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	08/29/2022

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: 08/29/22 Facility Number: 000321 Provider Number: 155614 AIM Number: 100286130 At this Emergency Preparedness survey, Lincoln Hills of New Albany was found 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 122. Quality Review completed on 09/06/22	E 0000	September 12th, 2022 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: MES321 Dear Mrs. Buroker: Please find enclosed the Plan of Correction for the State Licensure Survey conducted on August 29, 2022. 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 September 26, 2022. We are requesting paper compliance for this plan of correction. If you have any further questions, please do not hesitate to contact me at 317-512-4655. Sincerely, Kim Povinelli, HFA	

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

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.	
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).	K 0000	September 12th, 2022 Brenda Buroker, Director	

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	Survey Date: 08/29/22 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 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 122 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 09/06/22		Long-Term Care Division Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204 Re: Allegation of Compliance Event ID: MES321 Dear Mrs. Buroker: Please find enclosed the Plan of Correction for the State Licensure Survey conducted on August 29, 2022. 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 September 26, 2022. We are requesting paper compliance for this plan of correction. If you have any further questions, please do not hesitate to contact me at 317-512-4655. Sincerely, Kim Povinelli, HFA Administrator Lincoln Hills	

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			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.	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer			

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	patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on record review and interview, the facility failed to ensure 1 of 1 kitchen range hood extinguishing system was maintained in proper working order. This deficient practice was not in a resident area but could affect kitchen staff. Findings include: Based on record review on 08/29/22 between 9:15 a.m. and 12:00 p.m. with the Director of Facilities present, range hood suppression reports dated 07/06/22 and 01/17/22 from the facility's vendor all stated "No Electrical shut off upon system trip. All Electrical underneath Hood must Shut off upon system Trip." When asked, the Director of Facilities said he was aware of the situation and the facility was working to get it corrected. This finding was reviewed with the Administrator, Corporate Director, and Director of Facilities during the exit conference. 3.1-19(b)	K 0324	**K324** **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 1 of 1 kitchen range hood extinguishing system was maintained in proper working order. The deficient practice was not in a resident area but could affect kitchen staff. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All 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**	09/26/2022

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			deficient practice does not recur. Star Electric is scheduled September 26, 22 to connect Kitchen Hood switch to shunt Panel. **IV The facility will monitor the corrective action by implementing the following measures.** The Maintenance Director will monitor recommendations by SafeCare and schedule needed repairs. Corporate facilities staff will review recommendations and needed repairs when onsite. **V. Plan of Correction completion date.** Plan of Completion date is September 26th, 2022.	
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance,			

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	inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on observation and interview, the facility failed to ensure sprinkler heads in 1 of 10 smoke compartments were not loaded and covered with foreign material in accordance with LSC 9.7.5. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect laundry and kitchen, plus residents in the adjacent dining room. Findings include: Based on observations on 08/29/22 between 12:00 p.m. and 2:00 p.m. during a tour of the facility with the Director of Facilities and Maintenance Assistant, the following was noted: a. There were two sprinkler heads in the dryer inclosure covered with lint and dirt. b. there were three sprinkler heads in the kitchen	K 0353	**K353** **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 sprinkler heads in 1 of 10 smoke compartments were not loaded and covered with foreign material. The community failed to ensure the ceiling in 1 of 10 sprinklered smoke compartments was maintained to allow sprinkler heads to function to their full capability. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All residents have the potential to be affected by this deficient practice.	09/12/2022

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	partially covered with dirt and dust. Based on interview at the time of each observation, the Director of Facilities and Maintenance Assistant confirmed the sprinkler heads in the dryer inclosure and kitchen were loaded with dirt, dust, and lint. This finding was reviewed by the Administrator, Corporate Director, and Director of Facilities during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure the ceiling in 1 of 10 sprinklered smoke compartments was maintained to allow sprinkler heads to function to their full capability. This deficient practice could affect mostly kitchen staff, plus residents in the adjacent Dining Room. Findings include: Based on observations on 08/29/22 between 12:00 p.m. and 2:00 p.m. during a tour of the facility with the Director of Facilities and Maintenance Assistant, there were two missing small ceiling tiles and a third damaged ceiling tile in the kitchen Mop/Storage Closet which created an opening between the drop ceiling and the interstitial space above the drop ceiling. Based on interview at the time of observation, the Director of Facilities and Maintenance Assistant acknowledged the missing and damaged ceiling tiles in the kitchen Mop/Storage Closet and said they would be replaced as soon as possible. This finding was reviewed with the Administrator, Corporate Director and Director of Facilities during the exit conference.		**III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** Sprinkler heads in the effected smoke compartment have been cleaned and all others have been audited to ensure they are free of dust and lint. Missing and damaged ceiling tiles were replaced in the kitchen mop/storage closet. The maintenance staff have been re-educated to inspect ceiling tiles and sprinkler heads to ensure compliance. **IV The facility will monitor the corrective action by implementing the following measures.** The Maintenance Director will physically inspect ceiling tiles and sprinkler heads according to the TELS schedule and Corporate Facilities Staff will validate inspections when onsite. **V. Plan of Correction completion date.** Plan of Completion date is September 12th, 2022.	

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	3.1-19(b)			
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.			

