the facility If had access to the shutoff ove/oven in the memroy care If 19.3.2.5.4 states within a It, residential or commercial If that is used to prepare meals If the sound is the permitted, If the sound is the permitted, If the sound is the sound is the sound is the permitted, If the sound is t	K 0324	K 324 I. The corrective actions to accomplished for those residents found to have bee affected by the deficient practice. Observation - The Community	n		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SU		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	a. building <u>01</u>		COMPL	ETED
		155614	B. WING		10/16/	2024	
		<u> </u>		CTDEET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			OUNTRY CLUB DRIVE		
LINICOLN	N HILLS OF NEW A	I RANV			LBANY, IN 47150		
LINCOLI	· · · · · · · · · · · · · · · · · · ·	ALDANT		INEVVA	LBANT, IN 47 150		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		nining the cooking equipment			failed to ensure that the memo	ory	
	is not a sleeping ro				care oven shut off switch was		
		nining the cooking equipment			behind a locked door not in the		
		from the corridor by partitions			cooking area. The Maintenan	ce	
		.3.6.2 through 19.3.6.5.			Supervisor had an electrical		
		its of 19.3.2.5.3(1) through (10)			contractor re locate the oven t		
	and (13) are met.				so it is in the cooking area. Se		
		A switch meeting all of the			attached picture labeled "Linco	oln	
	following is provid				Hills Oven Timer"		
		n, or a switch located in a					
	restricted location, is provided within the cooking				II. The facility will identify		
	facility that deactivates the cooktop or range.				other residents that may	_	
	(b) The switch is used to deactivate the cooktop or range whenever the kitchen is not under staff				potentially be affected by the)	
	supervision.	the kitchen is not under staff			deficient practice.		
		n a timer, not exceeding a			All residents and staff have th	10	
		y, that automatically			potential to be affected by this		
	_	ktop or range, independent of			deficient practice.		
	staff action.	ktop of range, independent of			delicient practice.		
		tice could impact at least 10					
	residents and staff.	100 00 010 111 publi de 1000 10			III. The facility will put into		
					place the following systemat	ic	
	Findings include:				changes to ensure that the		
					deficient practice does not		
	Based on observation	on during a tour of the facility			recur.		
		ace Director on 10/16/24					
	between 11:45 AM	and 2:30 PM, there was a			This is a permanent fixt to the		
	cooktop stove/oven	in the memory care activities			deficiency and no more follow		
	_	erview at the time of			is needed.	•	
	observation, the Ma	aintenance Director stated the					
	disconnect for the a	appliance was located in a			IV The facility will monitor		
	different room than	the appliance.			the corrective action by		
					implementing the following		
	_	viewed with the Maintenance			measures.		
	Director at the exit	conference.					
					CarDon Corporate facilities wi		
	3.1-19(b)				inspect the oven timer on their		
					visits to ensure it is shutting of	f	
					the oven properly.		

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ANDILAN	or condition	155614		B. WING 10/16/202			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 326 COUNTRY CLUB DRIVE NEW ALBANY, IN 47150				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG			DATE
					V. Plan of Correction completion date.		
					Plan of Completion date is October 31st, 2024.		
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System						
	failed to ensure the heads were not obst closets in the hallwa accordance with LS edition, Section 8.5. located so as to min discharge as defined 8.5.5.3 or additional ensure adequate cov 8.5.5.2 and 8.5.5.3 or noncontinuous obst 18 inches below the horizontal plane mosprinkler deflector t from fully developing could affect at least Findings include: Based on observation Director on 10/16/2 PM, the therapy closalon had storage le ceiling. Based on in observation, the Ma	on and interview, the facility spray pattern for sprinkler ructed in 1 of 1 therapy ay next to the salon in C 19.3.5.1. NFPA 13, 2010 5.1 states sprinklers shall be imize obstructions to d in Section 8.5.5.2 and Section 1 sprinklers shall be provided to verage of the hazard. Sections do not permit continuous or ructions less than or equal to exprinkler deflector or in a pre than 18 inches below the hat prevent the spray pattern and the fact of the hallway next to the section that the hallway next to the section 18 inches from the terview at the time of intenance Director agreed the mentioned area was less than seciling	K 03	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 to 18 inches from the ceiling. The Maintenance Supervisor has removed those items from the shelf and has re educated the that they cannot store items we 18" of a any ceiling. See attack 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	hat he top staff rithin ched	10/31/2024

