CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039	
STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED	
		155614	B. WING		09/27/2023	
	ROVIDER OR SUPPLIER HILLS OF NEW A SUMMARY S		326 CC	ADDRESS, CITY, STATE, ZIP COD DUNTRY CLUB DRIVE ALBANY, IN 47150	(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
E 0000						
Bldg	conducted by the In accordance with 42 Survey Date: 09/27 Facility Number: 0 Provider Number: 1002 At this Emergency I Hills of New Alban with Emergency Pro Medicare and Medicand Suppliers, 42 C	00321 155614 286130 Preparedness survey, Lincoln y was found in compliance eparedness Requirements for caid Participating Providers FR 483.73 Certified beds, with a current	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: VM4721 Dear Mrs. Buroker: Please find enclosed the Plan Correction for the Life Safety of Recertification and Emergenc Preparedness Survey conduct on September 27, 2023. This letter is to inform you that the of correction attached is to set as Lincoln Hills of 3New Albar credible allegation of complian We allege substantial complia on October 27, 2023. We are requesting paper compliance this plan of correction. If you have any further questic please do not hesitate to conta me at 317-512-4655. Sincerely,	of Code y ted plan rve ny nce. nce for	

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

(X6) DATE

TITLE

Kimberly Povinelli Administrator 10/20/2023

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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: VM4721 Facility ID: 000321 If continuation sheet Page 1 of 27

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/24/2023 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155614	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 09/27/2023		
	PROVIDER OR SUPPLIED		STREET ADDRESS, CITY, STATE, ZIP COD 326 COUNTRY CLUB DRIVE 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 APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE		
				Kim Povinelli, HFA Administrator Lincoln Hills			
				Submission of this plan of correction in no way constitute an admission by Lincoln Hills of New Albany or its management company that the allegations contained in the survey report true and accurate portrayal of the provision of nursing care or othe services provided in this facility. The Plan of Correction is prepared executed solely because it required by Federal and State Law. This statement of deficiencies plan of correction will be review at the Monthly Quality Assurance/Assessment Committee meeting.	of t tissa the ner t. ared t is		
K 0000							
Bldg. 01	Licensure Survey v	e Recertification and State was conducted by the Indiana lth in accordance with 42 CFR	K 0000	October 16th, 2023 Brenda Buroker, Director Long-Term Care Division Indiana State Department of			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VM4721

Facility ID: 000321

If continuation sheet

Page 2 of 27

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) E			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLETED			ETED	
		155614	B. WING 09/27/2023			/2023	
				CTREET	ADDRESS CITY OTATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
LINIOOLA	LLIILLO OF NEW A	LDANN	326 COUNTRY CLUB DRIVE				
LINCOLN	I 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	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					Health		
Facility Number: 000321				2 North Meridian Street			
Provider Number: 155614				Indianapolis, IN 46204			
	AIM Number: 100	286130			•		
					Re: Allegation of Compliar	nce	
	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),				Event ID: VM4721		
					Dear Mrs. Buroker:		
	Life Safety from Fire and the 2012 edition of the						
	National Fire Protection Association (NFPA) 101,				Please find enclosed the Plan	of	
	Life Safety Code (LSC), Chapter 19, Existing				Correction for the Life Safety (
	Health Care Occupancies and 410 IAC 16.2.				Recertification and Emergency		
	•				Preparedness Survey conduct		
	This one story facility was determined to be Type				on September 27, 2023. This		
	_	n and was fully sprinklered.			letter is to inform you that the	olan	
		re alarm system with hard wired			of correction attached is to ser		
	_	the corridors and spaces open			as Lincoln Hills of 3New Alban		
		s battery operated smoke			credible allegation of complian	•	
	_	nt sleeping rooms. The facility			We allege substantial complia		
		66 and had a census of 118 at			on October 27, 2023. We are		
	the time of this surv		requesting paper compliance for				
		,			this plan of correction.		
	All areas where resi	idents have customary access			and plan of correction.		
		all areas providing facility			If you have any further questic	ns	
	•	kled. The facility has a			please do not hesitate to conta		
	-	orage garage and a wooden			me at 317-512-4655.	401	
		were not sprinkled.			1110 41 017 012 1000.		
	storage show which				Sincerely,		
	Quality Review con	npleted on 10/05/23			- C		
	Quarry 110 / 10 / 10 /						
					Kim Povinelli, HFA		
					Administrator		
					Lincoln Hills		
					Linouit i iiio		
			1				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VM4721 Facility ID: 000321

If continuation sheet Page 3 of 27

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/24/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155614		(X2) MULTIPLE C A. BUILDING B. WING	construction 01	(X3) DATE SURVEY COMPLETED 09/27/2023	
	PROVIDER OR SUPPLIE		326 C	ADDRESS, CITY, STATE, ZIP COD OUNTRY CLUB DRIVE ALBANY, IN 47150	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
K 0222 SS=E Bldg. 01	be equipped with requires the use egress side unless special locking at CLINICAL NEED LOCKING	ed means of egress shall not a latch or a lock that of a tool or key from the ss using one of the following rrangements: S OR SECURITY THREAT cking arrangements for the leeds of the patient are		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 conservices provided in this facily The Plan of Correction is present executed solely because required by Federal and State Law. This statement of deficiencies plan of correction will be revited the Monthly Quality Assurance/Assessment Committee meeting.	s of ent rt is a f the other ity. pared e it is e
	used, only one lo permitted on eac be made for the r by: remote contro locks or keys car	cking device shall be h door and provisions shall rapid removal of occupants of locks; keying of all ried by staff at all times; or le means available to the			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VM4721 Facility ID: 000321

