CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CO		ONSTRUCTION	(X3) DATE SURVEY COMPLETED 08/29/2022				
	PROVIDER OR SUPPLIER			326 CC	ADDRESS, CITY, STATE, ZIP COD DUNTRY CLUB DRIVE ALBANY, IN 47150		
(X4) ID PREFIX TAG E 0000	(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	
Bldg	conducted by the In accordance with 42 Survey Date: 08/29 Facility Number: 0 Provider Number: 100 At this Emergency Hills of New Alban with Emergency Production and Suppliers, 42 C The facility has 156 census of 122.	0/22 00321 155614 286130 Preparedness survey, Lincoln y was found in compliance eparedness Requirements for caid Participating Providers	E 00	000	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 Complian Event ID: MES321 Dear Mrs. Buroker: Please find enclosed the Plan Correction for the State Licens Survey conducted on August 2022. This letter is to inform y that the plan of correction attached is to serve as Lincoln Hills of New Albany credible allegation of compliance. We allege substantial compliance September 26, 2022. We are requesting paper compliance this plan of correction. If you have any further question please do not hesitate to cont me at 317-512-4655. Sincerely, Kim Povinelli, HFA	n of sure 29, you n	

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

TITLE

(X6) DATE

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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	T OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER 155614	A. BUILDING B. WING	UNSTRUCTION	COMPLETED 08/29/2022
	ROVIDER OR SUPPLIER I HILLS OF NEW A		326 C	ADDRESS, CITY, STATE, ZIP COD OUNTRY 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 APPROPR DEFICIENCY)	(X5) COMPLETION DATE
				Administrator Lincoln Hills Submission of this plan of correction in no way constituted an admission by Lincoln Hills New Albany or its management company that the allegations contained in the survey report true and accurate portrayal of provision of nursing care or deservices provided in this facily The Plan of Correction is present executed solely because required by Federal and Statt Law. This statement of deficiencies plan of correction will be revisat the Monthly Quality Assurance/Assessment Committee meeting.	of ent It is a fithe other ity. pared e it is e
K 0000					
Bldg. 01	Licensure Survey w	Recertification and State as conducted by the Indiana th in accordance with 42 CFR	K 0000	September 12th, 2022 Brenda Buroker, Director	

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 $MES321 \qquad {\tt Facility \, ID:} \quad 000321$

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155614	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 08/29/2022
	PROVIDER OR SUPPLIER		326 CC	ADDRESS, CITY, STATE, ZIP COD DUNTRY CLUB DRIVE ALBANY, IN 47150	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF Survey Date: 08/29		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) Long-Term Care Division Indiana State Department of Health	(X5) COMPLETION DATE
	Facility Number: 0 Provider Number: AIM Number: 100	155614		2 North Meridian Street Indianapolis, IN 46204 Re: Allegation of Complia	ance
	New Albany was for Requirements for P	-		Event ID: MES321	
	Life Safety from Fi National Fire Protect Life Safety Code (I Health Care Occupate This one story facil II (111) constructio The facility has a fi smoke detectors in to the corridors, plu alarms in all resider has a capacity of 15 the time of this surv All areas where resi were sprinkled and services were sprinkled and services were sprinkled and storage shed which	idents have customary access all areas providing facility kled. The facility has a corage garage and a wooden		Dear Mrs. Buroker: Please find enclosed the Plant Correction for the State Licer Survey conducted on August 2022. This letter is to inform that the plan of correction attached is to serve as Lincol Hills of New Albany credible allegation of compliance. We allege substantial compliance September 26, 2022. We are requesting paper compliance this plan of correction. If you have any further questing please do not hesitate to comme at 317-512-4655. Sincerely, Kim Povinelli, HFA Administrator Lincoln Hills	nsure : 29, you In e e on e e for
	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 Occupation of the Safety Code (I Health Care Occ	Code survey, Lincoln Hills of bund not in compliance with articipation in , 42 CFR Subpart 483.90(a), re and the 2012 edition of the ction Association (NFPA) 101, LSC), Chapter 19, Existing ancies and 410 IAC 16.2. ity was determined to be Type in and was fully sprinklered. The alarm system with hard wired the corridors and spaces open is battery operated smoke in sleeping rooms. The facility is and had a census of 122 at a determined to the corridors and spaces open in the sleeping rooms. The facility is and had a census of 122 at a determined to the corridors and spaces open in the sleeping rooms. The facility is and had a census of 122 at a determined to the corridors and spaces open in the sleeping rooms. The facility is and the sleeping rooms are specified at a census of 122 at a determined to the specified and had a census of 122 at a determined to the specified and had a census of 122 at a determined to the specified and had a census of 122 at a determined to the specified and had a census of 122 at a determined to the specified and had a census of 122 at a determined to the specified and had a census of 122 at a determined to the specified and had a census of 122 at a determined to the specified and had a census of 122 at a determined to the specified and had a census of 122 at a determined to the specified and had a census of 122 at a determined to the specified and had a census of 122 at a determined to the specified and had a census of 122 at a determined to the specified and had a census of 122 at a determined to the specified and had a census of 122 at a determined to the specified and had a census of 122 at a determined to the specified and had a census of 122 at a determined to the specified and had a census of 122 at a determined to the specified and had a census of 122 at a determined to the specified and the specifie		Event ID: MES321 Dear Mrs. Buroker: Please find enclosed the Plat Correction for the State Licer Survey conducted on August 2022. This letter is to inform that the plan of correction attached is to serve as Lincol Hills of New Albany credible allegation of compliance. We allege substantial compliance September 26, 2022. We are requesting paper compliance this plan of correction. If you have any further questing please do not hesitate to comme at 317-512-4655. Sincerely, Kim Povinelli, HFA Administrator	n of nsure: 29, you In e on e for

