STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155614	A. BUILDING 00 B. WING	06/09/2023

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

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F 0000 Bldg. 00	This visit was for the investigation of Complaints IN00404123 and IN00407228. Complaint IN00404123 - No deficiencies related to the allegations are cited. Complaint IN00407228 - No deficiencies related to the allegations are cited. Unrelated deficiency cited. Survey dates: June 8 and 9, 2023 Facility number: 000321 Provider number: 155614 AIM number: 100286130 Census bed type: SNF: 10 SNF/NF: 120 Total: 130 Census payor type: Medicare: 28 Medicaid: 86 Other: 16 Total: 130 This deficiency also reflects state findings cited in accordance with 410 IAC 16.2-3.1 Quality review completed on June 15, 2023.	F 0000	June 29, 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: BIOI11 Dear Mrs. Buroker: Please find enclosed the Plan of Correction for the Annual Survey conducted on June 9, 2023. This letter is to inform you that the plan of correction attached is to serve as Lincoln Hills of New Albany's credible allegation of compliance. We allege substantial compliance on June 29, 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	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kimberly Povinelli	Administrator	06/29/2023

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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			Administrator Lincoln Hills of New Albany 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.	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and			

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	§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview, the facility failed to ensure a hot liquid assessment was completed for a resident with a decline in function for 1 of 3 residents reviewed for accidents. (Resident G) Finding includes: Review of the Reportable to State incident report, dated 5/23/23, indicated Resident G spilled his coffee in his lap during dinner. The next day, the resident was discovered to have a reddened area with quarter size blister. The record for Resident G was reviewed on 6/8/23 at 11:00 a.m. The diagnoses included, but were not limited to, restlessness and agitation, unspecified pain, need for assistance with personal care, Alzheimer's disease with late onset and generalized anxiety disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 2/9/23, indicated the resident had severe cognitive impairment and required supervision of one staff member's assistance for eating. The Quarterly MDS assessment, dated 5/10/23, indicated the resident had a severe cognitive impairment and required extensive assistance of one staff member for assistance with eating. A care plan, initiated on 3/8/22 with a last reviewed date of 6/8/23, indicated the resident was unable to independently perform late loss ADLs (Activities of Daily Living) R/T (related to) dementia with behaviors, general weakness, and	F 0689	**F-689** **Free of Accident Hazards/Supervision/Devices** The facility must ensure that the resident environment remains as free of accident/hazards as possible, and that each resident receives adequate supervision and assistance devices to prevent accidents. The facility failed to ensure a hot liquid assessment/observation was completed for a resident with a decline in function for 1 of 3 residents reviewed for accidents. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident G was observed to need a cup with a no-spill lid and was provided one for use during meal and snack times. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** Current residents have the potential to be affected. Current residents were observed to ensure they can eat and drink hot liquids safely. Those who are not safe	06/29/2023

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	required assistance/encouragement for eating. The goal was for the resident to not experience a decline in level of participation of late loss ADLs. The approaches included, but were not limited to; dated 3/8/22, monitor for any eating/swallowing/meal issues; provide assistance and encouragement as needed and report any issues; and dated 6/8/23, cup with sipper end to assist with independence with drinking. A new care plan was added on 5/25/23 for burn wounds to Right and Left thighs. The goal was for it to heal with no complications and the approach was for treatment, monitoring and healing. A nurse's note, dated 5/24/23 at 2:21 p.m., indicated the resident was assessed by the nurse while in bed and observed superficial open areas to inner right and left thighs and outer left thigh. The Wound Physician was in the building and was asked to assess the resident. The Rash/Lesions Assessment, dated 5/24/23, indicated the resident had an injury to the inner and outer left and right thighs. The blisterlike, generalized widespread, rash/lesions. A nurse's note, dated 5/30/23 at 3:37 p.m., indicated the resident's skin was assessed by this nurse due to possible infection reported post burn wounds. The Wound Care physician was notified and sent pictures and she indicated it was not infected. The resident's record lacked a Hot Liquids assessment to address the decline in eating prior to the accident on 5/23/23 or afterwards. The Nursing Referral for Therapy to Screen, dated		were referred to OT for evaluation and treatment. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Staff will observe residents during meal service to identify any problems with managing drinking cups. Residents will have hot liquids poured for them and not have access to pour their own. Residents identified to have difficulty with drinking cups will be referred to OT for evaluation/treatment. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The DON or Designee will do 5 random observations during meal service to determine ability to manage drinking cups weekly for 4 weeks, then bi-weekly for 8 weeks, then monthly for 9 months. Any identified residents will be referred for an OT evaluation/treatment. The results of the audits will be reviewed at the monthly quality assurance meetings. Changes may be established to the auditing process, based upon the results of	