If continuation sheet

Page 4 of 27

PRINTED: 10/24/2023 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPLETED	
		155614	B. WII	NG		09/27	/2023
		<u> </u>	_	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEI	R			UNTRY CLUB DRIVE		
LINCOLN	HILLS OF NEW A	LBANY			LBANY, IN 47150		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF COR		TION (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
	staff at all times.						
	18.2.2.2.5.1, 18.2	.2.2.6, 19.2.2.2.5.1,					
	19.2.2.2.6						
	SPECIAL NEEDS	LOCKING					
	ARRANGEMENT	S					
	Where special loc	king arrangements for the					
	safety needs of th	ne patient are used, all of					
	the Clinical or Sec	curity Locking requirements					
	are being met. In	addition, the locks must be					
	electrical locks that fail safely so as to release upon loss of power to the device; the						
	building is protected by a supervised						
	automatic sprinkle	er system and the locked					
	space is protected	d by a complete smoke					
	detection system	(or is constantly monitored					
	at an attended loo	cation within the locked					
	space); and both	the sprinkler and detection					
	systems are arrar	nged to unlock the doors					
	upon activation.						
	18.2.2.2.5.2, 19.2	.2.2.5.2, TIA 12-4					
	DELAYED-EGRE						
	ARRANGEMENT	S					
	Approved, listed of	delayed-egress locking					
	* *	in accordance with					
		permitted on door					
		ng low and ordinary hazard					
		ngs protected throughout by					
		ervised automatic fire					
		or an approved, supervised					
	automatic sprinkle						
	18.2.2.2.4, 19.2.2	-					
		ROLLED EGRESS					
	LOCKING ARRAI						
		d Egress Door assemblies					
		dance with 7.2.1.6.2 shall					
	be permitted.						
	18.2.2.2.4, 19.2.2	2.4					
		BY EXIT ACCESS					

FORM CMS-2567(02-99) Previous Versions Obsolete

LOCKING ARRANGEMENTS

Elevator lobby exit access door locking in

Event ID:

VM4721

Facility ID: 000321

If continuation sheet

Page 5 of 27

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 09/27/2023		
	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 LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE	
	accordance with 7 on door assemblie throughout by an a automatic fire dete approved, supervisystem. 18.2.2.2.4, 19.2.2.1. Based on observ facility failed to ensthrough 1 of 2 lockereadily accessible for This deficient pract residents, as well as Findings include: Based on observation p.m. and 4:00 p.m. the Maintenance Sugate outside the D-I combination lock longate. The Maintenance pen the lock, hower from the courtyard supervisor did remote time of observation time of observation said the courtyard g. This finding was reand Maintenance Suconference. 3.1-19(b) 2. Based on observ facility failed to ensthrough 1 of 10 locked through	2.2.1.6.3 shall be permitted as in buildings protected approved, supervised action system and an sed automatic sprinkler 2.4 ation and interview, the sure the means of egress and exit courtyard gate was or residents, staff, and visitors. sice could affect at least 10	K 0222	K 222 Egress Doors I. The corrective actions to I accomplished for those residents found to have bee affected by the deficient practice. A. The facility failed to ensure means of egress through 1 of locked exit courtyard gate wa readily accessible for residen staff, and visitors. The Courty exit gate outside the D-Hall e was equipped with a combinal lock located on the outside of gate. B. The facility failed to ensure means of egress through 1 of locked exit doors was readily accessible for residents, staff visitors. D-Hall exit door was magnetically locked and could only be opened by entering a on a keypad located adjacent the exit door. The code to ope the exit door was not posted. II. The facility will identify other residents that may potentially be affected by the deficient practice.	the f 2 lists, vard with ation of the f 10 f, and d in code t to en	
deficient practice could affect at least 10 residents,						

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/24/2023 FORM APPROVED OMB NO. 0938-039

	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 09/27/2023		
	PROVIDER OR SUPPLIEI N 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 ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	N (X5) BE COMPLETION DATE		
	as well as staff and Findings include:			These deficient practices or affect at least 10 residents, well as staff and visitors.	ould		
	p.m. and 4:00 p.m. the Maintenance Su was magnetically lo opened by entering adjacent to the exit exit door was not p the time of observa Supervisor confirm	ons on 09/27/23 between 12:30 during a tour of the facility with apervisor, the D-Hall exit door ocked and could only be a code on a keypad located door. The code to open the osted. Based on interview at tion, the Maintenance ed the code was not posted. Eviewed with the Administrator upervisor during the exit		III. The facility will put into place the following system changes to ensure that the deficient practice does not recur. A The lock on the gate has removed. B The egress on D-Hall his been labeled with a code to ensure exit doors are readily assessable. See Attachments A-1 and IV The facility will monitor the corrective action by implementing the following measures. The Maintenance Director of the physically inspect egress doensure door codes are post that gates are free of locks according to the TELS scheland Corporate Facilities Stavalidate inspections when completion date. Plan of Correction completion date is O 16, 2023	natic e t as been as b y A-B or g will bors to ded and edule aff will borsite.		
K 0223 SS=E Bldg. 01	NFPA 101 Doors with Self-C Doors with Self-C Doors in an exit p	•					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155614		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/27/2023			
		ROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 326 COUNTRY CLUB DRIVE NEW ALBANY, IN 47150				
PRI) ID EFIX AG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	NTE.	(X5) COMPLETION DATE
		or hazardous area and kept in the cloopen by a release 7.2.1.8.2 that auto doors throughout entire facility upor * Required manua * Local smoke det smoke passing the required smoke dot * Automatic sprink * Loss of power. 18.2.2.2.7, 18.2.2 Based on observation failed to ensure 1 or had no impediment practice could affect as staff and visitors. Findings include: Based on observation p.m. and 4:00 p.m. the Maintenance Subarrier doors to the closing by a large of This was acknowled Supervisor who did the time of observation. This finding was resulted.	al fire alarm system; and sectors designed to detect rough the opening or a etection system; and sider system, if installed; and sider sider and interview, the facility of 10 sets of smoke barrier doors to closing. This deficient stat least 20 residents, as well sider sider at least 20 residents, as well sider side	K 02	223	K 223 Doors with Self-Closin Devices I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice. Based on observation and interview, the facility failed to ensure 1 of 10 sets of smoke barrier doors had no impedim to closing. The set of smoke barrier doors to the B-Hall we impeded from closing by a lar cone shaped wet floor sign II. The facility will identify other residents that may potentially be affected by the deficient practice. This deficient practice could a at least 20 residents, as well a staff and visitors. III. The facility will put into	ent re ge	10/16/2023