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MES321 Facility ID: 000321

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR MEDICARE & MEDICAID SERVICES						IB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155614	(X2) MULTIPLE A. BUILDING B. WING	construction 01	(X3) DATE SURVEY COMPLETED 08/29/2022	
	PROVIDER OR SUPPLIER	1	STREE 326 C	FADDRESS, CITY, STATE, ZIP COD OUNTRY CLUB DRIVE	00/29	72022
LINCOL	N HILLS OF NEW A	LBANY	NEW	ALBANY, IN 47150		
(X4) ID PREFIX TAG	(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 APPROPRI, DEFICIENCY)	ATE	(X5) COMPLETION DATE
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipme accordance with N Ventilation Contro Commercial Cook * residential cooki appliances such a	nt is protected in NFPA 96, Standard for Il and Fire Protection of Ing Operations, unless: Ing equipment (i.e., small Is microwaves, hot plates,		Submission of this plan of correction in no way constitut an admission by Lincoln Hills New Albany or its manageme company that the allegations contained in the survey reportrue and accurate portrayal of provision of nursing care or of services provided in this facility. The Plan of Correction is prepand executed solely because required by Federal and State Law. This statement of deficiencies plan of correction will be revised at the Monthly Quality Assurance/Assessment Committee meeting.	of ent t is a f the ther tty. pared it is	
SS=E	Cooking Facilities Cooking Facilities Cooking equipme accordance with N Ventilation Contro Commercial Cook * residential cooki appliances such a toasters) are used	nt is protected in NFPA 96, Standard for Il and Fire Protection of ing Operations, unless: ng equipment (i.e., small		Law. This statement of deficiencies plan of correction will be revie at the Monthly Quality Assurance/Assessment	s and	

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* cooking facilities open to the corridor in smoke compartments with 30 or fewer

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STATEM	ENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLA	N OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u>01</u>	COMPL	ETED
		155614	B. W	ING		08/29/	2022
	F PROVIDER OR SUPPLIEF LN HILLS OF NEW A			STREET ADDRESS, CITY, STATE, ZIP COD 326 COUNTRY CLUB DRIVE NEW ALBANY, IN 47150 ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	,	R LSC IDENTIFYING INFORMATION		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	DATE
	patients comply w 18.3.2.5.3, 19.3.2 * cooking facilities with 30 or fewer p conditions under Cooking facilities NFPA 96 per 9.2. enclosed as haza be open to the co 18.3.2.5.1 through through 19.3.2.5.8 Based on record refailed to ensure 1 of extinguishing syste working order. This resident area but consume the second of t	with the conditions under 1.5.3, or 1.5.3, or 2.5.3, or 2.5.3 in smoke compartments 1.5.3, or 3.5.3 in smoke compartments 1.5.3 in smoke compartments 1.5.4 in 18.3.2.5.4, 19.3.2.5.4 in 19.3.2.5.4 in 19.3.2.5.1 in 18.3.2.5.4, 19.3.2.5.1 in 18.3.2.5.4, 19.3.2.5.1 in 18.3.2.5.4 in 19.3.2.5.1 in 19.3.2.5.1 in 19.3.2.5.1 in 19.3.2.5	K 0	324	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 systemas maintained in proper work order. The deficient practice wont 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 potentiable affected by this deficient practice. III. The facility will put into place the following systemat changes to ensure that the	em king ras d	09/26/2022

