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	07/29/2022

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 a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00378436 and IN00383068. Complaint IN00378436 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00383068 - Substantiated. Federal/State deficiency related to the allegations is cited at F689. Survey dates: July 25, 26, 27, 28, and 29, 2022 Facility number: 000321 Provider number: 155614 AIM number: 100286130 Census Bed Type: SNF: 11 SNF/NF: 124 Total: 135 Census Payor Type: Medicare: 34 Medicaid: 88 Other: 13 Total: 135 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 3, 2022.	F 0000	August 12, 2022 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: MES311 Dear Mrs. Buroker: Please find enclosed the Plan of Correction for the Annual Survey conducted on July 29, 2022. 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 August 12, 2022. 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

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	07/29/2022

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
			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 689 Free of Accident Hazards/Supervision/Devices** **I. The corrective actions to be accomplished for those residents found to have been affected by the practice.** Resident's B, H, and F's fall interventions have been updated	

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	07/29/2022

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
			and put in place to ensure safe transfer procedures and implementation. **II. The facility will identify other residents that may potentially be affected by this practice**. Residents have the potential to be affected by this alleged deficient practice. Current resident's fall interventions have been audited to ensure fall interventions have been updated and are in place. **III. The facility will put into place the following systemic changes to ensure that the practice does not recur.** Nursing staff have been re-educated on fall policy, transfer procedures, and implementing interventions. **IV. The facility will monitor the corrective action by implementing the following measure.** DON/Designee will audit fall interventions to ensure they are in place and monitor transfers at least five (5) times per week for four (4) weeks, then weekly for four (4) weeks, then bi-weekly for (4) weeks, then monthly for 9 months to ensure these are all completed. The results of these	

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	07/29/2022

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
			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 **V. Plan of Correction completion date.** Plan of Completion date is August 12, 2022. **F 690 Bowel/Bladder Incontinence, Catheter, UTI** **1.The corrective actions to be accomplished for those residents found to have been affected by the practice.** Residents 110, 121, and 81 have had proper catheter care completed and suffered no ill effects from this alleged deficient practice.	

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	07/29/2022

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
			1.The facility will identify other residents that may potentially be affected by this practice. Residents residing at Lincoln Hills of New Albany have the potential to be affected by this alleged deficient practice. Residents with a foley catheter have been audited during catheter care to ensure proper catheter care has been provided efficiently. **1.The facility will put into place the following systemic changes to ensure that the practice does not recur.** Nursing staff have been re-educated on proper catheter care. **1.The facility will monitor the corrective action by implementing the following measure.** DON/Designee will complete foley catheter care competencies on 3 random nursing staff members per week for four (4) weeks, then weekly for four (4) weeks, then biweekly for (4) weeks, then monthly 3 additional months to ensure proper foley catheter care	

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	07/29/2022

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
			is completed correctly. 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. **V. Plan of Correction completion date.** Plan of Completion date is August 12, 2022. **F 692 Nutrition/Hydration Status Maintenance** **1.The corrective actions to be accomplished for those residents found to have been affected by the practice.** Residents 120, 77, and 103 physician orders for daily weights have been followed. Resident suffered no ill effects from this alleged deficient practice. **1.The facility will identify other residents that may potentially be affected by this**	

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	07/29/2022

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
			practice. Residents residing at Lincoln Hills of New Albany have the potential to be affected by this alleged deficient practice. Resident's orders have been audited to ensure weights are being obtained per physician's orders. **1.The facility will put into place the following systemic changes to ensure that the practice does not recur.** Licensed nurses, IDT team, and nurse managers were re-educated on physician orders related to scheduling of weights and notifications. **1.The facility will monitor the corrective action by implementing the following measure.** DON/Designee will audit 5 random residents records at least five (5) times per week for four (4) weeks, then weekly for four (4) weeks, then bi-weekly for (4) weeks, then monthly for an additional 3 months to ensure physician orders for weights are being followed. The results of these audits will be presented to the	

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	07/29/2022

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
			monthly Quality Assurance/Performance Improvement Committee. The facility will achieve 100% compliance threshold prior to adjusting the frequency of audits. Care Plan to be updated as indicated. **1.Plan of Correction Completion Date.** Plan of Completion date is August 12, 2022. **F 695 Respiratory/Tracheostomy Care and Suctioning** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** The facility failed to ensure oxygen concentrator filters were applied and maintained. Residents 48 and 112 have had their concentrators checked for proper placement and cleanliness of filters. Neither resident suffered any ill effects from this deficient practice.	

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	07/29/2022

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
			II. The facility will identify other residents that may potentially be affected by the deficient practice. Residents residing at Lincoln Hills of New Albany have the potential to be affected by this deficient practice. An audit of all residents with O2 orders has been completed to ensure all concentrators are clean and filters are placed properly. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** Nursing staff have been re-educated on appropriate placement and cleaning requirements for concentrators. Checking the equipment for placement and cleanliness has been added to care sheets. **IV. The facility will monitor the corrective action by implementing the following measures.** Director of nursing or designee will audit 5 residents with O2 orders to ensure oxygen concentrator filters are applied and clean per week for	

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	07/29/2022

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
			four weeks and continue weekly for no less than two additional months to ensure behavioral care plans and interventions are in place. 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. Care Plan to be updated as indicated. **V. Plan of Correction completion date.** Plan of Completion date is August 12, 2022. **F 740 Behavioral Health Services** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** The facility failed to ensure appropriate care planning and interventions were in place for a resident with a history of resident to resident aggression. Resident	

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	07/29/2022

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
			84's care plan has been updated with appropriate interventions in place. Psychosocial support provided with no changes in mood or behavior noted. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** Residents residing at Lincoln Hills of New Albany have the potential to be affected by this deficient practice. An audit of all residents has been completed with care plans and interventions updated as needed. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** IDT will review behavioral events during morning meeting and review care plans and intervention to ensure compliance. Staff have been re-educated regarding behavioral management and care plan interventions. **IV. The facility will monitor the corrective action by implementing the following measures.**	

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	07/29/2022

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
			Director of nursing or designee will audit 5 residents with behaviors per week for four weeks and continue weekly for no less than two additional months to ensure behavioral care plans and interventions are in place. 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. Care Plan to be updated as indicated. **V. Plan of Correction completion date.** Plan of Completion date is August 12, 2022.	
F 0689 SS=G 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 §483.25(d)(2)Each resident receives adequate supervision and assistance devices			

