STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155614	A. BUILDING -- B. WING	09/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LINCOLN HILLS OF NEW ALBANY	326 COUNTRY CLUB DRIVE NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 09/27/23 Facility Number: 000321 Provider Number: 155614 AIM Number: 100286130 At this Emergency Preparedness survey, Lincoln Hills of New Albany was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 156 certified beds, with a current census of 118. Quality Review completed on 10/05/23	E 0000	October 16th, 2023 Brenda Buroker, Director Long-Term Care Division Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204 Re: Allegation of Compliance Event ID: VM4721 Dear Mrs. Buroker: Please find enclosed the Plan of Correction for the Life Safety Code Recertification and Emergency Preparedness Survey conducted on September 27, 2023. This letter is to inform you that the plan of correction attached is to serve as Lincoln Hills of 3New Albany credible allegation of compliance. We allege substantial compliance on October 27, 2023. We are requesting paper compliance for this plan of correction. If you have any further questions, please do not hesitate to contact me at 317-512-4655. Sincerely,	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kimberly Povinelli	Administrator	10/20/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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			Kim Povinelli, HFA Administrator Lincoln Hills Submission of this plan of correction in no way constitutes an admission by Lincoln Hills of New Albany or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care or other services provided in this facility. The Plan of Correction is prepared and executed solely because it is required by Federal and State Law. This statement of deficiencies and plan of correction will be reviewed at the Monthly Quality Assurance/Assessment Committee meeting.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 09/27/23	K 0000	October 16th, 2023 Brenda Buroker, Director Long-Term Care Division Indiana State Department of	

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	Facility Number: 000321 Provider Number: 155614 AIM Number: 100286130 At this Life Safety Code survey, Lincoln Hills of New Albany was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be Type II (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors and spaces open to the corridors, plus battery operated smoke alarms in all resident sleeping rooms. The facility has a capacity of 156 and had a census of 118 at the time of this survey. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. The facility has a detached wooden storage garage and a wooden storage shed which were not sprinkled. Quality Review completed on 10/05/23		Health 2 North Meridian Street Indianapolis, IN 46204 Re: Allegation of Compliance Event ID: VM4721 Dear Mrs. Buroker: Please find enclosed the Plan of Correction for the Life Safety Code Recertification and Emergency Preparedness Survey conducted on September 27, 2023. This letter is to inform you that the plan of correction attached is to serve as Lincoln Hills of 3New Albany credible allegation of compliance. We allege substantial compliance on October 27, 2023. We are requesting paper compliance for this plan of correction. If you have any further questions, please do not hesitate to contact me at 317-512-4655. Sincerely, Kim Povinelli, HFA Administrator Lincoln Hills	

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			Submission of this plan of correction in no way constitutes an admission by Lincoln Hills of New Albany or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care or other services provided in this facility. The Plan of Correction is prepared and executed solely because it is required by Federal and State Law. This statement of deficiencies and plan of correction will be reviewed at the Monthly Quality Assurance/Assessment Committee meeting.	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the			

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	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 ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security 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 sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in			

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	accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 1. Based on observation and interview, the facility failed to ensure the means of egress through 1 of 2 locked exit courtyard gate was readily accessible for residents, staff, and visitors. This deficient practice could affect at least 10 residents, as well as staff and visitors. Findings include: Based on observation on 09/27/23 between 12:30 p.m. and 4:00 p.m. during a tour of the facility with the Maintenance Supervisor, the Courtyard exit gate outside the D-Hall exit was equipped with a combination lock located on the outside of the gate. The Maintenance Supervisor was able to open the lock, however, it was difficult to open from the courtyard side. The Maintenance Supervisor did remove the combination lock at the time of observation. Based on interview at the time of observation, the Maintenance Supervisor said the courtyard gate was almost never used. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure the means of egress through 1 of 10 locked exit doors was readily accessible for residents, staff, and visitors. This deficient practice could affect at least 10 residents,	K 0222	**K 222 Egress Doors** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** **A**. The facility failed to ensure the means of egress through 1 of 2 locked exit courtyard gate was readily accessible for residents, staff, and visitors. The Courtyard exit gate outside the D-Hall exit was equipped with a combination lock located on the outside of the gate. **B**. The facility failed to ensure the means of egress through 1 of 10 locked exit doors was readily accessible for residents, staff, and visitors. D-Hall exit door was magnetically locked and could only be opened by entering a code on a keypad located adjacent to the exit door. The code to open the exit door was not posted. **II. The facility will identify other residents that may potentially be affected by the deficient practice.**	10/16/2023