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155614	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 08/29/2022
	PROVIDER OR SUPPLIEF		326 (ET ADDRESS, CITY, STATE, ZIP COD COUNTRY CLUB DRIVE Y ALBANY, IN 47150	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) COMPLETION DATE
				deficient practice does not recur.	
				Star Electric is scheduled September 26, 22 to connec Kitchen Hood switch to shun Panel.	
				IV The facility will monito the corrective action by implementing the following measures.	
				The Maintenance Director we monitor recommendations by SafeCare and schedule need repairs. Corporate facilities seem will review recommendations needed repairs when onsite.	y ded staff s and
				V. Plan of Correction completion date. Plan of Completion date is	
				September 26th, 2022.	
K 0353 SS=E Bldg. 01	Sprinkler System Automatic sprinkle are inspected, tes accordance with N Inspection, Testin Water-based Fire	- Maintenance and Testing - Maintenance and Testing er and standpipe systems ted, and maintained in NFPA 25, Standard for the g, and Maintaining of Protection Systems. In design, maintenance,			

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155614	B. W	ING		08/29/	/2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	8			OUNTRY CLUB DRIVE		
LINCOL	N HILLS OF NEW A	LBANY		NEW ALBANY, IN 47150			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
	1	sting are maintained in a					
		nd 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						
			$ _{K0}$	252	K353		09/12/2022
			K U	333	K333		09/12/2022
	· ·	its were not loaded and			I. The corrective actions to b	10	
	_	n material in accordance with			accomplished for those		
		25, 2011 edition, at 5.2.1.1.1			residents found to have beer	1	
		show signs of leakage; shall			affected by the deficient	•	
	_	, foreign materials, paint, and			practice.		
		nd shall be installed in the			Practice		
		(e.g., up-right, pendent, or			Observation – The community		
	sidewall). Furthern	nore, at 5.2.1.1.2 any sprinkler			failed to ensure sprinkler head		
	that shows signs of	any of the following shall be			1 of 10 smoke compartments		
	replaced: (1) Leaka	age (2) Corrosion (3) Physical			not loaded and covered with		
		f fluid in the glass bulb heat			foreign material. The commun	ity	
		(5) Loading (6) Painting			failed to ensure the ceiling in 1	of	
		ne sprinkler manufacturer.			10 sprinklered smoke		
	-	ice could affect laundry and			compartments was maintained		
	kitchen, plus reside	nts in the adjacent dining			allow sprinkler heads to function	on to	
	room.				their full capability.		
	Findings include:				II. The facility will identify		
	Rosed on observation	ons on 08/29/22 between 12:00			other residents that may		
		during a tour of the facility with			potentially be affected by the)	
	_	lities and Maintenance			deficient practice.		
	Assistant, the follow				All residents have the potential	al to	
		sprinkler heads in the dryer			be affected by this deficient	או נט	
	inclosure covered w				practice.		
		sprinkler heads in the kitchen			practice.		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155614			A. BU	(X2) MULTIPLE CONSTRUCTION (X3) DATE SO A. BUILDING 01 COMPLE B. WING 08/29/2			ETED
	PROVIDER OR SUPPLIER			326 CO	ADDRESS, CITY, STATE, ZIP COD DUNTRY CLUB DRIVE LBANY, IN 47150		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	BROWINERIC DLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE).TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	AIE.	DATE
	partially covered w	ith dirt and dust.					
	Based on interview	at the time of each			III. The facility will put into		
	observation, the Dir	rector of Facilities and			place the following systema	tic	
	Maintenance Assistant confirmed the sprinkler				changes to ensure that the		
	heads in the dryer in	nclosure and kitchen were			deficient practice does not		
	loaded with dirt, du	st, and lint.			recur.		
	This finding was reviewed by the Administrator, Corporate Director, and Director of Facilities				Sprinkler heads in the effecte	d	
					smoke compartment have be		
	during the exit conf	Perence.			cleaned and all others have b		
					audited to ensure they are fre	e of	
	3.1-19(b)				dust and lint. Missing and		
					damaged ceiling tiles were		
		ration and interview, the			replaced in the kitchen		
	1	sure the ceiling in 1 of 10			mop/storage closet. The		
	_	compartments was maintained		maintenance staff have been			
	_	eads to function to their full			re-educated to inspect ceiling		
		ficient practice could affect			and sprinkler heads to ensure	;	
	1	f, plus residents in the adjacent			compliance.		
	Dining Room.						
	F' 1' ' 1 1				IV The facility will monitor		
	Findings include:				the corrective action by		
	Dagad on absorpation	ons on 08/29/22 between 12:00			implementing the following		
		during a tour of the facility with			measures.		
		lities and Maintenance			The Maintenance Director wil	1	
		re two missing small ceiling			physically inspect ceiling tiles	='	
		naged ceiling tile in the kitchen			sprinkler heads according to t		
		t which created an opening			TELS schedule and Corporate		
		eiling and the interstitial space			Facilities Staff will validate	-	
	_	ing. Based on interview at the			inspections when onsite.		
	_	, the Director of Facilities and					
		ant acknowledged the					
		ed ceiling tiles in the kitchen					
		t and said they would be			V. Plan of Correction		
	replaced as soon as	-			completion date.		
		viewed with the Administrator,			Plan of Completion date is		
	Corporate Director during the exit conf	and Director of Facilities			September 12th, 2022.		