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VM4721 Facility ID: 000321

If continuation sheet Page 8 of 27

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/24/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155614		(X2) MULTIPLE (A. BUILDING B. WING	CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 09/27/2023	
	PROVIDER OR SUPPLIER		326 C	CADDRESS, 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				place the following systematic changes to ensure that the deficient practice does not recur. Housekeeping staff were educing regarding not impeding doors closing and the cone was removed. See Attachment B	cated
				IV The facility will monitor the corrective action by implementing the following measures.	
				The Maintenance Director will physically inspect smoke barridoors and ensure they are cle from obstruction according to TELS schedule and Corporate Facilities Staff will validate inspections when onsite.	ier ear the
				V. Plan of Correction completion date.	
				Plan of correction date is Octo 16, 2023	bber
K 0271 SS=E Bldg. 01	7.7, provides a level the provisions of 7 changes in elevations				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VM4721 Facility ID: 000321

If continuation sheet

Page 9 of 27

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY	´	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING <u>01</u> COMPLETED B. WING 09/27/2023			
		155614	В. W.			09/21/2023	
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
LINCOLN	N HILLS OF NEW A	ALBANY			LBANY, IN 47150		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID		PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	· ·	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	3
	travel surface.	e a hard packed all-weather					
	18.2.7, 19.2.7 Based on observati	on and interview, the facility	$ _{K0}$	271	K 271 Discharge from Exits	10/27/2	2023
	failed to maintain the walking surface for 1 of 10		KU	2/1	I. The corrective actions to b		2023
		s. This deficient practice could			accomplished for those		
	_	sidents, as well as staff and			residents found to have bee	n	
	visitors.				affected by the deficient		
	Findings include:				practice.		
					The facility failed to maintain	the	
	Based on observati	ons on 09/27/23 between 12:30			walking surface for 1 of 10 ex		
	p.m. and 4:00 p.m.	during a tour of the facility with			discharge areas. The outside	exit	
	the Maintenance Supervisor, the outside exit				sidewalk from the G-Hall had	а	
		G-Hall had a section of the			section of the sidewalk that w		
		raised 5 to 6 inches due to a tree			raised 5 to 6 inches due to a t		
		e sidewalk. This was about 25			root pushing up the sidewalk.		
		Il exit door. The level change in			II. The facility will identify		
		alk to the public way could be a ile exiting from this area in the			other residents that may potentially be affected by the	_	
		ency. Based on interview at the			deficient practice.	"	
	_	n, the Maintenance Supervisor			denotern practice.		
		level change along the			This deficient practice could a	affect	
	sidewalk to the pub				at least 20 residents, as well a		
					staff and visitors.		
		eviewed with the Administrator			III. The facility will put into		
	_	supervisor during the exit			place the following systema	tic	
	conference.				changes to ensure that the		
	2.1.10/1-)				deficient practice does not		
	3.1-19(b)				recur.		
					The tree has been removed.		
					Stump and sidewalk repair is		
					scheduled for Friday 10/27.		
					IV The facility will monitor		
					the corrective action by		
					implementing the following		
				measures.			

CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039
	IT OF DEFICIENCIES OF CORRECTION			(X3) DATE SURVEY COMPLETED 09/27/2023	
	PROVIDER OR SUPPLIER		326 CC	ADDRESS, CITY, STATE, ZIP COD DUNTRY CLUB DRIVE ILBANY, 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
				The Maintenance Director will physically inspect exit dischargareas to ensure smooth walking surfaces according to the TEL schedule and Corporate Facili Staff will validate inspections wonsite.	ge ng .S ities
K 0281 SS=E Bldg. 01	discharge, is arrar and shall be eithe or capable of auto manual intervention	ans of Egress ans of egress, including exit aged in accordance with 7.8 continuously in operation matic operation without		V. Plan of Correction completion date. Plan of correction date is Octo 27, 2023	ober
	failed to ensure the of egress was prope leave the area in data illumination shall be failure of any single in an illumination lead in any designated at could affect at least and visitors. Findings include:	on and interview, the facility lighting for 2 of 10 exit means rly maintained and would not rkness. LSC 7.8.1.4 requires a arranged so that that the lighting unit does not result evel of less than 0.2 foot-candle rea. This deficient practice 30 residents as well as staff	K 0281	K 281 Illumination of Means Egress I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice. Based on observation and interview, the facility failed to ensure the lighting for 2 of 10 means of egress was properly maintained and would not leave the area in darkness.	exit

FORM CMS-2567(02-99) Previous Versions Obsolete

p.m. and 4:00 p.m. during a tour of the facility with

Event ID:

VM4721

Facility ID: 000321

If continuation sheet

A. There were outside lights on

Page 11 of 27

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUF			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	A. BUILDING <u>01</u> COMPLETE			ETED
		155614	B. W	B. WING 09/27/2023			2023
				CTREET	ADDRESS SITY STATE ZID SOD		
NAME OF F	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD		
LINIOOLA	LLULLO OF NEW A	LDANIX	326 COUNTRY CLUB DRIVE				
LINCOLN	NHILLS 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	CY 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
	the Maintenance Su	pervisor, the following was			the walls of the G-Hall and H-	Hall,	
	noted:				however, with the length and	size	
	a. The sidewalk fro	om the G-Hall exit past the			of the fence the sidewalk wou		
	H-Hall exit and bey	ond to the public way was			not have enough light provide	d in	
	between 150 and 20	00 feet in length. There was a			the event of an evacuation fro	m the	
	seven foot tall fence	e that was connected to the			G-Hall during the dark hours of	of the	
	outside wall of the	G-Hall and the outside wall of			night.		
	the H-Hall with the	sidewalk on the outside of the			B. The D-Hall exit discharge h	nad a	
	fence. There were	outside lights on the walls of			double light fixture, however,	one	
	the G-Hall and H-H	Iall, however, with the length			of the light bulbs was missing.		
	and size of the fenc	e the sidewalk would not have			II. The facility will identify		
	enough light provided in the event of an				other residents that may		
	evacuation from the G-Hall during the dark hours				potentially be affected by the	9	
	of the night.				deficient practice.		
	b. The D-Hall exit	discharge had a double light					
	fixture, however, or	ne of the light bulbs was		These deficient practices could			
	missing.				affect at least 30 residents as well		
	Based on interview	at the time of each		as staff and visitors.			
		as acknowledged by the			III. The facility will put into		
	_	visor who agreed the			place the following systemat	tic	
	_	k between the G-Hall and	changes to ensure that the				
		e light provided, furthermore,			deficient practice does not		
	_	ne missing bulb outside the			recur.		
	D-Hall exit door.				A Lighting will be installed a	t the	
					fence area on Friday 10/27.		
		viewed with the Administrator			B The missing bulb was		
		upervisor during the exit			replaced.		
	conference.				See Attachment C.		
	3.1-19(b)						
					IV The facility will monitor		
					the corrective action by		
					implementing the following		
					measures.		
					The Maintenance Director will		
					physically inspect outside mea		
					of egress to ensure appropria		
					lighting according to the TELS	3	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VM4721 Facility ID: 000321

If continuation sheet Page 12 of 27

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/24/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155614		A. BUILD B. WING	DING	01	COMPLI 09/27/	ETED	
	PROVIDER OR SUPPLIER		3:	26 COL	DDRESS, CITY, STATE, ZIP COD UNTRY CLUB DRIVE		
LINCOLN	N HILLS OF NEW AI	LBANY	N	IEW AL	_BANY, IN 47150		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		D EFIX 'AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE
					schedule and Corporate Facilit Staff will validate inspections w onsite.		
					V. Plan of Correction completion date.		
					Plan of correction date is Octob 27, 2023	ber	
K 0324 SS=E Bldg. 01	Ventilation Control Commercial Cookin * residential cookin appliances such as toasters) are used cooking in accordant 19.3.2.5.2 * cooking facilities smoke compartment patients comply wind 18.3.2.5.3, 19.3.2. * cooking facilities with 30 or fewer part conditions under 10 Cooking facilities properties of the UL 300 his patients comply wind 18.3.2.5.1 through 19.3.2.5.5 Based on observation failed to ensure staff use of the UL 300 his possible such as the cooking facilities of the UL 300 his patients are such as the cooking facilities of the UL 300 his patients are such as the cooking facilities of the UL 300 his patients are such as the cooking facilities of the UL 300 his patients are such as the cooking facilities are such as the cooking facilities of the UL 300 his patients are such as the cooking facilities	nt is protected in NFPA 96, Standard for I and Fire Protection of ing Operations, unless: ng equipment (i.e., small s microwaves, hot plates, I for food warming or limited ance with 18.3.2.5.2, open to the corridor in ents with 30 or fewer ith the conditions under 5.3, or in smoke compartments atients comply with 18.3.2.5.4, 19.3.2.5.4. protected according to 3 are not required to be rdous areas, but shall not rridor. in 18.3.2.5.4, 19.3.2.5.1	K 0324	4	K 324 Cooking Facilities I. The corrective actions to be accomplished for those residents found to have been		10/16/2023

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VM4721

Facility ID: 000321

If continuation sheet

Page 13 of 27

PRINTED: 10/24/2023 FORM APPROVED

ENTERSFOR	R MEDICARE & MEDIC					OM	B NO. 0938-039
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	<u> </u>	09/27/	/2023
				_	_		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
					DUNTRY CLUB DRIVE		
LINCOL	N HILLS OF NEW A	LBANY		NEW ALBANY, 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		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
IAG		otection of Commercial	+	IAG	offected by the deficient		DATE
					affected by the deficient		
		s, Section 10.5.7 states			practice.		
		provided to employees			<u> </u>		
		er use of portable fire			Based on observation and		
	_	ne manual activation of			interview, the facility failed to		
		equipment. Section 11.1.4 states			ensure staff were instructed in		
		nually operating the fire			proper use of the UL 300 hood	d fire	
	extinguishing system	•			suppression system in 1 of 1		
	conspicuously in th	e kitchen and shall be			kitchen. Kitchen staff #1 (cook	κ),	
	reviewed with empl	loyees by management. This			did not say she would pull the		
	deficient practice co	ould affect kitchen staff plus			range hood fire suppression		
any residents while in the adjacent main dining				system pull station before			
	room.				grabbing the fire extinguisher,		
					however, when asked, she did		
	Findings include:				know where it was located		
					II. The facility will identify		
	Based on observation	ons on 09/27/23 between 12:30			other residents that may		
		during a tour of the facility with			potentially be affected by the		
		pervisor, the kitchen was			deficient practice.	•	
		300 hood system. Based on			deficient practice.		
	_	nen staff #1 (cook), when asked			This deficient practice could a	ffoot	
		if there was a fire underneath			This deficient practice could a		
					residents in the dining room a	ıea,	
		she would grab the fire			staff, and visitors.		
		ng to the red ABC fire			III. The facility will put into		
	_	nd then changing her mind and			place the following systemat	IIC	
	1	er K-Class fire extinguisher.			changes to ensure that the		
	-	would pull the range hood fire			deficient practice does not		
		pull station, however, when			recur.		
	· ·	wwhere it was located. This			Kitchen staff have been educa		
		by the Maintenance			regarding appropriate policy a	nd	
	Supervisor at the tir	me of observation and			procedures involving the hood	l fire	
	interview with the k	kitchen staff #1 (cook). The			suppression station.		
	Maintenance Super	visor said more training for			See Attachment D		
	kitchen staff would						
					IV The facility will monitor		
	This finding was re	viewed with the Administrator			the corrective action by		
		upervisor during the exit			implementing the following		
	conference.	. 0			measures.		
			- 1				