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 01 COMPLETI				
		155614	B. Wl	ING	10/16/2024		
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
	I HILLS OF NEW A	IRANV			UNTRY CLUB DRIVE		
					LBANY, IN 47150		.
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	·	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PROVIDER'S PLAN OF CORRECTIO PREFIX (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROF TAG DEFICIENCY)			COMPLETION DATE
mo	REGUERTORT OF	CESC IDENTIFY THIS INFORMATION		ING	potential to be affected by this	,	DATE
This finding was reviewed with the Maintenance		viewed with the Maintenance			deficient practice.		
	Director at the exit				•		
	3.1-19(b)				III. The facility will put into		
					place the following systemat changes to ensure that the	IC	
					deficient practice does not		
					recur.		
					There is a current quarterly T	ELS	
					task to inspect all closets to ensure there is no storage witl	hin	
					18" of the ceiling. See attache		
					TELS task labeled "Lincoln Hil		
					Storage Room Audit Task"		
					IV The facility will monitor		
					the corrective action by		
					implementing the following		
					measures.		
					CarDon Corporate facilities wi	II	
					inspect all closets during their annual CQR to ensure that the	are.	
					is not items being stored within		
					18" of the ceiling.	· -	
					Ţ		
					N 81 60 #		
					V. Plan of Correction completion date.		
					completion date.		
					Plan of Completion date is		
					October 31st, 2024.		
					44/4/04 4.40		
					11/1/24, 1:49 PM		
					1 IVI		

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155614		A. BUILDING <u>01</u> COMPL		COMPLETED 10/16/2024			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 326 COUNTRY CLUB DRIVE NEW ALBANY, IN 47150				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
K 0353	NEDA 404			Inspect all storage closets to ensure nothing is stored within 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 withir of the ceiling. If found please remove and educate the stath using this area that you are no permitted to store items within of the ceiling.	n 18" nat is		
K 0353 SS=E Bldg. 01	1. Based on observation failed to maintain the MDS offices, 1 of 1 kitchen dishroom armechanical rooms, rooms, and 1 of 1 H edition, Section 3.3. a continuous ceiling irregularities, lumps traps hot air and gas cause the sprinkler temperature. Section	tion and interview, the facility e ceiling construction in 1 of 1 areas behind the dryer, 1 of 1 eas, 1 of 1 west wing 1 of 1 west wing water tank R offices. NFPA 13, 2010 5.4 defines a smooth ceiling as free from significant, or indentations. The ceiling es around the sprinkler and o operate at a specified in 8.5.4.1.1 states the distance or 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 communificated to ensure that multiple sprinkler head and escutcheor plates were tight to the ceiling had proper fire caulking aroun	ty n or		

