

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155614	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/13/2014
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
--------------------	--	---------------	---	----------------------

F000000	<p>This visit was for the Investigation of Complaints IN00147886, IN00150329, and IN00151282.</p> <p>IN00147886 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>IN00150329 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>IN00151282 - Substantiated. Federal/State deficiencies related to the allegations are cited at F441.</p> <p>Survey Dates: August 11,12 and 13, 2014</p> <p>Facility number: 000321 Provider number: 155614 AIM number: 100286130</p> <p>Survey Team: Gwen Pumphrey, RN-TC</p> <p>Census Bed Type: SNF: 9 SNF/NF: 134 Total: 143</p> <p>Census Payor Type: Medicare: 19 Medicaid: 101</p>	F000000		
---------	---	---------	--	--

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155614	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/13/2014
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
F000441 SS=D	<p>Other: 23 Total: 143</p> <p>Sample: 9</p> <p>This deficiency reflects a State findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed on August 21, 2014, by Brenda Meredith, R.N.</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155614		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/13/2014	
NAME OF PROVIDER OR SUPPLIER LINCOLN HILLS OF NEW ALBANY				STREET ADDRESS, CITY, STATE, ZIP CODE 326 COUNTRY CLUB DRIVE NEW ALBANY, IN 47150			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on interview and record review, the facility failed to include the tracking and monitoring of skin rashes as having been caused from a possible infectious organism (bacteria, viruses or parasites) in the facility infection control for 1 of 3 residents reviewed for infection control. [Resident A]</p> <p>Findings Include:</p> <p>On 8/12/14 at 1:00 p.m., the Infection Control Log was reviewed from January 2014 through August 2014. The log lacked documentation of any skin</p>	F000441	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The facility will continue to track and monitor skin rashes caused from a possible infectious organism as part of our facility Infection Control Program. The facility Infection Control Log has been reviewed and updated to include the skin rash identified for Resident A. (Attachment A) All residents residing on the same unit as Resident A have had a new skin assessment completed with the Infection Control Log	09/03/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155614		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/13/2014	
NAME OF PROVIDER OR SUPPLIER LINCOLN HILLS OF NEW ALBANY				STREET ADDRESS, CITY, STATE, ZIP CODE 326 COUNTRY CLUB DRIVE NEW ALBANY, IN 47150			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>infections for Resident A.</p> <p>On 8/12/14 at 1:00 p.m., the Director of Nursing indicated, the residents listed on the Infection Control Log with skin infections were "mostly related to cellulitis."</p> <p>On 8/12/14 at 4:30 p.m., LPN #1 indicated Resident A was treated for a skin rash.</p> <p>On 8/13/14 at 9:00 a.m., Resident A's clinical record was reviewed. Resident A had diagnoses including but not limited to recurrent urinary tract infections, dementia, and arthritis. Resident A was admitted to the facility on 4/23/14 and discharged from the facility on 8/8/14.</p> <p>A physician progress note, dated 5/27/14 and untimed, indicated the resident had shingles and contact dermatitis.</p> <p>A physician progress note, dated 6/8/14 and untimed, indicated, ..."shingles (resolved) and diffuse pruritis [itching], not related to shingles...await derm. [dermatologist] recommendations."</p> <p>The dermatologist note, dated 6/11/14 and untimed, indicated Resident A had scabies to his left shoulder.</p>		<p>updated as necessary. Any skin rashes noted to be caused by an infectious organism will be added to the Infection Control Log as they occur. At the time of identification of an infectious skin rash, any resident with the potential to be affected will be assessed and treated as appropriate. The DON and Administrator were inserviced by the Medical Director regarding the facility Infection Control Program (Attachment B).</p> <p>The DON will update the Infection Control Log as infections are identified. The DON and Administrator will review the Infection Control Log weekly times four weeks and then monthly. The Infection Control Log will be reported to the QA Committee quarterly. Any inconsistencies will be corrected with additional training or counseling completed as necessary. Administrator to monitor.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155614	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/13/2014
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>On 8/13/14 at 12:15 p.m., the Director of Nursing (DoN) was interviewed. She indicated, "this resident was admitted with dry skin. The resident developed a rash on the right fore arm. We notified the doctor and got an order to treat it. A few weeks later, a different doctor assessed him, determined he had shingles and contact dermatitis. At that point the rash was on the abdomen and arm. The resident showed some improvement, but at the request of his family, we sent the resident to a dermatologist who gave a diagnosis of scabies. This rash was on the residents left shoulder. I looked at the rash but didn't think it was scabies."</p> <p>The DoN confirmed the shingles nor the scabies was tracked by the infection control program. She indicated, the resident was being monitored by the 24 hour report and follow up forms in the clinical record. She indicated no other residents presented with similar symptoms as Resident A. When asked for documentation of the investigation, a copy of weekly skin assessments for residents on the same unit as Resident A was provided by the DoN. These assessments were the residents regularly scheduled skin assessments.</p> <p>On 8/13/14 at 12:25 p.m., the Administrator indicated, scabies was not</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155614	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/13/2014
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>an infection that needed to be tracked in the infection control log. She indicated the facility did investigate and assess other residents by reviewing the 24 hour report.</p> <p>On 8/13/14 at 1:35 p.m., the DoN and Administrator was interviewed. They were unable to provide documentation of Resident A's skin infections being tracked in the facility or documentation that preventative measures were taken to prevent the spread of the infection to other residents.</p> <p>A copy of the policy titled, "Surveillance and Control " was provided on 8/13/14 at 8:55 p.m. by the DoN. The policy stated, ...the infection control nurse will conduct individual resident surveillance activities...."</p> <p>This Federal Tag relates to Complaint IN00151282.</p> <p>3.1-18(b)(1) 3.1-18(b)(2) 3.1-18(b)(3)</p>			

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

PRINTED: 09/05/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155614	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/13/2014
NAME OF PROVIDER OR SUPPLIER LINCOLN HILLS OF NEW ALBANY			STREET ADDRESS, CITY, STATE, ZIP CODE 326 COUNTRY CLUB DRIVE NEW ALBANY, IN 47150		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	