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	as well as staff and visitors. Findings include: Based on observations on 09/27/23 between 12:30 p.m. and 4:00 p.m. during a tour of the facility with the Maintenance Supervisor, the D-Hall exit door was magnetically locked and could only be opened by entering a code on a keypad located adjacent to the exit door. The code to open the exit door was not posted. Based on interview at the time of observation, the Maintenance Supervisor confirmed the code was not posted. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b)		These deficient practices could affect at least 10 residents, as well as staff and visitors. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** A The lock on the gate has been removed. B The egress on D-Hall has been labeled with a code to ensure exit doors are readily assessable. See Attachments A-1 and A-B **IV The facility will monitor the corrective action by implementing the following measures.** The Maintenance Director will physically inspect egress doors to ensure door codes are posted and that gates are free of locks 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 0223 SS=E Bldg. 01	NFPA 101 Doors with Self-Closing Devices Doors with Self-Closing Devices Doors in an exit passageway, stairway			

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	enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 Based on observation and interview, the facility failed to ensure 1 of 10 sets of smoke barrier doors had no impediment to closing. This deficient practice could affect at least 20 residents, as well as staff and visitors. Findings include: Based on observations on 09/27/23 between 12:30 p.m. and 4:00 p.m. during a tour of the facility with the Maintenance Supervisor, the set of smoke barrier doors to the B-Hall were impeded from closing by a large cone shaped wet floor sign. This was acknowledged by the Maintenance Supervisor who did remove the wet floor sign at the time of observation. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b)	K 0223	**K 223 Doors with Self-Closing 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 impediment to closing. The set of smoke barrier doors to the B-Hall were impeded from closing by a large 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 affect at least 20 residents, as well as staff and visitors. **III. The facility will put into**	10/16/2023

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			place the following systematic changes to ensure that the deficient practice does not recur. Housekeeping staff were educated regarding not impeding doors from closing and the cone was removed. See Attachment B **IV The facility will monitor the corrective action by implementing the following measures.** The Maintenance Director will physically inspect smoke barrier doors and ensure they are clear from obstruction 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 0271 SS=E Bldg. 01	NFPA 101 Discharge from Exits Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit			

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	discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 Based on observation and interview, the facility failed to maintain the walking surface for 1 of 10 exit discharge areas. This deficient practice could affect at least 20 residents, as well as staff and visitors. Findings include: Based on observations on 09/27/23 between 12:30 p.m. and 4:00 p.m. during a tour of the facility with the Maintenance Supervisor, the outside exit sidewalk from the G-Hall had a section of the sidewalk that was raised 5 to 6 inches due to a tree root pushing up the sidewalk. This was about 25 feet from the G-Hall exit door. The level change in the concrete sidewalk to the public way could be a tripping hazard while exiting from this area in the event of an emergency. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the level change along the sidewalk to the public way. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b)	K 0271	**K 271 Discharge from Exits** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** The facility failed to maintain the walking surface for 1 of 10 exit discharge areas. The outside exit sidewalk from the G-Hall had a section of the sidewalk that was raised 5 to 6 inches due to a tree root pushing up the sidewalk. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** This deficient practice could affect at least 20 residents, as well as staff and visitors. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not 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.**	10/27/2023