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i ´		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLETED B. WING 10/16/2024		
		155614	B. WING		10/16/2024
NAME OF F	PROVIDER OR SUPPLIER	-		ET ADDRESS, CITY, STATE, ZIP COD	-
				COUNTRY CLUB DRIVE	
LINCOLN	N HILLS OF NEW A	LBANY	NEV	V ALBANY, IN 47150	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROP	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
		eted based on the type of		them. The Maintenance	
		pe of construction. This		Supervisor has gone to multi-	•
	aforementioned are	ould affect at least 5 staff in the		locations and fixed the defic	
	aforementioned are	as.		practice. See a few exampl	•
	Findings include:			pictures labeled "Lincoln Hil block 1 and Fire block 2."	is life
	Tilidings illelade.			Observation 2- The commun	oitv
	Based on observation	on during a tour of the facility	1	failed to ensure that the spa	-
		ce Director on 10/16/24	1	sprinkler heads were secure	
		and 2:30 PM, the following	1	spare head box. The Mainte	
	was observed in the	_	1	Supervisor has purchased a	
		observed to have a 0.5 inch		spare head box and installe	
	penetration around			'	
	b. a 2 inch penetrati	ion was observed behind the		II. The facility will identify	,
	left most dryer arou	and the pipe leading to the		other residents that may	
	dryer			potentially be affected by t	he
	c. 20 penetrations o	f 0.5 inches each around pipes		deficient practice.	
		s in the kitchen dishroom area			
	_	ation around the sprinkler head		All staff and residents have	•
	in the west wing me			potential to be affected by the	nis
	e. a 2 inch penetrati wing mechanical ro	on around the light in the west		deficient practice.	
	f. a 1.5 inch penetra	ation in the ceiling above 1 of 2	1		
	boilers in the west v	wing water tank room	1	III. The facility will put into)
	g. a 2 inch penetrati	ion around the sprinkler riser in		place the following system	atic
	the west wing water			changes to ensure that the	
	•	ation around the sprinkler head	1	deficient practice does not	
	in the HR office			recur.	
	Rased on interview	at the time of record review,		There is a current quarterly	TELS
		rector agreed there was a	1	task to inspect all fire sprink	•
		forementioned locations and	1	heads, escutcheon plates, o	
	provided the measu		1	penetrations to ensure they	_
	F10.1222 Me meusu		1	compliant. There is a currer	
	This finding was re	viewed with the Maintenance	1	quarterly TELS task in place	•
	Director at the exit		1	inspect these types of areas	
			1	attached TELS task labeled	
	3.1-19(b)			"Lincoln Hills Storage Room	Audit
	2 Based on observe	ation and interview, the facility		Task"	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			EY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLETED				
		155614	B. W	ING		10/16/2024	ļ
		1		STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	8			OUNTRY CLUB DRIVE		
LINCOLN	N HILLS OF NEW A	LBANY			LBANY, IN 47150		
(X4) ID	CHMMADV	STATEMENT OF DEFICIENCIE	1	ID	<u> </u>		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COV	(A3) IPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		DATE
ind		ne ceiling construction in		1710	IV The facility will monitor		DATE
		in accordance with NFPA 13,			the corrective action by		
		stallation of Sprinkler Systems.			implementing the following		
		tion, Section 6.2.7.1 states			measures.		
		, or other devices used to			incusures.		
	1 ~	pace around a sprinkler shall			CarDon Corporate facilities w	_{II}	
		be listed for use around a			inspect the community during		
	· ·	cient practice could affect at			annual CQR to ensure that the		
	_	nts, and visitors in this area.			sprinkler system and sprinkler		
		,			heads are compliant.		
	Findings include:						
	8						
	Based on observation	on during a tour of the facility			V. Plan of Correction		
		veen 11:45 AM and 2:30 PM			completion date.		
	with the Maintenan	ce Director, rooms C8 and B12					
	were both missing a	an escutcheon around 1 of 2			Plan of Completion date is		
	sprinkler heads loca				October 31, 2024.		
	aforementioned roo	oms. Based on interview at the			· ·		
	time of observation	, the Maintenance Director					
	agreed there was a	missing escutcheon in the					
	aforementioned loc	ation.			11/1/24, 1:45		
					PM		
	_	viewed with the Maintenance					
	Director at the exit	conference.			TELS		
					Inspect attic, ceilings, sprinkle	r	
	3.1-19(b)				heads, re barrier walls for		
					penetrations, seal with UL list	ed │	
		ation and interview, the facility			caulk if needed.		
		f 1 sprinkler systems was			Maintenance		
	_	are sprinklers, a spare sprinkler			Recurrence: Every		
	_	der wrench on the premises.			3 ¿ Months		
		for the Inspection, Testing,			Next Due:		
		f Water-Based Fire Protection			Assigned To:		
	l ⁻	ion, Section 5.4.1.4 states a			Category:		
		nklers (never fewer than six)			This month <u>Change</u>		
		on the premises so that any			¿ Nobody		
	_	been operated or damaged in			Facility Inspection		
		mptly replaced. The sprinklers			No assets linked to this task		
	_	the types and temperature			Resources		
	ratings of the sprink	clers on the property. The			ز Instructions		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		î ´	(X2) MULTIPLE CONSTRUCTION (X3		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLETED B. WING 10/16/2024		
		155614	_		10/10/2024
NAME OF P	PROVIDER OR SUPPLIER			CADDRESS, CITY, STATE, ZIP COD	
LINCOLN	N HILLS OF NEW A	I BANY		OUNTRY CLUB DRIVE ALBANY, IN 47150	
				1	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION	TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
		cept in a cabinet located where		Inspect attic, ceilings, sprinkle	
	_	which they are subjected will at		heads, re barrier walls for	
		degrees Fahrenheit. A special		penetrations, seal with UL list	ed
	-	all be provided and kept in the		caulk if needed.	
		n the removal and installation			
	all residents and sta	deficient practice could affect			
	an residents and sta	If in the facility.			
	Findings include:				
	Based on observation	ons during a tour of the facility			
		ce Director on 10/16/24			
	between 11:45 AM	and 2:30 PM, 5 of 17 spare			
	-	e not supported in the spare			
	-	d were resting on the bottom			
		orinkler cabinet. Based on			
		e of observation, the tor agreed 5 of the sprinkler			
	heads were not supp	-			
	This finding was reviewed with the Maintenance Director at the exit conference.				
	3.1-19(b)				
K 0363	NFPA 101				
SS=E Bldg. 01	Corridor - Doors				
	1. Based on observa	ation and interview, the facility	K 0363	K 363	10/31/2024
		f 1 bio med rooms had no			
	-	ing and would resist the		I. The corrective actions to	oe e
		This deficient practice could		accomplished for those	
	affect at least 2 resid	dents and staff.		residents found to have bee	n
	Findings include:			affected by the deficient practice.	
	Based on observation	on during a tour of the facility		Observation - The community	
		n 11:45 AM and 2:30 PM with		failed to ensure that reception	
	the Maintenance Di	rector, the bio med room was		door and the bio med door wo	
	observed to be prop	pped open using the wheel of a		latch into the door frame. The	;