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	19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation and interview, the facility failed to ensure 1 of 7 resident room corridor doors on the D Hall would close completely and latch into its door frame. This deficient practice could affect up to 10 residents, staff and visitors. Findings include: Based on observations on 08/29/22 between 12:00 p.m. and 2:00 p.m. during a tour of the facility with the Director of Facilities and Maintenance Assistant, the corridor door to resident room D8 would not close completely and latch into the door frame because the door was not level. There was a two inch gap between the entire length of the door and the door frame when closed fully. Based on interview at the time of observation, the Director of Facilities and Maintenance Assistant agreed the corridor door to room D8 failed to close complete and latch into its door frame when tested. This finding was reviewed with the Administrator, Corporate Director, and Director of Facilities during the exit conference. 3.1-19(b)	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 1 of 7 resident room corridor doors on the D Hall would close completely and latch into its door frame. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** Residents on D hallway 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.** The Maintenance Director has repaired the door and it now closes completely and latches	09/12/2022

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			correctly into its door frame. Maintenance staff have been re-educated on door inspections to ensure compliance. **IV The facility will monitor the corrective action by implementing the following measures.** The Maintenance Director will physically inspect corridor doors according to the TELS schedule and Corporate Facilities Staff will validate inspections when onsite. **V. Plan of Correction completion date.** Plan of Completion date is September 12th, 2022.	
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility	K 0372	**K 372**	09/12/2022

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	failed to ensure 2 of 9 smoke barrier walls were protected to maintain the smoke resistance of the smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. This deficient practice could affect up to 20 residents, as well as staff and visitors. Findings include: Based on observations on 08/29/22 between 12:00 p.m. and 2:00 p.m. during a tour of the facility with the Director of Facilities and Maintenance Assistant, the following was noted: a. The smoke barrier wall above the smoke barrier doors between the E hall and center corridor had a one and a half inch conduit that was open with wires running through it that was not proper fire stopped. b. The smoke barrier wall above the smoke barrier doors near the Assistant DON office had a one half inch gap around a conduit that ran through the smoke barrier wall that was not properly fire stopped. Based on interview at the time of each observation, the Director of Facilities and Maintenance Assistant said the openings through the smoke barrier walls would be filled with a proper fire stop material as soon as possible. This finding was reviewed with the Administrator, Corporate Director, and Director of Facilities during the exit conference. 3.1-19(b)		**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 2 of 9 smoke barrier walls were protected to maintain the smoke resistance of the smoke barrier. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All 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.** The maintenance director used the proper fire stop material to fill the openings above the smoke barrier doors between E Hall and center corridor and the opening near the ADON's office. Maintenance staff have been re-educated on smoke barrier walls and proper fire stop material to ensure compliance.	

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			IV The facility will monitor the corrective action by implementing the following measures. The Maintenance Director will physically inspect the facility according to the TELS schedule to ensure compliance and Corporate Facilities Staff will validate inspections when onsite. **V. Plan of Correction completion date.** Plan of Completion date is September 12th, 2022.	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 2 of over 20 wet locations, were provided with ground fault circuit interrupter (GFCI) protection against electric shock. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily accessible location.	K 0511	**K 511** **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 2 of over 20 wet locations were provided with	09/12/2022

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	Informational Note: See 215.9 for ground-fault circuit interrupter protection for personnel on feeders. (B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in 210.8(B)(1) through (8) shall have ground-fault circuit-interrupter protection for personnel. (1) Bathrooms (2) Kitchens (3) Rooftops (4) Outdoors Exception No. 1 to (3) and (4): Receptacles that are not readily accessible and are supplied by a branch circuit dedicated to electric snow-melting, deicing, or pipeline and vessel heating equipment shall be permitted to be installed in accordance with 426.28 or 427.22, as applicable. Exception No. 2 to (4): In industrial establishments only, where the conditions of maintenance and supervision ensure that only qualified personnel are involved, an assured equipment grounding conductor program as specified in 590.6(B)(2) shall be permitted for only those receptacle outlets used to supply equipment that would create a greater hazard if power is interrupted or having a design that is not compatible with GFCI protection. (5) Sinks - where receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink. Exception No. 1 to (5): In industrial laboratories, receptacles used to supply equipment where removal of power would introduce a greater hazard shall be permitted to be installed without GFCI protection. Exception No. 2 to (5): For receptacles located in patient bed locations of general care or critical care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection shall not be required.		ground fault circuit interrupter protection against electric shock. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** Residents in these areas 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.** The Maintenance Director has replaced both receptacles with proper GFCI. Maintenance staff have been re-educated regarding GFCI protection to ensure compliance. **IV The facility will monitor the corrective action by implementing the following measures.** The Maintenance Director will physically inspect wet areas to ensure GFCI protection is present where needed. Corporate Facilities Staff will inspection when onsite. **V. Plan of Correction**	

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	08/29/2022

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	(6) Indoor wet locations (7) Locker rooms with associated showering facilities (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect mostly staff. Findings include: Based on observations on 08/29/22 between 12:00 p.m. and 2:00 p.m. during a tour of the facility with the Director of Facilities and Maintenance Assistant, the following was noted: a. The electric receptacle to the left of the large two compartment sink in the kitchen was not provided with GFCI protection. When tested with a GFCI testing device, it did not break the electrical circuit. b. The electric receptacle in the West Unit Mechanical Room was within three feet of the mop sink and was not provided with GFCI protection. When tested with a GFCI testing device, it did not break the electrical circuit. Based on interview at the time of each observation, the Director of Facilities and Maintenance Assistant agreed the previously mentioned receptacles were not GFCI protected. This finding was reviewed with the Administrator, Corporate Director, and Director of Facilities during the exit conference. 3.1-19(b)		**completion date.** Plan of Completion date is September 12th, 2022.	

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