FORM CMS-2567(02-99) Previous Versions Obsolete

3.1-19(b)

Event ID:

VM4721

Facility ID: 000321

The Maintenance Director will

If continuation sheet

Page 14 of 27

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/24/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155614		A. BUILDING B. WING	01	COMPLETED 09/27/2023	
	ROVIDER OR SUPPLIER		326 CO	ADDRESS, CITY, STATE, ZIP COD DUNTRY CLUB DRIVE LBANY, 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
				provide education to dietary st during orientation and during routine fire drills according to t TELS schedule and Corporate Facilities Staff will validate education when onsite.	he
				V. Plan of Correction completion date.	
				Plan of correction date is Octo 16, 2023	ber
K 0341 SS=E Bldg. 01	and components a accordance with N Code, and NFPA Code to provide et part of the building occupied, detection alarm control unit. detection is also in appliance circuit p supervising station Fire alarm system transmission paths integrity. 18.3.4.1, 19.3.4.1, Based on observation failed to ensure 2 of detectors in the faciliair flow would adverse	n is installed with systems approved for the purpose in IFPA 70, National Electric 72, National Fire Alarm fective warning of fire in any in installed at each fire. In new occupancy, istalled at notification ower extenders, and intransmitting equipment. wiring or other is are monitored for 9.6, 9.6.1.8 In and interview, the facility fed hard wired smoke lity were not installed where risely affect its operation.	K 0341	K 341 Fire Alarm System – Installation I. The corrective actions to be accomplished for those	10/16/2023
	NFPA 72, 2010 edit smoke detectors sha the airstream of sup	ion, 17.7.6.3.2 requires that Il not be located directly in ply registers. Section 17.7.4.1 erved by air handling systems,		accomplished for those residents found to have been affected by the deficient practice.	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VM4721

Facility ID: 000321

If continuation sheet

Page 15 of 27

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CO	ONSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	01	COMPLE	ETED
		155614	B. W	ING		09/27/2	2023
				CTREET	ADDRESS CITY STATE ZIR COD		
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
LINICOLA		AL DANIX			DUNTRY CLUB DRIVE		
LINCOLI	N HILLS OF NEW A	ALBANY		I NEW 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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	.,,	DATE
	detectors shall not	be located where air flow			The facility failed to ensure 2	of 64	
	prevents operation	of the detectors. A.17.7.4.1			hard wired smoke detectors ir	the	
	states detectors sho	ould not be located in a direct			facility were not installed when	re air	
	airflow or closer th	an 36 inches from an air supply			flow would adversely affect its	;	
	diffuser or return a	ir opening. This deficient			operation.		
	practice could affect	ct up to 7 residents in the F Hall			A. A ceiling mounted smoke		
	and staff in the Business Hall				detector in the F Hall near the	exit	
	Findings include:				door was only 12 inches from	the	
					air supply vent.		
					B. A ceiling mounted smoke		
	Based on observati	ons on 09/27/23 between 12:30			detector in the Business Hall		
	p.m. and 4:00 p.m. during a tour of the facility with				outside the Human Resources	s	
	the Maintenance Supervisor, the following was				Office was only 12 inches fror	n the	
	noted:				air supply vent.		
	a. A ceiling mounted smoke detector in the F Hall				II. The facility will identify		
	near the exit door v	vas only 12 inches from the air			other residents that may		
	supply vent.				potentially be affected by the	9	
	b. A ceiling mount	ted smoke detector in the			deficient practice.		
	Business Hall outsi	ide the Human Resources					
	Office was only 12	inches from the air supply			This deficient practice could a	ffect	
	vent.				residents, staff, and visitors.		
		at the time of each					
		aintenance Supervisor agreed			III. The facility will put into		
		s in question were to close to			place the following systemat	tic	
	air supply vents.				changes to ensure that the		
					deficient practice does not		
	_	eviewed with the Administrator			recur.		
		upervisor during the exit			Both affected smoke detectors		
	conference.				have been moved an appropr		
					distance from air supply vents		
	3.1-19(b)				See Attachments E-1` and E-2	2	
					IV The facility will monitor		
					the corrective action by		
					implementing the following		
					measures.		
					The Maintenance Director will		
					physically inspect smoke		

10/24/2023 PRINTED: FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID 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 09/27/2023 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 DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE detectors to ensure appropriate placement distance from air vents according to the TELS schedule and Corporate Facilities Staff will validate inspections when onsite. V. Plan of Correction completion date. Plan of correction date is October 16. 2023 K 0345 **NFPA 101** SS=C Fire Alarm System - Testing and Bldg. 01 Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on observation and interview, the facility K 0345 K 345 Fire Alarm System -10/16/2023 failed to maintain the fire alarm system to assure **Testing and Maintenance** that it had accurate time and date information in I. The corrective actions to be accordance with the requirements of NFPA 101accomplished for those

FORM CMS-2567(02-99) Previous Versions Obsolete

visitors.

Findings include:

Event ID:

2012 edition, Sections 19.3.4 and 9.6 and NFPA 72

- 2010 edition, Sections 14.1, 14.1.1. This deficient

practice could affect all residents, staff and

Based on an observation and interview during a

Supervisor on 09/27/23 at 1:46 p.m., the date and

tour of the facility with the Maintenance

VM4721

Facility ID: 000321

practice.