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLETED B. WING 10/16/2024			COMPLETED
		155614	B. W	ING		10/16/2024
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD	1
NAME OF P	PROVIDER OR SUPPLIEF	8			UNTRY CLUB DRIVE	
LINCOLN	HILLS OF NEW A	LBANY			LBANY, IN 47150	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
		ox. Based on interview at the			Maintenance Supervisor has	
		, the Maintenance Director			repaired the doors so they late	ch
	_	ntioned door was propped			properly into the door frame.	
	open.					
					II. The facility will identify	
		viewed with the Executive			other residents that may	
	· ·	tenance Director at the exit			potentially be affected by the	9
	conference.				deficient practice.	
	3.1-19(b)				All residents and staff have the	
	3.1-17(0)				potential to be affected by this	
	2. Based on observa	ation and interview, the facility			deficient practice.	7
		f 1 reception doors to the office			denoient praeties.	
		bio med rooms were able to				
	-	. This deficient practice could			III. The facility will put into	
		sidents, staff, and visitors.			place the following systemat	tic
					changes to ensure that the	
	Findings include:				deficient practice does not	
	_				recur.	
		on during a tour of the facility				
		en 11:45 AM and 2:30 PM with			There is a current monthly TE	LS
		rector, the reception door to			task to inspect all corridor doc	ors
	-	vas unable to latch into the			and fire doors to ensure they	
		ned room was unable to latch			and latch properly. See attacl	
		ed on interview at the time of			TELS task labeled "Lincoln Hi	lls
	· ·	nintenance Director agreed the			Fire Door Inspection Task."	
		entioned locations were			"	
	unable to latch.				IV. The feelite will were to	
	This find:	wiewed with the M-inter			IV The facility will monitor	
	_	viewed with the Maintenance			the corrective action by	
	Director at the exit	comerence.			implementing the following	
					measures.	
					CarDon Corporate facilities wi	iii
					inspect all fire doors, office do	I
					corridor doors to ensure they	
					and latch during their quarterly	
					visits	, 5110
					1.51.0	
					V. Plan of Correction	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155614		(X2) MULTIPLE CO A. BUILDING B. WING	01	(X3) DATE SURVEY COMPLETED 10/16/2024	
	PROVIDER OR SUPPLIE N HILLS OF NEW <i>F</i>		326 CC	ADDRESS, CITY, STATE, ZIP COD DUNTRY CLUB DRIVE ALBANY, IN 47150	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
				completion date. Plan of Completion date is October 31st, 2024.	
				11/1/24, 1:25 PM	
				TELS Check Fire, Resident Room Entrance and Restroom Door proper closing and latching. Maintenance Recurrence: Every	's for