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	07/29/2022

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
	to prevent accidents. Based on observation, record review, and interview the facility failed to ensure interventions were implemented for falls and to ensure safe transfer procedures were implemented for a resident that required maximum assistance which resulted in bilateral knee fractures (Resident B) for 3 of 5 residents reviewed for accident hazards. (Residents B, H, and F) Findings include: 1. The clinical record for Resident B was reviewed on 7/26/22 at 9:30 a.m. The diagnoses included, but were not limited to, end stage renal disease, diabetes mellitus, fracture of shaft of left fibula, nondisplaced supracondylar fracture without intracondylar extension of lower end of right femur, edema, renal osteodystrophy, specified disorders of bone density and structure, pain, heart failure, muscle weakness, renal dialysis, and anemia. The current care plan, dated 1/10/22 and last revised on 7/26/22, indicated the resident was unable to independently perform ADL's (activities of daily living) related to ESRD (End Stage Renal Disease) on dialysis, blindness, incontinence, anxiety, pain, weakness, impaired vision and required assistance and encouragement for bed mobility, transfers, toileting and eating. The interventions included, but were not limited to, with a start date of 1/10/22 staff were to provide assistance with transfers (use assistive device) Hoyer lift with two staffs' assistance and follow PT/OT (Physical Therapy and Occupational therapy) recommendations. There was no stop date from the original start date of 1/10/22 related to the resident's use of a Hoyer	F 0689	**F 689 Free of Accident Hazards/Supervision/Devices** **I. The corrective actions to be accomplished for those residents found to have been affected by the practice.** Resident's B, H, and F's fall interventions have been updated and put in place to ensure safe transfer procedures and implementation. **II. The facility will identify other residents that may potentially be affected by this practice**. Residents have the potential to be affected by this alleged deficient practice. Current resident's fall interventions have been audited to ensure fall interventions have been updated and are in place. **III. The facility will put into place the following systemic changes to ensure that the practice does not recur.** Nursing staff have been re-educated on fall policy, transfer procedures, and implementing interventions. **IV. The facility will monitor the corrective action by implementing the following measure.**	08/12/2022

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	07/29/2022

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
	lift for transfers by staff. The nurse's note, dated 3/2/22 at 11:38 a.m., indicated the resident required the assistance of two staff members with ADL's and transfers via Hoyer lift. The Quarterly MDS assessment, dated 4/26/22, indicated the resident required total dependence of two staff members for transfers. The activity of the resident to be able to move from seated to standing position did not occur. The resident walking with an assistive devise did not occur. Transfer between surfaces including to or from bed, chair, wheelchair total dependence full staff. The resident had lower extremity impairment on both sides. The Quarterly MDS assessment, dated 6/14/22, indicated the resident required total dependence of two staff members for transfers. The activity of the resident to be able to move from seated to standing position did not occur. The resident walking with an assistive devise did not occur. Transfer between surfaces including to or from bed, chair, wheelchair total dependence full staff. The resident had lower extremity impairment on both sides. The resident was cognitively intact. The nurse's notes, dated 6/14/22 at 3:00 p.m., indicated Resident B was up in his wheelchair. The nurse and CNA (Certified Nursing Aide) were attempting to transfer the resident back to bed. The nurse lost her footing and fell with the resident falling on top of the nurse. The resident complained of pain to his knees after staff assisted the resident to bed. Pain medication was administered and effective with the resident's pain. An order for X-rays of the resident's bilateral knees was ordered. The nurse would continue to		DON/Designee will audit fall interventions to ensure they are in place and monitor transfers at least five (5) times per week for four (4) weeks, then weekly for four (4) weeks, then bi-weekly for (4) weeks, then monthly for 9 months to ensure these are all completed. 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 **V. Plan of Correction completion date.** Plan of Completion date is August 12, 2022.	

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	07/29/2022

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
	monitor. The Event Report, dated 6/14/22 at 3:00 p.m., indicated the resident had a witnessed fall. The resident was being transferred by the nursing staff from the wheelchair to the bed by 2 staff members. One staff member tripped over an obstacle and lost her footing. The staff member fell and the resident fell on top of the staff member. A period of time after the fall the resident complained of pain and the resident's knees were swollen. The report indicated no assistive devices were used at the time of the fall. The nurse's note, dated 6/15/22 at 3:24 p.m., indicated the resident attended dialysis, and then he was transferred to the hospital per physician's order for increased swelling and pain in his left knee. The CT (computed tomography) scan, dated 6/15/22, indicated the resident had a nondisplaced fracture of the left fibular head. Additional fractures were not seen, but could be a difficulty due to osteopenia. There were no displaced fracture. The right extremity had a minimally displaced, minimally impacted fracture along the posterior and lateral distal familiar metaphysis. This correlated for underlying etiologies given the patient's age. Renal osteodystrophy were most likely. The physician's order, dated 6/24/22, indicated staff were to apply the ACE wrap to LLE (left lower extremity) until further notice (Please wrap from foot up to over knee) twice a day, the resident could be up as tolerated, knee immobilizer to the right leg until further notice (Check skin daily underneath immobilizer) twice a day.			

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	07/29/2022

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
	During an interview on 7/27/22 at 1:03 p.m., Resident B indicated his fall was an accident. He was on oxygen at the time and when the nurses picked him up, the nurse got tangled in his 02 tubing and his knees hit directly on the floor. He was grateful he did not hit his head. He was afraid the nurse was hurt also. He ended up with knee fractures, but they were healing up. He did use a Hoyer lift when he was assisted into his wheelchair for dialysis. During an interview on 7/28/22 at 1:00 p.m., RN 8 indicated a nurse and a CNA were transferring the resident to his wheelchair and the nurse tripped over a cord. The nurse fell and the resident fell with her. He received fractures to his knees. He had an immobilizer on one leg and an ace wrap on the other leg. She indicated gait belts should be used for the residents and employee safety. She felt like more education was needed to be provided to make employees aware of the clutter on the floors like oxygen tubing. After the accident the resident only got up with the Hoyer lift. He could not bear weight on his legs. During an interview on 7/28/22 at 2:08 p.m., the Physical Therapy Supervisor indicated therapy was working with the resident on using a slide board for transfers from the bed to the wheelchair before the accident. When the resident was admitted to the facility, he was completely immobile. He was able to use the slide board. When physical therapy worked with a resident, they always used a gait belt. They do not pass out gait belts to every resident because they always ended up lost. Several residents came from the hospital with gait belts and those were used. When transferring a resident it was safer for the resident when the gait belts were used.			