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			The Maintenance Director will physically inspect exit discharge areas to ensure smooth walking surfaces 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 27, 2023	
K 0281 SS=E Bldg. 01	NFPA 101 Illumination of Means of Egress Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 Based on observation and interview, the facility failed to ensure the lighting for 2 of 10 exit means of egress was properly maintained and would not leave the area in darkness. LSC 7.8.1.4 requires illumination shall be arranged so that that the failure of any single lighting unit does not result in an illumination level of less than 0.2 foot-candle in any designated area. This deficient practice could affect at least 30 residents as well as staff and visitors. Findings include: Based on observations on 09/27/23 between 12:30 p.m. and 4:00 p.m. during a tour of the facility with	K 0281	**K 281 Illumination of Means of 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 exit means of egress was properly maintained and would not leave the area in darkness. **A.** There were outside lights on	10/27/2023

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	the Maintenance Supervisor, the following was noted: a. The sidewalk from the G-Hall exit past the H-Hall exit and beyond to the public way was between 150 and 200 feet in length. There was a seven foot tall fence that was connected to the outside wall of the G-Hall and the outside wall of the H-Hall with the sidewalk on the outside of the fence. There were outside lights on the walls of the G-Hall and H-Hall, however, with the length and size of the fence the sidewalk would not have enough light provided in the event of an evacuation from the G-Hall during the dark hours of the night. b. The D-Hall exit discharge had a double light fixture, however, one of the light bulbs was missing. Based on interview at the time of each observation, this was acknowledged by the Maintenance Supervisor who agreed the connecting sidewalk between the G-Hall and H-Hall needed more light provided, furthermore, he acknowledged the missing bulb outside the D-Hall exit door. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b)		the walls of the G-Hall and H-Hall, however, with the length and size of the fence the sidewalk would not have enough light provided in the event of an evacuation from the G-Hall during the dark hours of the night. **B.** The D-Hall exit discharge had a double light fixture, however, one of the light bulbs was missing. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** These deficient practices could affect at least 30 residents as well as staff and visitors. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** A Lighting will be installed at the fence area on Friday 10/27. B The missing bulb was replaced. See Attachment C. **IV The facility will monitor the corrective action by implementing the following measures.** The Maintenance Director will physically inspect outside means of egress to ensure appropriate lighting according to the TELS	

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			schedule and Corporate Facilities Staff will validate inspections when onsite. **V. Plan of Correction completion date.** Plan of correction date is October 27, 2023	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on observation and interview, the facility failed to ensure staff were instructed in the proper use of the UL 300 hood fire suppression system in 1 of 1 kitchen. NFPA 96, Standard for Ventilation	K 0324	**K 324 Cooking Facilities** **I. The corrective actions to be accomplished for those residents found to have been**	10/16/2023

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Control and Fire Protection of Commercial Cooking Operations, Section 10.5.7 states instruction shall be provided to employees regarding the proper use of portable fire extinguishers and the manual activation of fire-extinguishing equipment. Section 11.1.4 states instructions for manually operating the fire extinguishing system shall be posted conspicuously in the kitchen and shall be reviewed with employees by management. This deficient practice could affect kitchen staff plus any residents while in the adjacent main dining room. Findings include: Based on observations on 09/27/23 between 12:30 p.m. and 4:00 p.m. during a tour of the facility with the Maintenance Supervisor, the kitchen was provided with a UL 300 hood system. Based on interview with kitchen staff #1 (cook), when asked what she would do if there was a fire underneath the hood. She said she would grab the fire extinguisher, pointing to the red ABC fire extinguisher first, and then changing her mind and pointing to the silver K-Class fire extinguisher. She did not say she would pull the range hood fire suppression system pull station, however, when asked, she did know where it was located. This was acknowledged by the Maintenance Supervisor at the time of observation and interview with the kitchen staff #1 (cook). The Maintenance Supervisor said more training for kitchen staff would be a priority. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b)		**affected by the deficient practice.** Based on observation and interview, the facility failed to ensure staff were instructed in the proper use of the UL 300 hood fire suppression system in 1 of 1 kitchen. Kitchen staff #1 (cook), did not say she would pull the range hood fire suppression system pull station before grabbing the fire extinguisher, however, when asked, she did know where it was located **II. The facility will identify other residents that may potentially be affected by the deficient practice.** This deficient practice could affect residents in the dining room area, staff, and visitors. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** Kitchen staff have been educated regarding appropriate policy and procedures involving the hood fire suppression station. See Attachment D **IV The facility will monitor the corrective action by implementing the following measures.** The Maintenance Director will	