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Event ID:

2UHH21 Facility ID: 000321

If continuation sheet

خ Months

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 01 COMPLETED				
		155614	B. WING 10/16/2024				
	PROVIDER OR SUPPLIEI			326 CO	ADDRESS, CITY, STATE, ZIP COD DUNTRY CLUB DRIVE LBANY, IN 47150		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					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						
	failed to conduct questimes under varying shift fire drills. This all residents, staff a Findings include: Based on record residents	view and interview, the facility harterly fire drills at unexpected g conditions on the 3 of 4 third is deficient practice could affect and visitors in the facility. view on 10/16/24 between 10:00 with the Maintenance Director,	K 0	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		10/31/2024
	the third shift fire d PM, 1:00 AM, 3:00 interview at the tim Maintenance Direc and 4 were within 2 This finding was re Director at the exit	lrills were conducted at 11:00 AM, and 1:00 AM. Based on the of record review, the tor agreed that quarters 2, 3, 2 hours of each other.			community-based fire drills we 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 of frequency and timing of these drills.	e y n the	
	3.1-19(b) 3.1-51(c)				II. The facility will identify other residents that may potentially be affected by the deficient practice. All staff and residents have th potential to be affected by this deficient practice.	e	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155614	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 10/16/2024
NAME OF P	ROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP COD OUNTRY CLUB DRIVE	
LINCOLN	I HILLS OF NEW A	LBANY		ALBANY, IN 47150	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE DATE
				III. The facility will put into place the following systema changes to ensure that the deficient practice does not recur.	tic
				The Maintenance Supervisor reeducated by CarDon Corpo Facilities on the frequency an timing of these fire drills.	rate
				IV The facility will monitor the corrective action by implementing the following measures.	
				CarDon Corporate Facilities valudit the fire drills time and frequency during their quarter 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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Event ID:

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11/12/2024 PRINTED: FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01 COMPLETED 155614 B. WING 10/16/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 326 COUNTRY CLUB DRIVE LINCOLN HILLS OF NEW ALBANY NEW ALBANY, IN 47150 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE K 0753 **NFPA 101** SS=E Combustible Decorations Bldg. 01 Based on observation and interview, the facility K 0753 K 753 10/31/2024 failed to ensure the corridor door to room H12 was maintained in accordance with 19.7.5.6. 19.7.5.6 I. The corrective actions to be states combustible decorations shall be prohibited accomplished for those in any health care occupancy, unless one of the residents found to have been following criteria is met: affected by the deficient (1) They are flame-retardant or are treated with practice. approved fire-retardant coating that is listed and labeled for application to the material to which it is Observation 1- The community applied. failed to ensure that resident room (2) The decorations meet the requirements of door H12 was decoration and free NFPA 701, Standard Methods of Fire Tests for of combustible materials. The Flame Propagation of Textiles and Films. Maintenance Supervisor had a (3) The decorations exhibit a heat release rate not fellow staff member remove the exceeding 100 kW when tested in accordance with decorations from the door. NFPA 289, Standard Method of Fire Test for Individual Fuel Packages, using the 20 kW ignition source. II. The facility will identify (4)*The decorations, such as photographs, other residents that may paintings, and other art, are attached directly to potentially be affected by the the walls, ceiling, and non-fire-rated doors in deficient practice. accordance with the following: (a) Decorations on non-fire-rated doors do not All staff and residents on the H interfere with the operation or any required Hall have the potential to be latching of the door and do not exceed the area affected by this deficient practice.

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limitations of 19.7.5.6(b), (c), or (d).

(b) Decorations do not exceed 20 percent of the

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2UHH21

Facility ID: 000321

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SU			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u> COMPLETED			
		155614	B. W	ING	<u> </u>	10/16/2024	
		ı		STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIE	R			OUNTRY CLUB DRIVE		
	N HILLS OF NEW A	J RANV					
LINCOLN	NITILLS OF NEW A	ALDAIN I		INEVV A	LBANY, IN 47150		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	1
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
	-	oor areas inside any room or					
	-	ompartment that is not			III. The facility will put into		
	-	ut by an approved automatic			place the following systema	tic	
		accordance with Section 9.7.			changes to ensure that the		
		not exceed 30 percent of the			deficient practice does not		
	_	oor areas inside any room or			recur.		
	*	ompartment that is protected					
		pproved supervised automatic			Observation 1- The Maintena	nce	
		accordance with Section 9.7.			Supervisor was reeducated th		
		not exceed 50 percent of the			nothing is to be attached to ar		
		oor areas inside patient			corridor or fire doors within the	e	
		ring a capacity not exceeding			community.		
		moke compartment that is					
		ut by an approved, supervised			IV The facility will monitor		
	_	system in accordance with			the corrective action by		
	Section 9.7.				implementing the following		
		ations, such as photographs			measures.		
		ich limited quantities that a					
		lopment or spread is not			CarDon Corporate Facilities w		
	present.				audit all resident room doors t		
	-	tice could affect over 5			ensure they are compliant dur	ing	
		visitors in the vicinity of room			their quarterly site visits.		
	H12						
					V. Plan of Correction		
	Findings include:				completion date.		
		tal at the second					
		on with the Maintenance			Plan of Completion date is		
	_	our of the facility from 11:45			October 31st, 2024.		
		e door to room H12 was fully					
		loween themed plastic					
		. When asked if the material					
		ith a flame retardant, the					
		tor stated he was not sure, but					
		to have been. At the time of					
	· ·	aintenance Director had a staff					
	member remove the	e covering.					
	יין ניין.						
	These finding were						
	iviaintenance Direct	tor during the exit conference.					
l l			1		1		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155614		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	X3) DATE SURVEY COMPLETED 10/16/2024	
	PROVIDER OR SUPPLIER		326 CC	ADDRESS, CITY, STATE, ZIP COD DUNTRY CLUB DRIVE ALBANY, IN 47150	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)	(X5) COMPLETION DATE
K 0918 SS=F Bldg. 01	1. Based on record facility failed to ma Standby System in Standard for Emerg Systems, Section 8. Health Care Faciliti This deficient pract occupants. Findings include: Based on observation between 11:45 AM Maintenance Direct generator indicated interview at the tim Maintenance Direct serviced on 10/11/2 generator had show service, the contract issue.	review and interview, the intain 1 of 1 Emergency Power accordance with NFPA 110, ency and Standby Power 4.9, as required by NFPA 99 es Code, Section 6.4.1.1.6.1. ice could affect all building on and interview on 10/16/2024 and 2:30 PM with the or, the digital panel on the "low coolant temp." Based on e of observation, the or stated the generator was 4 and he believed that if the n that message at the time of tor would have addressed the viewed with the Maintenance conference.	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 survey. The "low Coolant Tem light was illuminated at the digit panel at the nurse station. The Maintenance Supervisor called to Cummins Crosspoint Generators to make the repair top off the coolant. Observation 2- The community failed to conduct the 36-month hour generator run test. The Maintenance Supervisor completed this run test on October 29th. See attached	of p" tal e out and