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	07/29/2022

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
	During an interview on 7/29/22 at 9:41 a.m., the DON indicated a nurse and a CNA were transferring the resident from the wheelchair to the bed. The nurse tripped over a cord and fell. The resident fell on top of the nurse hitting his knees on the floor. He sustained bilateral knee fractures. He required the assistance of two staff lift with a gait belt and could use a slide board for transfers. Some days he would use the Hoyer lift if he felt weak. After the accident the resident was a complete Hoyer lift for transfers. The resident was unable to stand and used a wheelchair for mobility. "The staff did not use the slide board or Hoyer lift on the day the accident occurred." or he "Fell off the slide board when the nurse lost her footing." During an interview on 7/29/22 at 1:10 p.m., CNA 9 indicated she was one of the CNA's that helped the nurse transfer the resident. He required the assistance of two staff for transfers. He sat on the side of the bed, and they lifted the resident from underneath his arms with their arms. When they got the resident up his knees buckled and he fell. They did not use a gait bed or Hoyer lift to assist with transferring the resident. 2. The clinical record for Resident H was reviewed on 7/27/22 at 10:00 a.m. The diagnoses included, but were not limited to, spinal stenosis of cervical region, dementia with behavioral disturbance, orthostatic hypotension, dysarthria and anarthria, unsteadiness on feet, low vision of left eye, attention and concentration deficit following cerebral infarction, other seizures, and muscle weakness The care plan, dated 7/24/19 and last revised 7/8/22, indicated the resident was at risk for falling and fall related injuries related to Cervical 6 and 7			

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	07/29/2022

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
	moderate canal stenosis with a history of falls, impaired mobility, impaired cognition with poor safety awareness, and use of anti-depressant medication. The interventions included, but were not limited to, anti-slip strips to be added to bedside to minimize the risk of slips when arising from bed (dated 7/20/22), bolster mattress to bed (dated 7/8/22), anti-rollbacks to wheelchair (dated 7/1/22), replace crocs with tennis shoes (dated 6/3/22), nursing staff to provide hourly checks to ensure safety (dated 6/1/22), psychiatric NP (Nurse Practitioner) to review medications to see if they were contributing to falls (dated 6/1/22), resident to be a third shift get up, staff to assist with toileting and ADLs (dated 5/25/22), footboard to be fixed and secured to bed (dated 5/25/22), staff to offer stand-by assist while ambulating, as resident will allow (dated 4/23/22), NP to review medications (dated 4/23/22), ensure proper footwear is in place while resident is up during the day (dated 4/12/22), ensure resident is wearing non slip socks while abed (dated 2/27/22), place sign on resident's walker to remind her to use her walker (dated 7/12/21), educate staff to remind resident to use walker while up ambulating (dated 6/2/21), non-skid socks in place at all times when out of bed (dated 6/2/21), cue and remind the resident to utilize the call light to seek assistance as needed (dated 7/24/20). During an observation, on 7/27/22 at 10:17 a.m., Resident H was resting in bed. There were no non-skid strips observed in her room, and there was no sign observed in the room to remind the resident to use her walker. During an observation on 7/28/22 at 8:33 a.m., The resident was lying in bed, she had one shoe on her right foot and only a sock on the left foot. Her other shoe was not in sight. There were no			

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	07/29/2022

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
	non-skid strips in the room and no sign could be located on her walker or in the room to remind the resident to use her walker. During an observation, on 7/29/22 at 9:32 a.m., The resident was lying in bed with no non-skid strips on the floor or any signs observed in the room. The nurse's note, dated 2/26/22 at 6:25 p.m., indicated at 4:10 p.m. the resident was ambulating without her walker. Staff observed her to reach down to pick up something and then fall to the floor on her left side. The IDT (Interdisciplinary Team) follow-up, dated 2/27/22 at 4:38 p.m., indicated a new intervention was added for staff to remind the resident to use her walker was put into place. The nurse's note, dated 4/11/22 at 9:46 p.m., indicated a QMA (Qualified Medication Aide) found the resident lying on the floor next to her bed. She was not using her walker and was walking over to her dresser and fell. The IDT follow up, dated 4/12/22 at 8:44 a.m., indicated the resident did not have proper footwear on and the intervention would be for staff to ensure the resident had on non-slip socks while abed and to ensure resident had good fitting shoes in place while up during the day. The nurse's note, dated 4/23/22 at 3:31 a.m., indicated the resident was found lying prone in the hall way outside her room door. The IDT follow-up dated 4/23/22 at 9:48 p.m., indicated it was unclear what the resident was doing up as it was the middle of the night.			

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	07/29/2022

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
	Therapy would evaluate the resident due to the increase in the number of falls recently and the NP would be made aware and asked to review the resident's medications. The nurse's note, dated 4/30/22 at 2:20 p.m., indicated the resident was observed ambulating in the unit, towards the dining room, without her walker as an assistive device. The on duty nurse began to walk towards the resident to provide assistance, at that time the resident began to back up to dining room chair and attempted to sit back in a chair. The resident missed the seat of the dining room chair, which caused her to stumble to the left and the resident was observed to very slowly fall to the dining room floor and land onto her left side. The IDT follow-up dated 5/1/22 at 9:17 p.m., indicated the intervention was for the resident to have an MRI (magnetic resonance imaging) of her head. The nurse's note, dated 5/22/22 at 7:00 p.m., indicated at 4:30 p.m., the nurse was walking down the H Hallway and heard a screeching like sound from the resident's room. The nurse approached the room and observed the resident sitting on the top of the footboard of the bed. As the nurse was entering the resident's room, the footboard appeared to break on one side, causing one side of the footboard to fall to the floor. This caused the resident to fall to her left side, and land on the floor next to the bed. The nurse's note, dated 5/22/22 at 7:00 p.m. indicated at 5:45 p.m., indicated the nurse heard yelling from the resident's room and entered to observe the resident sitting in the floor next to her bed in front of the bedside chair she was			