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			provide education to dietary staff during orientation and during routine fire drills according to the TELS schedule and Corporate Facilities Staff will validate education when onsite. **V. Plan of Correction completion date.** Plan of correction date is October 16, 2023	
K 0341 SS=E Bldg. 01	NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 Based on observation and interview, the facility failed to ensure 2 of 64 hard wired smoke detectors in the facility were not installed where air flow would adversely affect its operation. NFPA 72, 2010 edition, 17.7.6.3.2 requires that smoke detectors shall not be located directly in the airstream of supply registers. Section 17.7.4.1 requires in spaces served by air handling systems,	K 0341	**K 341 Fire Alarm System – Installation** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.**	10/16/2023

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	detectors shall not be located where air flow prevents operation of the detectors. A.17.7.4.1 states detectors should not be located in a direct airflow or closer than 36 inches from an air supply diffuser or return air opening. This deficient practice could affect up to 7 residents in the F Hall and staff in the Business Hall.. Findings include: Based on observations on 09/27/23 between 12:30 p.m. and 4:00 p.m. during a tour of the facility with the Maintenance Supervisor, the following was noted: a. A ceiling mounted smoke detector in the F Hall near the exit door was only 12 inches from the air supply vent. b. A ceiling mounted smoke detector in the Business Hall outside the Human Resources Office was only 12 inches from the air supply vent. Based on interview at the time of each observation, the Maintenance Supervisor agreed the smoke detectors in question were to close to air supply vents. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b)		The facility failed to ensure 2 of 64 hard wired smoke detectors in the facility were not installed where air flow would adversely affect its operation. A. A ceiling mounted smoke detector in the F Hall near the exit door was only 12 inches from the air supply vent. B. A ceiling mounted smoke detector in the Business Hall outside the Human Resources Office was only 12 inches from the air supply vent. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** This deficient practice could affect residents, staff, and visitors. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** Both affected smoke detectors have been moved an appropriate distance from air supply vents. See Attachments E-1` and E-2 **IV The facility will monitor the corrective action by implementing the following measures.** The Maintenance Director will physically inspect smoke	

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			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 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Testing and 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 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, 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 visitors. Findings include: Based on an observation and interview during a tour of the facility with the Maintenance Supervisor on 09/27/23 at 1:46 p.m., the date and	K 0345	**K 345 Fire Alarm System - Testing and Maintenance** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** 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	10/16/2023

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	time on the main fire alarm control panel was incorrect. The display on the main fire alarm control panel indicated the time to be 11:38 a.m. which was over two hours slower than the actual local time. Furthermore, the date on the panel showed it to be 10/31/2023 and not the correct date of 09/27/2023. Based on interview at the time of observation, the Maintenance Supervisor indicated he was not aware of the discrepancy and would speak with the fire alarm inspection company to get the time and date set correctly. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b)		main fire alarm control panel was incorrect. Furthermore, the date on the panel showed it to be 10/31/2023 and not the correct date of 09/27/2023. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** This deficient practice could affect residents, staff, and visitors. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** Fire alarm system has been adjusted and now reflects the correct date and time. See Attachment F. **IV The facility will monitor the corrective action by implementing the following measures.** The Maintenance Director will physically inspect the fire alarm system for time and date accuracy according to the TELS schedule and Corporate Facilities Staff will validate inspections when onsite. **V. Plan of Correction completion date.**	