If continuation sheet

residents found to have been

The facility failed to maintain the

fire alarm system to assure that it had accurate time and date

information in accordance with the

requirements of NFPA 101- 2012

edition. The date and time on the

affected by the deficient

Page 17 of 27

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 09/27/2023	
	ROVIDER OR SUPPLIER		326 CC	ADDRESS, CITY, STATE, ZIP COD DUNTRY CLUB DRIVE ALBANY, IN 47150	
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OR time on the main fir incorrect. The disp control panel indica which was over two local time. Furthern showed it to be 10/3 date of 09/27/2023. of observation, the lindicated he was no and would speak with company to get the	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION re alarm control panel was lay on the main fire alarm ted the time to be 11:38 a.m. re hours slower than the actual more, the date on the panel results on interview at the time Maintenance Supervisor t aware of the discrepancy the the fire alarm inspection time and date set correctly. Wiewed with the Administrator repervisor during the exit			m LS sities

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VM4721 Facility ID: 000321

If continuation sheet Page 18 of 27

PRINTED: 10/24/2023 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID 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 09/27/2023 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 DEFICIENCY) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE Plan of correction date is October 16. 2023 K 0351 **NFPA 101** SS=E Sprinkler System - Installation Bldg. 01 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation and interview, the facility K 0351 K 351 Sprinkler System -10/16/2023 failed to ensure that a complete automatic Installation sprinkler system or documentation of fire I. The corrective actions to be retardant material was provided for 1 of 1 accomplished for those overhang canopies. NFPA 13-2010 Edition, residents found to have been Section 8.15.7.1 states sprinklers shall be installed affected by the deficient under exterior roofs, canopies, porte-cocheres, practice. balconies, decks, or similar projections exceeding 4 ft. (1.2 m) in width. Section 8.15.7.2 states The facility failed to ensure that a

FORM CMS-2567(02-99) Previous Versions Obsolete

sprinklers shall be permitted to be omitted where

decks, or similar projections are constructed with

the canopies, roofs, porte-cocheres, balconies,

Event ID:

VM4721

Facility ID: 000321

complete automatic sprinkler

system or documentation of

fire-retardant material was provided

If continuation sheet

Page 19 of 27

10/24/2023 PRINTED: FORM APPROVED

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 09/27/2023 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 materials that are noncombustible or for 1 of 1 overhang canopies. limited-combustible, or fire retardant. Textiles There was a 20 foot by 20-foot such as canvas used as an awning shall meet fabric canopy not sprinkled and NFPA 701, Standard Methods of Fire Tests for attached to the building outside Flame Propagation of Textiles and Films. This the Memory Care Unit and above deficient practice could affect at least 10 residents, the deck with no sprinkler staff, and visitors. coverage under the fabric canopy and no flame spread Findings include: documentation for the fabric canopy. Based on observations on 09/27/23 between 12:30 II. The facility will identify p.m. and 4:00 p.m. during a tour of the facility with other residents that may the Maintenance Supervisor, there was a 20 foot potentially be affected by the by 20 foot fabric canopy not sprinkled and deficient practice. attached to the building outside the Memory Care Unit and above the deck. Based on interview at This deficient practice could affect the time of observation, the Maintenance memory care residents, staff, and Supervisor said it was a "Sunsail Canopy" and visitors. acknowledged there was no sprinkler coverage under the fabric canopy and further said he has III. The facility will put into looked for flame spread documentation for the place the following systematic fabric canopy but has not been able to find changes to ensure that the anything. deficient practice does not recur. This finding was reviewed with the Administrator Canopy has been removed. and Maintenance Supervisor during the exit See Attachment G conference. 3.1-19(b) IV The facility will monitor the corrective action by implementing the following measures. The Maintenance Director will physically inspect the premises to

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VM4721

Facility ID: 000321

ensure that fabric canopies or similar items meet requirements according to the TELS schedule and Corporate Facilities Staff will validate inspections when onsite.

If continuation sheet

Page 20 of 27

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155614		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 01 COMPLETED B. WING 09/27/2023					
	PROVIDER OR SUPPLIE		326 C	T ADDRESS, CITY, STATE, ZIP COD COUNTRY 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		
				V. Plan of Correction completion date. Plan of correction date is Octo 16, 2023	bber		
K 0353 SS=E Bldg. 01	Sprinkler System Automatic sprinkl are inspected, tes accordance with Inspection, Testir Water-based Fire Records of system inspection and te secure location a	- Maintenance and Testing - Maintenance and Testing er and standpipe systems sted, and maintained in NFPA 25, Standard for the ng, and Maintaining of e Protection Systems. m design, maintenance, sting are maintained in a nd readily available. r system last checked					
	b) Who provided						
	Provide in REMA coverage for any automatic sprinkl 9.7.5, 9.7.7, 9.7.8.1. Based on obserfacility failed to ensmoke compartmen replaced. NFPA 2 sprinklers shall not	RKS information on non-required or partial er system. B, and NFPA 25 vation and interview, the sure sprinkler heads in 1 of 10 nts covered with corrosion were 5, 2011 edition, at 5.2.1.1.1 a show signs of leakage; shall	K 0353	K 353 Sprinkler System - Maintenance and Testing I. The corrective actions to b accomplished for those residents found to have been			
	physical damage; a correct orientation sidewall). Further that shows signs of	n, foreign materials, paint, and and shall be installed in the (e.g., up-right, pendent, or more, at 5.2.1.1.2 any sprinkler f any of the following shall be tage (2) Corrosion (3) Physical		affected by the deficient practice. A. Based on observation and interview, the facility failed to ensure sprinkler heads in 1 of	10		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VM4721 Facility ID: 000321