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	07/29/2022

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
	previously sitting in. The bedside table was observed to be laying on the floor, at resident's feet. A styrofoam cup of water was observed to be spilled onto the floor. The IDT follow-up dated 5/25/22 at 11:45 a.m., indicated the intervention was for the resident's footboard to be fixed and secured. The IDT follow-up dated 5/25/22 at 11:58 a.m., indicated the new intervention was for therapy to give the resident a wheelchair with anti-rollback device on it and therapy was to focus on improving her balance. The nurse's note, dated 5/30/22 at 5:00 p.m., indicated at 3:50 p.m. the resident attempted to transfer herself from an unlocked wheelchair. The nurse was unable to reach the resident before she lost her balance during an attempted self-transfer and slid off the seat onto the floor. The IDT follow-up dated 6/1/22 at 11:44 a.m., indicated the resident had been found on 5/29/22 in another room. She was up ambulating without her walker and went into another room and fell in front of the bathroom with her brief around her calves. The new intervention would be for the resident to be a 3rd shift get up between 5:30 a.m. and 6:00 a.m. Staff were to toilet and get the resident ready for the day and offer to lay her down on top of the covers if she wanted to sleep a little longer. The nurse's note, dated 6/2/22 at 7:33 p.m., indicated the resident had a witnessed fall in the hallway when her right leg twisted causing her to fall to the floor. The IDT follow-up, dated 6/3/22 at 8:46 a.m.,			

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	07/29/2022

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
	indicated the psychiatric NP had just changed resident's medication order 2 days ago due to recent increase in falls. The resident was ambulating in the hallway without an assistive device. The resident did not remember to use it or her wheelchair even though there were reminder notes posted in her room and on the devices. The new intervention would be for staff to provide hourly safety checks on resident. The nurse's note, dated 6/29/22 at 5:12 p.m., indicated the resident had an unwitnessed fall. She was found in the activities room lying on the floor. The IDT follow-up, dated 7/1/22 at 11:07 a.m., indicated the resident was attending an activity in the activity room with an activities assistant. The activities assistant got up and walked across the hall into the dining room and told the resident to follow her. The resident stood up from the wheelchair to begin to attempt to walk, but fell to the floor. The resident only had on one shoe which was a croc. The new intervention would be for activities staff to assist residents in their wheelchairs when moving about the unit and the resident to wear well-fitting shoes when up. The nurse's note, dated 7/7/22 at 6:30 p.m., indicated the resident had an unwitnessed fall at 9:30 a.m. with no injury. She had landed on her bottom. The IDT follow-up, dated 7/8/22 at 10:28 a.m., indicated the resident had a fall in her room. The nurse manager reported she was ambulating in her room and looking out the window and was educated about the need to use wheelchair for safety. The resident refused to use a wheelchair initially but eventually sat in the wheelchair. Staff			

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	07/29/2022

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
	walked away and re-checked a few moments later, and the resident was on the floor in front of her wheelchair. The resident had cognitive impairment, but was wearing appropriate shoes and fully dressed. The intervention discussed, was to ensure with the therapy department that anti-rollback devices were placed on the wheelchair. The nurse's note, dated 7/19/22 at 8:54 p.m., indicated the staff were called to the room and the resident was observed lying on the floor by her bed. She indicated she'd hit her head, but was unable to explain what she was doing prior to the fall. The IDT follow-up, dated 7/20/22 at 11:42 a.m., indicated the resident was found on the floor lying on her right side and was unable to report how the fall occurred. She had non-skid socks on and was toileted after the assessment was completed. The interventions added, was for the resident to have a bolster mattress to assist the resident with bed parameters while resting, in addition the resident would have anti-slip strips placed on the floor of the open side of the bed to decrease risk of slips when resident arises. During an interview, on 7/29/22 at 10:47 a.m., LPN (Licensed Practical Nurse) 11 indicated the resident had several interventions, including anti slip strips to her bedside, hourly checks, non-slip socks while abed, a sign on her walker to remind usage, educate staff to remind the resident to use a walker. She did not see any non-skid strips in the resident's room. She normally did have a sign, but she did not currently see a sign to remind her to use her walker. Non-skid strips should be applied the same day it is made as an intervention.			

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	07/29/2022

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
	During an interview on 7/29/22 at 12:40 p.m., the DON typically non-slip strips were placed pretty quickly. They communicated it with maintenance to put them down and they should be in place in less than 24 hours. 3. The clinical record for Resident F was reviewed on 7/28/22 at 9:00 a.m. The diagnoses included, but were not limited to, epilepsy not intractable with status epilepticus, mood disorder, conversion disorder with seizures or convulsions, dementia, repeated falls, history of shoulder fracture, and a history of clavicle fracture. The care plan, dated 3/1/21 and last revised 7/26/22, indicated the resident was at risk for falling and fall related injuries related to impaired cognition, poor safety awareness, seizures, unsteady gait, and use of anti-psychotic medication. The interventions included, but were not limited to, bed in lowest position and encourage to get assistance with transfers (5/31/22), change in medication administration time of anti-seizure medication (3/31/22), bolster mattress to bed (3/18/22), staff to do hourly checks for safety due to seizures being cause of falls (2/14/22), bed placed against wall (1/17/22), light added to provide visibility during toileting (12/2/21), assist with ADL's as needed to meet needs, assist with transfers as needed, cue and remind resident to utilize call light to seek assistance as needed, keep personal items and frequently used items within reach, and report any noted functional changes (3/1/21). The physician's orders included, but were not limited to the following: -Levetiracetam tablet 750 mg 1 tablet every 12 hours at 7:00 a.m. and 7:00 p.m. Special			

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	07/29/2022

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
	instructions: time specific to maintain level of medication in system to attempt to prevent or decrease seizure activity. Medication should be administered as close to 5:00 a.m. as possible to keep the every 12 hour requirement, with a start date of 4/12/22. -Resident to be on 15 minute checks due to mental change every shift, which started on 7/8/22. The nurse's note, dated 12/2/21 at 2:48 a.m. indicated the resident's call light was on and she was observed sitting on the floor with no injuries. Staff would increase rounding to ensure safety. The IDT follow-up note, dated 12/2/21 at 9:52 a.m., indicated the resident's fall may have been due to low lighting and additional lighting would be added for better visibility. The nurse's note, dated 12/21/21 at 4:21 a.m., indicated the resident was found lying on her left side across the bed with her right leg up in the air. Her upper and lower extremities had small jerking movements, bilateral eyes blinking, mouth smacking, and the resident's bed and gown were soaked. The resident had a seizure that lasted off and on about 30 minutes. The MD ordered to do a CBC (complete blood count), BMP (basic metabolic panel), Keppra level, and urinalysis. The nurse's note, dated 12/21/21 at 5:28 p.m., indicated the resident was heard yelling out for help but it was muffled in sound. She was in the prone position between the bed and the wall, unable to get up or move. She had a small 1 cm (centimeter) cut with very little blood noted. The second injury was to the right cheek bone. Both areas were reddened in color and swollen. The resident was inconsolable at the time and was			