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155614	A. Bl	UILDING	onstruction 01	COMPL	LETED
	PROVIDER OR SUPPLIER	DER OR SUPPLIER LS OF NEW ALBANY SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL 19(b) PA 101 rridor - Doors r					
21002.				1	25/11/1, 11/1/100		
(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 APPROPR	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
	3.1-19(b)						
K 0363	NFPA 101						
SS=E	Corridor - Doors						
Bldg. 01	Corridor - Doors						
g. • .	-	corridor openings in other					
	-						
		_					
	•						
		_					
		-					
	-						
	Clearance betwee	en bottom of door and floor					
	covering is not ex	ceeding 1 inch. Powered					
	-						
	if provided with a	device capable of keeping					
	the door closed w	hen a force of 5 lbf is					
	applied. There is	no impediment to the					
	closing of the doo	rs. Hold open devices that					
	release when the	door is pushed or pulled are					
	permitted. Nonrate	ed protective plates of					
	unlimited height a	re permitted. Dutch doors					
	meeting 19.3.6.3.6	6 are permitted. Door					
	frames shall be la	beled 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. Ir	n sprinklered compartments					
	there are no restri	ctions in area or fire					
	resistance of glass	s or frames in window					
	assemblies.						

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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 COMPL					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155614	A. BU B. W		<u>U1</u>	08/29/	
		100014	B. W			00/29/	<u> </u>
NAME OF I	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
LINCOLN	N HILLS OF NEW A	LBANY			LBANY, IN 47150		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
	483, and 485 Show in REMARK fire protection ratin devices, etc. Based on observation failed to ensure 1 or doors on the D Hall latch into its door frould affect up to 1 Findings include: Based on observation p.m. and 2:00 p.m. the Director of Facil Assistant, the corried would not close correduced door frame because was a two inch gap the door and the does based on interview Director of Facilities agreed the corridor complete and latch tested. This finding was re	Parts 403, 418, 460, 482, (S details of doors such as angs, automatics closing on and interview, the facility of 7 resident room corridor awould close completely and rame. This deficient practice of residents, staff and visitors. Ons on 08/29/22 between 12:00 during a tour of the facility with lities and Maintenance for door to resident room D8 anpletely and latch into the the door was not level. There between the entire length of for frame when closed fully, at the time of observation, the se and Maintenance Assistant door to room D8 failed to close into its door frame when	K 0	363	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 restroom corridor doors on the D li would close completely and la 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 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 the second control of the second closes completely and latches the second control of the second closes completely and latches the second control of the second closes completely and latches control of the second control of the	y dident Hall dtch	09/12/2022