If continuation sheet Page 21 of 27

CENTERS FO	R MEDICARE & MEDIC					OM	IB NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILD	ING	01	COMPI	LETED
		155614	B. WING			09/27	/2023
			S	TREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF	PROVIDER OR SUPPLIE	R			OUNTRY CLUB DRIVE		
LINCOL	N HILLS OF NEW A	AI BANY			LBANY, IN 47150		
LIITOOL							_
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	II	D	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PRE	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	T.	AG	DEFICIENCY)		DATE
	Damage (4) Loss of	f fluid in the glass bulb heat			smoke compartments covered	d	
	responsive element	(5) Loading (6) Painting			with corrosion were replaced.	Two	
	unless painted by t	he sprinkler manufacturer.			of four sprinkler heads in the		
	This deficient prac	tice could affect mostly laundry			laundry dryer/folding room cov	/ered	
	staff plus all reside	nt while in the adjoining smoke			with corrosion.		
	compartment.				B . Based on observation and		
	_				interview, the facility failed to		
	Findings include:				ensure 1 of over 500 sprinkler		
					heads in the facility were		
	Based on observati	ons on 09/27/23 between 12:30			maintained. The sprinkler hea	d	
		during a tour of the facility with			near the side exit door from th		
		upervisor, there were two of			main dining room was a glass		
		s in the laundry dryer/folding			type sprinkler head. The sprin		
	_	corrosion. Based on interview			head was empty with no color		
		vation, the Maintenance			the glass bulb.		
		the two sprinkler heads in the			II. The facility will identify		
		covered with corrosion and			other residents that may		
	should be replaced				potentially be affected by the		
	should be replaced	•			deficient practice.	7	
	This finding was re	eviewed with the Administrator			dencient practice.		
		upervisor during the exit			Those deficient practices coul	٨	
	conference.	upervisor during the exit			These deficient practices coul		
	conference.				affect mostly laundry staff plus resident while in the adjoining		
	3.1-19(b)				, ,		
	3.1-19(0)				smoke compartment.		
	2 Rased on observ	vation and interview, the			III. The facility will put into		
		sure 1 of over 500 sprinkler			place the following systemat	ic	
	1	were maintained. NFPA 25,			changes to ensure that the		
		spection, Testing, and			deficient practice does not		
		ater-Based Fire Protection			•		
		5 requires glass bulb sprinklers			recur.		
		the bulbs have emptied. This			All 3 affected sprinkler heads	havo	
		ould affect over 30 residents			•	ııav e	
	_				been replaced.	пο	
	while in the dining	100111.			See Attachment H-1, H-2 and	⊓-3	
	Findings include:						
	r manigs include:				IV The facility will may be		
	Rosed on observati	ons on 09/27/23 between 12:30			IV The facility will monitor		
					the corrective action by		
	p.m. and 4:00 p.m.	during a tour of the facility with			implementing the following		I

the Maintenance Supervisor, the sprinkler head

measures.

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155614	B. W	ING		09/27/	/2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	8			OUNTRY CLUB DRIVE		
LINCOLN	N HILLS OF NEW A	LBANY			LBANY, IN 47150		
					,		ī
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENC!)		DATE
		oor from the main dining room			The Maintenance Director will		
		ne sprinkler head. The empty with no color in the					
	-	on interview at the time of			physically inspect sprinkler he		
	-	nintenance Supervisor agreed			for signs of corrosion, damage missing color in the glass bulb		
	the sprinkler head was empty with no color in the				according to the TELS schedu		
glass bulb.				and Corporate Facilities Staff			
	giass outo.				validate inspections when ons		
This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference.					110.		
				V. Plan of Correction			
				completion date.			
	3.1-19(b)						
				Plan of correction date is Octo	ber		
					16, 2023		
K 0355	NFPA 101						
SS=E	Portable Fire Extir	nguishers					
Bldg. 01	Portable Fire Extir	_					
		guishers are selected,					
		d, and maintained in					
		NFPA 10, Standard for					
	Portable Fire Extir	•					
	18.3.5.12, 19.3.5.						
		on and interview, the facility	K 0	355	K 355 Portable Fire		10/16/2023
		f 22 portable fire extinguishers			Extinguishers		
	•	ear maintenance documented			I. The corrective actions to b	е	
		n accordance with NFPA 10.			accomplished for those	_	
	· ·	ition, Section 7.3.1.1.2 states fire			residents found to have been	1	
	_	be internally examined at ling those specified in Table			affected by the deficient		
		7.3.1.2.1 states every six years,			practice.		
		extinguishers that require a			The facility failed to ensure 1.	of 22	
	_	test shall be emptied and			The facility failed to ensure 1 or portable fire extinguishers had		
		olicable internal examination			date of 6-year maintenance	1 1110	
		ed in the manufacturer's			documented on each containe	r in	
	-	this standard. Sections 7.3.3.1			accordance with NFPA 10. NF		
		e fire extinguishers that pass			10, 2010 Edition. The portable		
		ar requirement shall have the			extinguisher in the corridor ou		
		nation recorded on a durable			room G7 had a maintenance	.5.40	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VM4721 Facility ID: 000321

If continuation sheet Page 23 of 27

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155614		(X2) MULTIPLE C A. BUILDING B. WING	construction 01	(X3) DATE SURVEY COMPLETED 09/27/2023	
	PROVIDER OR SUPPLIER		326 C	ADDRESS, CITY, STATE, ZIP COD OUNTRY CLUB DRIVE ALBANY, IN 47150	
	SUMMARY: (EACH DEFICIEN REGULATORY OR weatherproof label inches by 3.5 inches the shell and shall in maintenance was poinclude the initials of maintenance and the performing the main service collar shall the container indicaservice and the name the maintenance or practice could affect and visitors. Findings include: Based on observation p.m. and 4:00 p.m. the Maintenance Suportable fire extinguoutside room G7 has indicating the 6-year performed in 2015. of observation, the backnowledged the procording outside room service collar with 6 in 2015, and was particularly the finding was reconstructed.	ETATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION that is a minimum size of 2 s. The label shall be affixed to relude the month and year the erformed. The label shall of the person performing the ename of the agency rename. A verification of the located around the neck of ting the month and year of the of the agency performing recharge. This deficient that at least 20 residents, staff ons on 09/27/23 between 12:30 during a tour of the facility with pervisor, the ABC type tisher located in the corridor dia maintenance collar affixed or maintenance was last Based on interview at the time Maintenance Supervisor ortable fire extinguisher in the m G7 had a maintenance of-year maintenance occurring			e ffect d d is s in to