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	07/29/2022

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
	sent to the hospital. The nurse's note, dated 12/24/21 at 1:00 p.m., indicated the resident had a 3 night stay at the hospital and had a UTI (urinary tract infection) which she was receiving an antibiotic for. She had a close displaced fracture of the acromial end of her right clavicle. The nurse's note, dated 1/15/22 at 6:35 p.m., indicated at 7:30 a.m. the nurse entered the resident's room to observe her lying face down on the floor, next to her bed. She was not answering questions appropriately. The right side of her face observed to be twitching and quivering. The physician was notified with orders to send the resident to the hospital. The IDT follow-up, dated 1/17/22 at 8:04 p.m., indicated the resident had a recent new diagnosis of seizures and in the past had falls due to seizures. Her bed would be placed against the wall, and staff were to ensure bed was in lowest position to floor. The nurse's note, dated 2/13/22 at 6:18 a.m., indicated the resident was found on floor face down in the prone position. The patient had a change of her normal level of consciousness. She was unable to communicate and was sent to the hospital. The nurse's note, dated 2/13/22 at 1:51 p.m., indicated the resident returned to the facility and checks resumed per facility protocol. The nurse's note, dated 2/13/22 at 6:26 p.m., indicated at 4:10 p.m., the nurse was called to the room by the on duty CNA. The resident was found lying on the floor, on her right side, outside			

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	07/29/2022

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
	of the bathroom. She had slurred speech and garbled speech, and was not able to verbalize answers to questions at the time of fall. Her right eye and right side of mouth were observed to be involuntarily twitching. She was not able to follow commands and was moaning and yelling out. She was sent to the hospital. The IDT follow-up notes dated 2/14/22 at 3:18 p.m. and 3:24 p.m., indicated the new intervention would be to do hourly checks on the resident for her safety. The nurse's note, dated 2/14/22 at 10:40 p.m., indicated the resident fell and hit her head with loss of consciousness very briefly. She was sent out to the hospital. The nurse's note, dated 3/31/22 at 5:57 a.m., indicated at 5:53 a.m., the CNA heard a noise and entered the resident's room. She found the resident sitting upright with her back up against the bed. She had a very small non bleeding abrasion right forearm and right side. The CNA stayed with the resident until the next shift arrived due to history of seizures. The MD was notified with orders to monitor abrasion and for seizure activity. The IDT follow-up, dated 3/31/22 at 4:10 p.m., indicated the resident fell and was sent out the hospital. Staff did not witness any seizure activity and the fall was unwitnessed. She arrived back without any new orders. The resident was given Keppra at the hospital as she had not yet received her morning dose. As needed Ativan was ordered for seizures. The IDT follow-up, dated 3/31/22 at 4:20 p.m., indicated the resident had a fall around 5:30 a.m.			

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	07/29/2022

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
	The new intervention would be for the administration times of her Keppra to be given earlier. The nurse's note, dated 4/12/22 at 4:25 p.m., indicated the order was clarified for times of administration of the resident's Keppra to be given specifically at 5:00 a.m. and 5:00 p.m. The clinical record lacked documentation of the administration times being updated to 5:00 a.m. and 5:00 p.m. as ordered. The nurse's note, dated 5/29/22 at 2:37 a.m., indicated the nurse heard a loud thud and found the resident on the floor crying out with a skin tear on her elbow. The resident was sent out to the hospital for evaluation. The nurse's note, dated 5/29/22 at 9:08 a.m., indicated the resident returned to the facility at 7:35 a.m. with no new orders. The nurse's note, dated 7/4/22 at 9:00 a.m., indicated the resident had an unwitnessed fall and was unable to follow commands and non-verbal, appeared to have hit her head. She was sent to the hospital for evaluation. The nurse's note, dated 7/4/22 at 5:25 p.m., indicated the resident was transported back to the facility by her family member. All workup was negative. The IDT follow-up, dated 7/5/22 at 12:43 p.m., indicated the resident was known to have falls related to seizure activity. She had been seen by multiple neurologists. She had increased confusion 1 to 2 days prior to seizures and was observed to "not be herself". Nursing would			

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	07/29/2022

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
	monitor for these changes and place appropriate interventions at that time. The nurse's note, dated 7/8/22 at 3:15 p.m., indicated the resident was awake throughout the night, had increased anxiety and agitation, along with audible and visible hallucinations. The NP was notified with new orders provided included lorazepam 2 mg/ml (milligrams per milliliter), 1 mL IM (intramuscularly) related to increased anxiety and agitation. Every 15 minute checks were initiated per DON instruction. During a continuous observation on 7/28/22 from 8:40 a.m. to 9:31 a.m., the following observations of Resident F were made: - At 8:40 a.m., the resident was in her room, with the room door was closed. Staff could not observe the resident from the hallway as they were walking by. - At 8:54 a.m. CNA 12 entered the resident's room, picked up her tray, and exited the room, closing the door behind her. - The resident was not checked on again by staff until 9:31 a.m. when 2 CNAs entered the resident's room. During a continuous observation on 7/28/22 from 10:14 a.m., to 10:38 a.m., no staff were observed to physically check on the resident. Her curtain was pulled, and she was not able to be observed from the hallway. During a continuous observation, on 7/28/22 at 1:05 p.m., the resident was in her room, in bed, with the curtain pulled and was not visible from the hall. At 1:28 p.m. 2 CNAs entered the resident's room and exited one minute later pulling the door nearly closed with a 1 inch gap. Both			

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	07/29/2022

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
	CNAs re-entered the room at 1:30 p.m., and exited at 1:34 p.m. carrying trash, and closed the door behind them. No staff observed or checked on the resident until 1:51 p.m. when the resident came out into the hallway. During an interview, on 7/28/22 at 1:27 p.m., CNA 12 indicated she was caring for the resident. She checked each resident every 2 hours and was not aware of any residents who required more frequent monitoring. She was not aware of the resident having any history of seizures. During an interview, on 7/28/22 at 1:18 p.m., CNA 13 indicated most of the residents were to be checked on every 2 hours. She was not aware of any residents who required more frequent checks for safety. During a continuous observation, on 7/29/22 at 9:30 a.m., the resident was lying in bed with her curtain pulled and was not visible from the hallway. No staff were observed to check on the resident until 9:50 a.m. when a housekeeper entered the room to clean. Staff did not check on the resident again, until 10:29 a.m. when CNA 12 entered the room. During an interview, on 7/29/22 at 10:36 a.m., CNA 14 indicated she did not have any residents who had frequent checks. During an interview, on 7/29/22 at 10:40 a.m., LPN 11 indicated the resident had 15 minute checks in place for seizure activity. She did not maintain a log of the checks. During an interview, on 7/29/22 at 12:36 p.m., the DON indicated they did not have sheets for the 15 minute checks. She expected that the nurse or a			