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	5/31/23, indicated OT (occupational therapy) evaluated the resident due to a fall only and was not referred for a change in feeding skills/adaptive equipment needs after his coffee spill on 5/23/23. During an interview with LPN (Licensed Practical Nurse) 1 on 6/8/23 at 10:25 a.m., she indicated that the resident was only alert to his name. During an interview with Activities Aide on 6/8/23 at 10:33 a.m., she indicated the resident used to use a regular coffee cup with a handle, but since he spilled his coffee on himself, now he used a "sippy" cup with a lid and handles. During an interview with CNA (Certified Nurse Aide) on 6/8/23 at 10:40 a.m., she indicated the resident had been more tired and required more help in the last couple of weeks and was not really capable of helping himself. During an interview on 6/8/23 at 1:50 p.m., the Executive Director indicated the resident still liked to feed himself when he could and was using a regular coffee cup at that time. He had no injury initially but the next day, he had blistered areas on his thighs. During an interview with the DON on 6/8/23 at 2:00 p.m., she indicated the staff did not notice there was an area on his legs until the next day and since he usually wore dark clothing, it wasn't initially noticed his pants might have been wet. Sometimes he could feed himself and other times he needed help if he would allow it. Staff wanted him to try to maintain what abilities he still had. The aides on the night shift that put him to bed should have noticed if his pants were wet or not. During an interview with CNA 3 on 6/8/23 at 2:25		the audits. Date of Compliance: June 29, 2023	

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	p.m., she indicated the resident was feeding himself that night as he had good and bad days where he could feed himself independently and other days he needed more help. He was steady with his hands to hold things like a cup until recently. She also indicated she first noticed his burns the next day when she went to lay him down and had pulled his pants down. She did not actually see him spill the coffee on himself that evening and only saw a cup on the floor next to him. During an interview with the OT Therapy Supervisor on 6/8/23 at 2:45 p.m., she indicated the nursing supervisor came to her after the resident spilled his coffee and she gave her some different cups to try. Staff were to let her know if there was anything else that needed to be done. She did not do a formal assessment on him to determine if he was safe with hot liquids by himself and that it depended on the situation if she would do that type of assessment as one was not normally done. He was on her list to evaluate since PT (physical therapy) was getting ready to discharge him due to making no progress. During an interview with the DON on 6/9/23 at 8:10 a.m., she indicated staff had tried to group the residents who needed to be fed together at one table with a nurse or aide there to monitor them. If they saw someone who was having trouble holding their cup, then the resident would get a cup with a lid and handles. She indicated they did not do Hot Liquid assessments on any residents and would have to ask therapy if they did one. During an interview with the Dietary Manager/Cook on 6/9/23 at 8:35 a.m., she indicated the kitchen sent the coffee in a big carafe to the dementia unit and the aides would			

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	pour it out to the residents with their meals. The coffee machine maintained a temperature of 160 degrees Fahrenheit. The kitchen was notified the day before (6/8/23) that the resident needed a special cup. The staff kept it back on the unit for him to make sure he had it as it had not come back on his tray yesterday or today. During an interview with the Corporate Nurse on 6/9/23 at 12:30 p.m., she indicated the facility did not have a specific Hot Liquids assessment policy. The MDS was completed quarterly and would reflect any changes the resident had. 3.1-45(a)(1)			