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VM4721 Facility ID: 000321

If continuation sheet

Page 24 of 27

10/24/2023 PRINTED: FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB							IB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	LETED
		155614	B. WI	NG		09/27	/2023
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEI	R		326 CC	DUNTRY 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	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					V. Plan of Correction		
					completion date.		
					Plan of correction date is Octo	ber	
					16, 2023		
K 0511	NFPA 101						
SS=D	Utilities - Gas and	I Clastria					
Bldg. 01	Utilities - Gas and						
Diag. 01		gas or related gas piping					
		PA 54, National Fuel Gas					
		riring and equipment					
	complies with NFPA 70, National Electric Code. Existing installations can continue in						
	service provided i						
	18.5.1.1, 19.5.1.1						
		on and interview, the facility	K 0	511	K 511 Utilities - Gas and Elec	ctric	10/16/2023
	failed to ensure 1 o	f over 20 wet locations, was			I. The corrective actions to b	е	
	provided with grou	nd fault circuit interrupter			accomplished for those		
	(GFCI) protection a	against electric shock. NFPA			residents found to have been	n	
	70, NEC 2011 Edit	ion at 210.8 Ground-Fault			affected by the deficient		
	Circuit-Interrupter	Protection for Personnel,			practice.		
	_	circuit-interruption for					
		provided as required in			Based on observation and		
	` ' ' ' '	C). The ground-fault			-	interview, the facility failed to	
	-	shall be installed in a readily			ensure 1 of over 20 wet locati		
	accessible location.				was provided with ground faul		
		: See 215.9 for ground-fault			circuit interrupter (GFCI) prote	ection	
		protection for personnel on			against electric shock. The		
	feeders.	volling Units All 125 14			electric receptacle within two		
	` '	velling Units. All 125-volt, and 20-ampere receptacles			of the sink in the west unit Par	nıry	
		ations specified in 210.8(B)(1)			was provided with a GFCI	otod	
	through (8) shall ha				receptacle, however, when te	sieu	
		orotection for personnel.			with a GFCI testing device it	an.	
	(1) Bathrooms	notection for personner.			indicated the receptacle had a		
	(2) Kitchens				Open Ground and did not breathe electrical circuit.	лc	
	(3) Rooftops				II. The facility will identify		
	(5) 1100110pb				i i iio iaoiiity wiii iaoiitiiy		i .

FORM CMS-2567(02-99) Previous Versions Obsolete

(4) Outdoors

Exception No. 1 to (3) and (4): Receptacles that are

Event ID:

VM4721

Facility ID: 000321

other residents that may

potentially be affected by the

If continuation sheet

Page 25 of 27

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	NG		09/27/	
				_			
NAME OF I	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP COD		
					OUNTRY CLUB DRIVE		
LINCOL	N HILLS OF NEW A	LBANY		NEW A	LBANY, IN 47150		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DE CLUBERIG DE ANTOE CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	·	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.IE	DATE
		ole and are supplied by a			deficient practice.		
		cated to electric snow-melting,					
		and vessel heating equipment			This deficient practice could a	ffect	
		o be installed in accordance			mostly nursing staff.		
	with 426.28 or 427.				III. The facility will put into		
		(4): In industrial establishments			place the following systemat	ic	
	_	nditions of maintenance and			changes to ensure that the		
		that only qualified personnel			deficient practice does not		
	_	sured equipment grounding			recur.		
	conductor program	as specified in 590.6(B)(2)					
	shall be permitted f	or only those receptacle			The GFCI receptable has bee	n	
	outlets used to supp	oly equipment that would			properly grounded.		
	create a greater hazard if power is interrupted or				See Attachment J		
	having a design that is not compatible with GFCI						
	protection.						
	(5) Sinks - where re	eceptacles are installed within			IV The facility will monitor		
	1.8 m (6 ft.) of the	outside edge of the sink.			the corrective action by		
	Exception No. 1 to	(5): In industrial laboratories,			implementing the following		
	receptacles used to	supply equipment where			measures.		
	removal of power v	vould introduce a greater					
	hazard shall be peri	nitted to be installed without			The Maintenance Director will		
	GFCI protection.				physically inspect outlets to		
		(5): For receptacles located in			ensure GFCI outlets are prope	erly	
	patient bed location	s of general care or critical			installed and grounded accord	ling	
	care areas of health	care facilities other than those			to the TELS schedule and		
	covered under				Corporate Facilities Staff will		
	210.8(B)(1), GFCI	protection shall not be required.			validate inspections when ons	ite.	
	(6) Indoor wet loca						
	` '	vith associated showering					
	facilities				V. Plan of Correction		
		e bays, and similar areas where			completion date.		
	electrical						
		nt, electrical hand tools.			Plan of correction date is Octo	ber	
	· ·	Wet Locations, requires all			16, 2023		
	_	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 nursing					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VM4721 Facility ID: 000321

If continuation sheet Page 26 of 27

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/24/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155614		A. B	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/27/2023				
	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 PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	.D BE	(X5) COMPLETION DATE		
	p.m. and 4:00 p.m. the Maintenance Sureceptacle within to unit Pantry was prohowever, when test it indicated the receand did not break the interview at the time Maintenance Super the west unit Pantry protected.	ons on 09/27/23 between 12:30 during a tour of the facility with apervisor, the electric wo feet of the sink in the west wided with a GFCI receptacle, and with a GFCI testing device exptacle had an Open Ground ne electrical circuit. Based on the of observation, the visor agreed the receptacle in a was not properly GFCI exiewed with the Administrator upervisor during the exit							

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: VM4721 Facility ID: 000321 If continuation sheet Page 27 of 27