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	07/29/2022

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
	staff member checked on the resident every 15 minutes. She would expect them to be going and physically checking on the resident and visualizing them. She thought the resident's Keppra was changed to be given earlier. The Fall Prevention Policy and Procedure, dated 5/2016, provided on 1/29/22 at 10:37 a.m. by the CS (Clinical Support), included, but was not limited to, "... Step Three: Strategies of Intervention... Strategies for interventions to prevent falls will be individual for each patient... Care Planning... Care plans are a vital part of the nursing process and serve as individualized pathway used by all caregivers... Fall risk care plans will be kept current by the IDT and other associates within each community. Individualized interventions on the fall care plan will be duplicated onto care sheets to ensure care plan strategies are integrated into the health system..." This tag relates to Complaint IN00383068 3.1-45(a)(1)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without			

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	07/29/2022

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
	an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on observation, record review, and interview, the facility failed to ensure proper catheter care and monitoring of the indwelling urinary catheter bag for 3 of 4 residents reviewed for indwelling urinary catheters. (Residents 110, 121 and 81) Findings include: 1. During an observation on 7/26/22 at 9:00 a.m., Resident 110's indwelling urinary catheter bag was lying flat on the floor, under the bedside table support bar. During an observation on 7/28/22 at 1:27 p.m., CNAs (Certified Nurse Aides) 3 and 4 were performing perineal and catheter care for Resident 110. The indwelling urinary catheter bag was in a	F 0690	**F 690 Bowel/Bladder Incontinence, Catheter, UTI** **1.The corrective actions to be accomplished for those residents found to have been affected by the practice.** Residents 110, 121, and 81 have had proper catheter care completed and suffered no ill effects from this alleged deficient practice. **1.The facility will identify other residents that may**	08/12/2022

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	07/29/2022

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
	pouch, hung under the wheelchair and resting on the floor. As the resident was pushed next to the bed, the pouch was dragging on the floor. CNA 3 filled a basin with multiple washcloths and warm water. He had not added soap onto the washcloths. CNA 4 applied soap from the bathroom onto one washcloth. CNA 3 washed the crease, to the right of the penis, with the wet washcloth. He obtained another wet washcloth without soap and with 2 swipes of the same area of the washcloth he cleaned the left crease. He obtained another wet washcloth without soap and cleaned the scrotum with 3 swipes of the same area of the washcloth. He obtained a wet washcloth and cleaned down the tubing 2 inches without holding the tubing. The penis was not cleaned. The resident was rolled onto his right side and the rectum was cleaned with a wet washcloth with no soap. Another wet washcloth was used on the rectum. The resident was not dried and the clean brief was applied. The urine was drained from the catheter bag, which was half full of orange urine. The clinical record for Resident 110 was reviewed on 7/26/22 at 1:30 p.m. The diagnoses included, but were not limited to, dysuria, abnormal findings in urine, and benign prostatic hyperplasia with lower urinary tract symptoms. The 5 Day MDS (Minimum Data Set) assessment, dated 7/7/22, indicated the resident was moderately cognitively impaired. The care plan, dated 7/20/22 and last revised on 7/21/22, indicated the resident had a urinary tract infection. The interventions, dated 7/20/22, indicated to assist with incontinence care, encourage fluids, and to report continued or worsening symptoms of UTI (urinary tract		**potentially be affected by this practice.** Residents residing at Lincoln Hills of New Albany have the potential to be affected by this alleged deficient practice. Residents with a foley catheter have been audited during catheter care to ensure proper catheter care has been provided efficiently. **1.The facility will put into place the following systemic changes to ensure that the practice does not recur.** Nursing staff have been re-educated on proper catheter care. **1.The facility will monitor the corrective action by implementing the following measure.** DON/Designee will complete foley catheter care competencies on 3 random nursing staff members per week for four (4) weeks, then weekly for four (4) weeks, then biweekly for (4) weeks, then monthly 3 additional months to ensure proper foley catheter care is completed correctly. The results of these audits will be presented to the monthly Quality Assurance/Performance	

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	07/29/2022

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
	infection). The care plan, dated 7/5/22 and last revised on 7/7/22, indicated the resident had an indwelling urinary catheter related to urinary retention. The interventions, dated 7/7/22, indicated to avoid tugging of the catheter during transfers and care delivery, catheter care every shift and as needed, do not allow the tubing or any part of the drainage system to touch the floor, and to keep the catheter bag below the level of the bladder. The physician's order, dated 7/20/22, indicated to administer ciprofloxacin hydrochloride tablet, 500 mg (milligrams) twice a day upon rising and before bedtime. The medication was to be discontinued on 7/25/22. The nurse's note, dated 7/16/22 at 11:55 p.m., indicated the resident's foley was patent with dark yellow urine. The physician's note, dated 7/17/22 at 4:25 p.m., indicated the resident had a foley with blood in the urine. The urinalysis indicated blood was in the urine, would send urine culture. The nurse's note, dated 7/20/22 at 8:23 a.m., indicated the resident had complaints of urinary catheter pain. The perineal catheter area was red, inflamed, and irritated. The urine was a concentrated amber red color. A urinalysis was obtained and an antibiotic was ordered. The urinalysis culture note, dated 7/21/22 at 10:39 a.m., indicated greater than 100,000 pseudomonas aeruginosa. There was 3 plus blood, 2 plus protein, and 3 plus leukocytes. During an interview on 7/28/22 at 1:53 p.m., CNA 3		Improvement Committee. The facility will achieve 100% compliance threshold prior to adjusting the frequency of audits. Plan to be updated as indicated. **V. Plan of Correction completion date.** Plan of Completion date is August 12, 2022.	