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155614	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 08/29/2022
	N OF CORRECTION IDENTIFICATION NUMBER		STREET 326 CO NEW A		
(X4) ID PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
				correctly into its door frame. Maintenance staff have been re-educated on door inspection ensure compliance. IV The facility will monitor	ns to
				the corrective action by implementing the following measures.	
				The Maintenance Director will physically inspect corridor doo according to the TELS schedu and Corporate Facilities Staff validate inspections when onsi	le vill
				V. Plan of Correction completion date. Plan of Completion date is	
K 0372 SS=E Bldg. 01	Barrie Subdivision of Bui Barrier Construction 2012 EXISTING Smoke barriers shall be postriers shall be postriers shall be postrium wall. Smokin duct penetration systems where are is installed for smoke barriers and to the smoke barriers and the smoke barriers and the smoke barriers. 19.3.7.3, 8.6.7.1(1) Describe any medical system in REMAR	nall be constructed to a stance rating per 8.5. Smoke ermitted to terminate at an e dampers are not required as in fully ducted HVAC approved sprinkler system oke compartments adjacent er.	K 0372	September 12th, 2022.	09/12/2022

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DEPARTMENT OF HEALTH AND HUMAN SERVICES 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 01 155614 B. WING 08/29/2022 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 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE failed to ensure 2 of 9 smoke barrier walls were protected to maintain the smoke resistance of the I. The corrective actions to be smoke barrier. LSC Section 19.3.7.5 requires accomplished for those smoke barriers to be constructed in accordance residents found to have been with LSC Section 8.5 and shall have a minimum ½ affected by the deficient hour fire resistive rating. This deficient practice practice. could affect up to 20 residents, as well as staff and visitors. Observation - The Community failed to ensure that 2 of 9 smoke Findings include: barrier walls were protected to maintain the smoke resistance of Based on observations on 08/29/22 between 12:00 the smoke barrier. p.m. and 2:00 p.m. during a tour of the facility with the Director of Facilities and Maintenance II. The facility will identify Assistant, the following was noted: other residents that may a. The smoke barrier wall above the smoke barrier potentially be affected by the doors between the E hall and center corridor had a deficient practice. one and a half inch conduit that was open with wires running through it that was not proper fire All residents have the potential to be affected by this deficient b. The smoke barrier wall above the smoke barrier practice. 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 III. The facility will put into place the following systematic Based on interview at the time of each changes to ensure that the observation, the Director of Facilities and deficient practice does not Maintenance Assistant said the openings recur. through the smoke barrier walls would be filled with a proper fire stop material as soon as The maintenance director used the possible. proper fire stop material to fill the openings above the smoke barrier This finding was reviewed with the Administrator, doors between E Hall and center Corporate Director, and Director of Facilities corridor and the opening near the during the exit conference. ADON's office. Maintenance staff have been re-educated on smoke 3.1-19(b) barrier walls and proper fire stop

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Event ID:

MES321

Facility ID: 000321

material to ensure compliance.

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DEPARTMENT	OF HEALTH AND HU	MAN SERVICES				FOI	RM APP	ROVED
CENTERS FOR	MEDICARE & MEDIC	AID SERVICES				OM	B NO. 09	38-039
STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CON	NSTRUCTION	(X3) DATE	SURVEY	7
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	G	01	COMPLETED		
		155614	B. WING			08/29/	2022	
	NAME OF PROVIDER OR SUPPLIER LINCOLN HILLS OF NEW ALBANY (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION STREET ADDRESS, CITY, STATE, ZIP COD 326 COUNTRY CLUB DRIVE NEW ALBANY, IN 47150 ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) IV The facility will monitor							
(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		ΔTE	COMP	LETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG					ATE
					IV The facility will monitor			
					the corrective action by			
					implementing the following			
					measures.			
					The Maintenance Director wil	I		
					physically inspect the facility			
					according to the TELS sched	ule to		
					ensure compliance and Corp	orate		
					Facilities Staff will validate			
					inspections when onsite			

K 051 SS=E	1
SS=E	Ξ
Blda	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

K 511

I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.