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 01 COMPLETED				
		155614	B. W	ING		10/16/	2024
NAME OF F				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	ę.		326 CC	OUNTRY CLUB DRIVE		
LINCOLN	HILLS OF NEW A	LBANY		NEW A	LBANY, IN 47150		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					picture labeled "Lincoln Hills 4		
		review, observation, and			Hour Run.		
		ty failed to document 36-month					
		generator testing for 1 of 1			II. The facility will identify		
		ors in accordance with NFPA			other residents that may		
		NFPA 99, Health Care Facilities , Section 6.4.1.1.6.1 states Type			potentially be affected by the	•	
		tial electrical system power			deficient practice.		
		ll be classified as Type 10,			All staff and residents have th	ے ا	
		enerator sets per NFPA 110.			potential to be affected by this		
	_	ndard for Emergency and			deficient practice.		
		stems, 2010 Edition, Section			denoisin praesies:		
	1 .	EPSS shall be tested at least					
	once within every 3	36 months. Section 8.4.9.1			III. The facility will put into		
	states Level 1 EPSS	S shall be tested continuously			place the following systemat	ic	
	for the duration of i	ts assigned class (See Section			changes to ensure that the		
	4.2). Section 8.4.9.	2 states where the assigned			deficient practice does not		
	class is greater than	4 hours, it shall be permitted			recur.		
		t after 4 continuous hours.					
		es the minimum load for this			Observation 1-This is a perma	nent	
		ed in 8.4.9.5.1, 8.4.9.5.2, or			fix to the deficiency as Cummi	ns	
		3.4.9.5.3 states for spark-ignited			Crosspoint Generators made		
		be the available EPSS load.			repairs to the generator.		
	_	ice could affect all residents,			Observation 2- There is a	_	
	staff, and visitors.				36-month 4 hour run test TELS		
	F' 1' ' 1 1				task. See attached TELS task		
	Findings include:				labeled "Lincoln Hills 36 Month Test"	ı run	
	Based on record rev	view with the Maintenance			1.550		
		24 between 10:00 and 11:45 AM,			IV The facility will monitor		
		riod emergency generator			the corrective action by		
		ion for four continuous hours			implementing the following		
	_	nergency generator was not			measures.		
	available for review	v. Based on interview at the					
	time of record revie	ew, the Maintenance Director			CarDon Corporate facilities wi	II	
	stated he was did no	ot have the documentation at			inspect the generator, sub par	nel,	
	this time.				and outside contractor paperw	ork	
					during their quarterly site visits	S.	
		viewed with the Maintenance					
	Director during the	exit conference.			V. Plan of Correction		

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155614	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction (x)	c3) date survey COMPLETED 10/16/2024
	PROVIDER OR SUPPLIE		326 CC	ADDRESS, CITY, STATE, ZIP COD DUNTRY CLUB DRIVE ALBANY, IN 47150	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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	
				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 rur	

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OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED <u>01</u> 155614 B. WING 10/16/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 326 COUNTRY CLUB DRIVE LINCOLN HILLS OF NEW ALBANY NEW ALBANY, IN 47150 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE 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.

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