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	07/29/2022

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
	indicated during catheter perineal care, he would clean the inner thighs, then clean the catheter tubing 2 inches downward. He would then clean the resident's backside, front to back, and apply a clean brief. He should dry the resident after wiping and he had not dried the resident during care. 2. During an observation on 7/26/22 at 8:35 a.m., Resident 121's indwelling urinary catheter was folded in half on the floor, with the bed in low position. The catheter bag was one quarter full of yellow urine. The clinical record for Resident 121 was reviewed on 7/26/22 at 2:15 p.m. The diagnoses included, but were not limited to, disorders of electrolyte and fluid balance, benign prostatic hyperplasia without lower urinary tract symptoms, anemia, and malignant neoplasm of the prostate. The Quarterly MDS assessment, dated 7/20/22, indicated the resident was cognitively intact. The care plan, dated 7/12/22 and last revised on 7/12/22, indicated the resident had an indwelling urinary catheter related to a sacral wound. The interventions, dated 7/12/22, indicated to avoid tugging of the catheter during transfers and care delivery, catheter care every shift and as needed, do not allow the tubing or any part of the drainage system to touch the floor and keep the catheter bag below the level of the bladder. The nurse's note, dated 7/7/22 at 8:07 a.m., indicated the resident was diaphoretic and unable to answer questions. His axillary temperature was 99.6 degrees. The nurse's note, dated 7/7/22 at 9:35 a.m.,			

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	07/29/2022

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
	indicated the resident was assessed to be sent to a local hospital emergency room. The nurse's note, dated 7/7/22 at 12:58 p.m., indicated the resident had been admitted to a local hospital for sepsis and a UTI. The nurse's note, dated 7/10/22 at 5:44 p.m., indicated the resident returned to the facility with orders for ceftazidime every 8 hours by IV (intravenous) picc line in the right upper extremity. The physician's order, dated 7/11/22, indicated to flush the foley catheter with 10 mL (milliliters) of normal saline once per day on the 6:00 p.m. to 6:00 a.m. shift. The physician's order, dated 7/11/22, indicated to perform urinary catheter care every shift for both day and night. The physician's order, dated 7/11/22, indicated to administer ceftazidime in D5W (dextrose 5 percent in water) piggyback, 2 grams/50 mL intravenously, 3 times daily. The discontinuation date was 07/18/2022. The nurse's note, dated 7/21/22 at 2:02 a.m., indicated the foley catheter was patent to the bedside drain with amber urine. The urinalysis, dated 7/26/22, indicated greater than 100,000 CFU (colony forming units)/mL pseudomonas aeruginosa. The urine had 3 plus leukocytes, 21 to 50 red blood cells, greater than 50 white blood cells. During an interview on 7/29/22 at 10:55 a.m., LPN (Licensed Practical Nurse) 5 indicated the resident was sent to the hospital due to sepsis from a UTI.			

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	07/29/2022

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
	It came on suddenly. 3. During an observation on 7/29/22 10:30 a.m., Resident 81's catheter bag was lying on the floor slightly under the recliner footrest. The catheter was half full of yellow urine. The clinical record for Resident 81 was reviewed on 7/29/22 at 11:20 a.m. The diagnosis included, but was not limited to, retention of urine. The 5 Day MDS assessment, dated 6/20/22, indicated the resident was moderately cognitively impaired. The care plan, dated 7/28/22 and last revised on 7/28/22, indicated the resident had an indwelling urinary catheter, urologist to assess use on 8/3/22. The interventions dated 7/28/22 indicated to avoid tugging of catheter during transfers and care delivery, catheter care every shift and as needed, do not allow tubing or any part of the drainage system to touch the floor, keep catheter bag below level of the bladder. The physician's order, dated 6/17/22, indicated urinary catheter care every shift. The order was discontinued on 6/24/22. The physician's order, dated 6/29/22, indicated to flush the foley catheter with 10 mL of normal saline once per day. The nurse's note, dated 7/26/22 at 4:27 p.m., indicated the resident's urine was cloudy and concentrated with sediment, which clogged the catheter tube and she had to flush the tubing. During an interview on 7/29/22 at 12:24 p.m., the DON (Director of Nursing) indicated the catheter			

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	07/29/2022

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
	bags should not be on the floor. If they were, there was the potential of an infection or contamination to occur. During catheter or perineal care, the foreskin should be pulled back, even if a shower had been conducted that day. They should use soap on the washcloth and dry the area cleaned. The tubing should be cleaned with the washcloth from the resident down the tubing. She would have to check the policy for the distance down the tubing. The current Bed Bath/Perineal Care policy was provided on 7/29/22 at 12:46 p.m. by the Regional Clinical Support. The policy included, but was not limited to, "... Perineal Care... 21. Wet and soap folded washcloth. Catheter Care: 22. If resident has catheter, check for leakage, secretions or irritation. Gently wipe four inches of catheter from meatus out... For Males: A. Pull back foreskin if male is uncircumcised. Wash and rinse the tip of penis using circular motion beginning with urethra. B. Continue washing down the penis to the scrotum and inner thighs. Rinse off soap and dry... 25. Gently pat area dry with towel in same direction as when washing..." 3.1-41(a)(2)			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as			

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	07/29/2022

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
	usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on record review and interview, the facility failed to follow the physician order for notification and ensure daily weights were obtained for 3 of 5 residents reviewed for nutrition/hydration. (Residents 120, 77, and 103) Findings include: 1. During an interview on 7/26/22 at 10:57 a.m., Resident 120 indicated she was concerned with her weight gain as she thought she had gained 10 pounds in one day. The clinical record for Resident 120 was reviewed on 7/26/22 at 11:00 a.m. The diagnoses included, but were not limited to, hyperkalemia, hypokalemia, fluid overload, congestive heart failure (CHF), and chronic kidney disease stage 4 (severe). The Significant Change MDS (Minimum Data Set) assessment, dated 6/28/22, indicated the resident was alert and oriented and cognitively intact. The physician's orders indicated the following: - daily weights related to CHF: notify NP/MD (Nurse Practitioner/Medical Doctor) if weight gain	F 0692	**F 692 Nutrition/Hydration Status Maintenance** **1.The corrective actions to be accomplished for those residents found to have been affected by the practice.** Residents 120, 77, and 103 physician orders for daily weights have been followed. Resident suffered no ill effects from this alleged deficient practice. **1.The facility will identify other residents that may potentially be affected by this practice.** Residents residing at Lincoln Hills of New Albany have the potential to be affected by this alleged deficient practice. Resident's orders have been audited to ensure weights are being obtained per physician's orders.	08/12/2022