V. Plan of Correction completion date.

Plan of Completion date is September 12th, 2022.

Observation - The Community failed to ensure that 2 of over 20 wet locations were provided with

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accessible location.

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K 0511

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 155614 B. WING 08/29/2022 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 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Informational Note: See 215.9 for ground-fault ground fault circuit interrupter circuit interrupter protection for personnel on protection against electric shock. feeders. (B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles II. The facility will identify installed in the locations specified in 210.8(B)(1) other residents that may through (8) shall have ground-fault potentially be affected by the circuit-interrupter protection for personnel. deficient practice. (1) Bathrooms (2) Kitchens Residents in these areas have the (3) Rooftops potential to be affected by this (4) Outdoors deficient practice. 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, III. The facility will put into deicing, or pipeline and vessel heating equipment place the following systematic shall be permitted to be installed in accordance changes to ensure that the with 426.28 or 427.22, as applicable. deficient practice does not Exception No. 2 to (4): In industrial establishments recur. only, where the conditions of maintenance and supervision ensure that only qualified personnel The Maintenance Director has are involved, an assured equipment grounding replaced both receptacles with conductor program as specified in 590.6(B)(2) proper GFCI. Maintenance staff shall be permitted for only those receptacle have been re-educated regarding outlets used to supply equipment that would GFCI protection to ensure create a greater hazard if power is interrupted or compliance. having a design that is not compatible with GFCI protection. IV The facility will monitor (5) Sinks - where receptacles are installed within the corrective action by 1.8 m (6 ft.) of the outside edge of the sink. implementing the following Exception No. 1 to (5): In industrial laboratories, measures. receptacles used to supply equipment where removal of power would introduce a greater The Maintenance Director will hazard shall be permitted to be installed without physically inspect wet areas to GFCI protection. ensure GFCI protection is present Exception No. 2 to (5): For receptacles located in where needed. Corporate Facilities patient bed locations of general care or critical Staff will inspection when onsite. care areas of health care facilities other than those covered under

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210.8(B)(1), GFCI protection shall not be required.

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V. Plan of Correction

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		01	COMPLETED	
		155614	B. W	B. WING		08/29/2022	
				CTREET	ADDRESS OF A STATE ZID COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
LINICOLA		LDANIV					
LINCOLI	N HILLS OF NEW A	LDANT		INEVV A	LBANY, IN 47150		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE
	(6) Indoor wet locat	tions			completion date.		
	(7) Locker rooms w	vith associated showering					
	facilities				Plan of Completion date is		
	(8) Garages, service	e bays, and similar areas where			September 12th, 2022.		
	electrical						
	diagnostic equipme	ent, electrical hand tools.					
		Wet Locations, requires all					
	•	ed equipment within the area of					
		have ground-fault circuit					
		protection. Note: Moisture can					
		resistance of the body, and					
		is more subject to failure.					
	This deficient pract	ice could affect mostly staff.					
	Findings include:						
		ons on 08/29/22 between 12:00					
	1	during a tour of the facility with					
		ilities and Maintenance					
	Assistant, the follow	_					
		eptacle to the left of the large					
	_	ink in the kitchen was not					
	_	I protection. When tested with					
	_	ice, it did not break the					
	electrical circuit.						
		eptacle in the West Unit					
		was within three feet of the					
	_	not provided with GFCI					
	1 ^	ested with a GFCI testing					
	· · · · · · · · · · · · · · · · · · ·	reak the electrical circuit.					
	Based on interview						
	1	rector of Facilities and					
		tant agreed the previously					
	inentioned receptac	les were not GFCI protected.					
	This finding was	viewed with the Administrator,					
	_						
	during the exit conf	and Director of Facilities					
	during the exit conf	erence.					
	2 1 10(1)						
	3.1-19(b)						

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		COMPLETED		
		155614	B. WING		08/29/2022		
NAME OF PROVIDER OR SUPPLIER LINCOLN HILLS OF NEW ALBANY			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		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE

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