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			Plan of correction date is October 16, 2023	
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation 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 failed to ensure that a complete automatic sprinkler system or documentation of fire retardant material was provided for 1 of 1 overhang canopies. NFPA 13-2010 Edition, Section 8.15.7.1 states sprinklers shall be installed under exterior roofs, canopies, porte-cocheres, balconies, decks, or similar projections exceeding 4 ft. (1.2 m) in width. Section 8.15.7.2 states sprinklers shall be permitted to be omitted where the canopies, roofs, porte-cocheres, balconies, decks, or similar projections are constructed with	K 0351	**K 351 Sprinkler System – Installation** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** The facility failed to ensure that a complete automatic sprinkler system or documentation of fire-retardant material was provided	10/16/2023

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

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			V. Plan of Correction completion date. Plan of correction date is October 16, 2023	
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on observation and interview, the facility failed to ensure sprinkler heads in 1 of 10 smoke compartments covered with corrosion were replaced. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical	K 0353	**K 353 Sprinkler System - Maintenance and Testing** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** **A**. Based on observation and interview, the facility failed to ensure sprinkler heads in 1 of 10	10/16/2023

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	Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect mostly laundry staff plus all resident while in the adjoining smoke compartment. Findings include: Based on observations on 09/27/23 between 12:30 p.m. and 4:00 p.m. during a tour of the facility with the Maintenance Supervisor, there were two of four sprinkler heads in the laundry dryer/folding room covered with corrosion. Based on interview at the time of observation, the Maintenance Supervisor agreed the two sprinkler heads in the laundry area were covered with corrosion and should be replaced. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of over 500 sprinkler heads in the facility were maintained. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems at 5.2.1.1.5 requires glass bulb sprinklers shall be replaced if the bulbs have emptied. This deficient practice could affect over 30 residents while in the dining room. Findings include: Based on observations on 09/27/23 between 12:30 p.m. and 4:00 p.m. during a tour of the facility with the Maintenance Supervisor, the sprinkler head		smoke compartments covered with corrosion were replaced. Two of four sprinkler heads in the laundry dryer/folding room covered with corrosion. **B**. Based on observation and interview, the facility failed to ensure 1 of over 500 sprinkler heads in the facility were maintained. The sprinkler head near the side exit door from the main dining room was a glass bulb type sprinkler head. The sprinkler head was empty with no color in the glass bulb. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** These deficient practices could affect mostly laundry staff plus all resident while in the adjoining smoke compartment. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** All 3 affected sprinkler heads have been replaced. See Attachment H-1, H-2 and H-3 **IV The facility will monitor the corrective action by implementing the following measures.**	

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	near the side exit door from the main dining room was a glass bulb type sprinkler head. The sprinkler head was empty with no color in the glass bulb. Based on interview at the time of observation, the Maintenance Supervisor agreed the sprinkler head was empty with no color in the glass bulb. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b)		The Maintenance Director will physically inspect sprinkler heads for signs of corrosion, damage, or missing color in the glass bulb 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 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to ensure 1 of 22 portable fire extinguishers had the date of 6-year maintenance documented on each container in accordance with NFPA 10. NFPA 10, 2010 Edition, Section 7.3.1.1.2 states fire extinguishers shall be internally examined at intervals not exceeding those specified in Table 7.3.1.1.2. Section 7.3.1.2.1 states every six years, stored pressure fire extinguishers that require a 12-year hydrostatic test shall be emptied and subjected to the applicable internal examination procedure as detailed in the manufacturer's service manual and this standard. Sections 7.3.3.1 through 7.3.3.2 state fire extinguishers that pass the applicable 6-year requirement shall have the maintenance information recorded on a durable	K 0355	**K 355 Portable Fire Extinguishers** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** The facility failed to ensure 1 of 22 portable fire extinguishers had the date of 6-year maintenance documented on each container in accordance with NFPA 10. NFPA 10, 2010 Edition. The portable fire extinguisher in the corridor outside room G7 had a maintenance	10/16/2023

