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	02/27/2025

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
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00452723 and IN00452878. Complaint IN00452723 - Federal/State deficiency related to the allegations is cited a F656. Complaint IN00452878 - No deficiencies related to the allegations are cited Survey dates: February 26 and 27, 2025 Facility number: 000321 Provider number: 155614 AIM number: 100286130 Census Bed Type: SNF/NF: 124 SNF: 9 Total: 133 Census Payor Type: Medicare: 12 Medicaid: 96 Other: 25 Total: 133 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 5, 2025.	F 0000	March 10, 2025 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: C0VM11 Dear Mrs. Buroker: Please find enclosed the Plan of Correction for the Complaint Survey conducted on February 27, 2025. 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 March 10, 2025. 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

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			Kim Povinelli, HFA 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 **F656 Develop/Implement Comprehensive Care Plans** **I The corrective actions to be accomplished for those residents found to have been affected by the practice**. Resident D care plans have been revised and updated.	

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			II The facility will identify other residents that may potentially be affected by this practice. All residents have the potential to be affected by this practice. Current residents with fall intervention care plans will be audited by 02/28/2025 to validate that fall intervention care plans are appropriate and accurate. III> **The facility will put into place the following systemic changes to ensure that the deficient practice does not occur.** Licensed nurses and the social service director/staff will be educated by 03/10/2025 on developing and implementing individualized fall intervention care plans. **IV< The facility will monitor the corrective action by implementing the following measures.** Director of nursing or designee will audit 5 residents fall interventions care plans twice a week for 8 weeks, then monthly for 4 months to ensure fall intervention care plans are revised and implemented with appropriate individualized interventions. The results of these	

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			audits will be presented to the monthly Quality Assurance/Performance Improvement Committee. The facility will achieve 100% compliance threshold prior to adjusting the frequency of audits. Plan to be updated as indicated.	
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan Based on interview and record review, the facility failed to ensure a plan of care was in place timely, for a resident's non-compliance with a fall intervention related to the use of hipsters for 1 of 3 residents reviewed for care plans. (Resident D) Findings include: The clinical record for Resident D was reviewed on 2/27/25 at 9:28 a.m. The resident's diagnoses included, but were not limited to, vascular dementia and abnormalities of the gait. The care plan, dated 7/22/24, indicated the resident was at risk for falls. The resident was to wear hipsters (help reduce the risk of injuries from a fall, such as hip fractures, through impact-absorbing foam pads) at all times as the resident would allow to decrease risk of injury with falls. The progress note, dated 2/20/25 at 9:24 p.m., indicated the resident was walking in the dining room and fell over onto her left hip. The residents' hipsters were not on. The nurse practitioner was notified and a new order received for an x-ray. The progress note, dated 2/21/25 at 1:26 a.m.,	F 0656	**F656 Develop/Implement Comprehensive Care Plans** **I The corrective actions to be accomplished for those residents found to have been affected by the practice**. Resident D care plans have been revised and updated. **II The facility will identify other residents that may potentially be affected by this practice.** All residents have the potential to be affected by this practice. Current residents with fall intervention care plans will be audited by 02/28/2025 to validate that fall intervention care plans are appropriate and accurate. III> **The facility will put into place the following systemic changes to ensure that the deficient**	03/10/2025

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	indicated the resident was sent to the hospital due to a left hip fracture. The Interdisciplinary Team (IDT) note, dated 2/21/25 at 11:59 a.m., indicated the resident's hipsters were on her dresser. Per the staff, the resident does not like the hipsters and may remove them at times. On 2/26/25, a plan of care was implemented for non-compliance with fall interventions. The resident's plan of care lacked documentation of the resident's non-compliance with the fall intervention until 2/26/25. During an interview, on 2/27/25 at 10:53 a.m., Certified Nursing Aide (CNA) 4 indicated the resident frequently removed her hipsters and clothing and had done that for the past 2 to 3 months. The resident was able to dress and undress herself. During an interview, on 2/27/25 at 2:57 p.m., the Director of Nursing indicated the staff were aware the resident was removing her hipsters, but she was not. The resident was care planned for disrobing. During an interview, on 2/27/25 at 3:42 p.m., the Director of Nursing indicated the facility did not have a policy on care plans but they follow the Resident Assessment Instrument (RAI) manual. This Citation relates to Complaint IN00452723 3.1-35(a)		**practice does not occur.** Licensed nurses and the social service director/staff will be educated by 03/10/2025 on developing and implementing individualized fall intervention care plans. **IV< The facility will monitor the corrective action by implementing the following measures.** Director of nursing or designee will audit 5 residents fall interventions care plans twice a week for 8 weeks, then monthly for 4 months to ensure fall intervention care plans are revised and implemented with appropriate individualized interventions. The results of these audits will be presented to the monthly Quality Assurance/Performance Improvement Committee. The facility will achieve 100% compliance threshold prior to adjusting the frequency of audits. Plan to be updated as indicated. We respectfully request an IDR for this deficiency. Resident's care plan was updated timely during the 5 day follow up period following her fall while she was still out of the building.	