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	weatherproof label that is a minimum size of 2 inches by 3.5 inches. The label shall be affixed to the shell and shall include the month and year the maintenance was performed. The label shall include the initials of the person performing the maintenance and the name of the agency performing the maintenance. A verification of service collar shall be located around the neck of the container indicating the month and year of service and the name of the agency performing the maintenance or recharge. This deficient practice could affect at least 20 residents, staff and visitors. Findings include: Based on observations on 09/27/23 between 12:30 p.m. and 4:00 p.m. during a tour of the facility with the Maintenance Supervisor, the ABC type portable fire extinguisher located in the corridor outside room G7 had a maintenance collar affixed indicating the 6-year maintenance was last performed in 2015. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the portable fire extinguisher in the corridor outside room G7 had a maintenance service collar with 6-year maintenance occurring in 2015, and was past due. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3-1.19(b)		service collar with 6-year maintenance occurring in 2015 and was past due. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** This deficient practice could affect at least 20 residents, staff, and visitors. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** Fire extinguisher has met maintenance requirements and is properly tagged. See Attachment I **IV The facility will monitor the corrective action by implementing the following measures.** The Maintenance Director will physically inspect portable fire extinguishers to ensure maintenance documentation is in place and accurate according to the TELS schedule and Corporate Facilities Staff will validate inspections when onsite.	

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K 0511 SS=D Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 1 of over 20 wet locations, was provided with ground fault circuit interrupter (GFCI) protection against electric shock. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily accessible location. Informational Note: See 215.9 for ground-fault circuit interrupter protection for personnel on feeders. (B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in 210.8(B)(1) through (8) shall have ground-fault circuit-interrupter protection for personnel. (1) Bathrooms (2) Kitchens (3) Rooftops (4) Outdoors Exception No. 1 to (3) and (4): Receptacles that are	K 0511	**K 511 Utilities - Gas and Electric** **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 over 20 wet locations was provided with ground fault circuit interrupter (GFCI) protection against electric shock. The electric receptacle within two feet of the sink in the west unit Pantry was provided with a GFCI receptacle, however, when tested with a GFCI testing device it indicated the receptacle had an Open Ground and did not break the electrical circuit. **II. The facility will identify other residents that may potentially be affected by the**	10/16/2023

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	not readily accessible and are supplied by a branch circuit dedicated to electric snow-melting, deicing, or pipeline and vessel heating equipment shall be permitted to be installed in accordance with 426.28 or 427.22, as applicable. Exception No. 2 to (4): In industrial establishments only, where the conditions of maintenance and supervision ensure that only qualified personnel are involved, an assured equipment grounding conductor program as specified in 590.6(B)(2) shall be permitted for only those receptacle outlets used to supply equipment that would create a greater hazard if power is interrupted or having a design that is not compatible with GFCI protection. (5) Sinks - where receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink. Exception No. 1 to (5): In industrial laboratories, receptacles used to supply equipment where removal of power would introduce a greater hazard shall be permitted to be installed without GFCI protection. Exception No. 2 to (5): For receptacles located in patient bed locations of general care or critical care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection shall not be required. (6) Indoor wet locations (7) Locker rooms with associated showering facilities (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect mostly nursing		**deficient practice.** This deficient practice could affect mostly nursing staff. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** The GFCI receptable has been properly grounded. See Attachment J **IV The facility will monitor the corrective action by implementing the following measures.** The Maintenance Director will physically inspect outlets to ensure GFCI outlets are properly installed and grounded 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155614	A. BUILDING 01 B. WING	09/27/2023

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	staff. Findings include: Based on observations on 09/27/23 between 12:30 p.m. and 4:00 p.m. during a tour of the facility with the Maintenance Supervisor, the electric receptacle within two feet of the sink in the west unit Pantry was provided with a GFCI receptacle, however, when tested with a GFCI testing device it indicated the receptacle had an Open Ground and did not break the electrical circuit. Based on interview at the time of observation, the Maintenance Supervisor agreed the receptacle in the west unit Pantry was not properly GFCI protected. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b)			