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	07/29/2022

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
	of greater than 2 lbs (pounds) in 24 hours once a day, dated 5/25/22 to 6/20/22. - Monitor for increased edema, shortness of breath and lung sounds. Notify MD if condition declines every shift, dated 6/21/22. The vital signs record, between 5/20/22 and 7/26/22, indicated the following days the resident had a weight gain 2 pounds or more in a single day and the physician was not notified: - 5/8 - weight 204 - 5/9 - weight 208.4 = 4.4 pound weight gain from the previous day - 6/4 - weight 216 - 6/5 - weight 220.4 = 4.4 pound weight gain from the previous day - 6/8 - weight 228.6 - 6/9 - weight 231.6 = 3 pound weight gain from the previous day - 6/26 - weight 202 - 6/27 - weight 204 = 2 pound weight gain from the previous day - 7/1 - weight 204 - 7/2 - weight 208.4 = 4.4 pound weight gain from the previous day A care plan, dated 5/23/22, indicated the resident had the potential for fluid volume excess or exacerbation related to congestive heart failure. The interventions included, but were not limited to, administer medications per MD order, assess and report for fluid excess (wt. gain, increased BP (blood pressure); full/bounding pulse, jugular vein distention, SOB (shortness of breath),, moist		**1.The facility will put into place the following systemic changes to ensure that the practice does not recur.** Licensed nurses, IDT team, and nurse managers were re-educated on physician orders related to scheduling of weights and notifications. **1.The facility will monitor the corrective action by implementing the following measure.** DON/Designee will audit 5 random residents records at least five (5) times per week for four (4) weeks, then weekly for four (4) weeks, then bi-weekly for (4) weeks, then monthly for an additional 3 months to ensure physician orders for weights are being followed. 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. Care Plan to be updated as indicated.	

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	07/29/2022

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
	cough, rales, rhonchi, wheezing, edema, worsening of edema, nausea/vomiting, liquid stools). During an interview with LPN (Licensed Practical Nurse) 7 on 7/28/22 at 1:40 p.m., she indicated that depending on the parameters set by the physician for either 2 or 5 pound daily weight gain in a CHF resident, the physician would be notified. During an interview with the Director of Nursing (DON) on 7/28/22 at 4:25 p.m. she was made aware of the missing notification to physician regarding a weight gain of 2 pounds or more in a single day. She indicated that sometimes the staff would put the notification in a book that was picked up every morning and then given to the NP or MD to address. During a second interview with the DON on 7/29/22 at 9:41 a.m., she indicated she was unable to find any nursing notification in the NP/MD book. The Nurse Practitioner thought it was unrealistic for residents to be weighed daily with orders for the physician to be notified if a weight gain of 2 pounds or greater occurred as the physician would probably be called everyday. 2. The clinical record for Resident 77 was reviewed on 7/29/22 at 1:58 p.m. The diagnoses included, but were not limited to, atrial fibrillation, edema, hypertension, and acute on chronic combined systolic and diastolic congestive heart failure. The care plan, dated 9/22/22, indicated the resident had potential for fluid volume excess/exacerbation related to congestive heart failure and the potential for dehydration related to routine diuretic use. The interventions included, but were not limited to, assess and report for fluid excess including weight gain, increased blood		**1.Plan of Correction Completion Date.** Plan of Completion date is August 12, 2022.	

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	07/29/2022

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
	pressure, full/bounding pulse, jugular vein distention, and shortness of breath. The physician's order, dated 10/12/21, indicated the resident received lasix 80 mg twice daily. The physician's order, dated 6/16/22, indicated to obtain daily weights once a day upon rising between 7:00 a.m. and 11:00 a.m. The July TAR (Treatment Administration Record) indicated the following: -On 7/4/22 the resident weighed 180.6 lbs (pounds) -On 7/7/22 the resident weighed 193 lbs -On 7/14/22 the resident weighed 191.4 lbs -On 7/15/22 the resident weighed 197.1 lbs -On 7/1722 the resident weighed 192.6 lbs -On 7/19/22 clinical record indicated the resident up in wheelchair and weight was not obtained prior to getting her up. -On 7/20/22 the resident weighed 196.2 lbs -On 7/24/22 the resident weighed 198.9 The order for daily weights was lacking documentation on July 3, 5, 6, 10, 13, 16, 19, 21, 22, 23, 26, and 27. The only documented refusals were on 7/13/22, 7/21/22, and 7/26/22. The nurse's note, dated 7/5/22 at 2:36 p.m., indicated the resident's weights remained within her baseline. She continued with daily weights and reports to the NP for weight increases in excess of 2 lbs within 24 hours. The clinical record lacked documentation of any notification to the physician of any increases in weight greater than 2 lbs within 24 hours.			

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	07/29/2022

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
	3. The clinical record for Resident 103 was reviewed on 7/29/22 at 2:00 p.m. The diagnoses included, but were not limited to, generalized edema and hypertension. The physician's progress note, dated 6/18/22 at 4:42 p.m., indicated the resident had a chief complaint of edema with increasing left labial swelling which started a few days back with trace pedal edema. The resident indicated she'd used lasix as a maintenance medication the the past, She had no daily monitoring of her weight. New orders were given to start Lasix 20 mg daily, klor-con 20 meq daily, and daily standing weights. The physician's order, dated 6/18/22 thru 7/12/22, indicated to obtain daily weights while the resident was on Lasix one time daily between 6:00 a.m. and 6:00 p.m. The physician's order, dated 6/18/22 thru 7/11/22, indicated to administer lasix 20 mg 1 tablet daily upon rising. The June TAR indicated the following: -On June 19, 2022 the weight was marked as not completed due to not documented by the prior shift. -On June 24, 25, and 26, 2022, the weight was not completed due to the lift scale being broken. The July TAR indicated the following. -The order for daily weights was not documented as completed on July 2, 3, 4, 5, 10, or 12, 2022. -The only documented refusals were on July 4 and 5, 2022. During an interview, on 7/29/22 at 9:24 a.m., the			

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	07/29/2022

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
	DON indicated the lift scale was broken on one of them. They educated staff a couple weeks ago if one was broken to use the other one. She was aware on some days they did not document why the weight was not conducted. On 7/28/22 at 4:25 p.m., the DON presented a copy of the facility's current policy titled, Change in a resident's Condition or Status dated October 2010. The policy included, but was not limited to, "Policy Statement: Our facility shall promptly notify...his or her Attending Physician...of changes in the resident's medical/mental condition and status...Policy Interpretation and Implementation: 1. The Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On-Call Physician when there has been:...h. Instructions to notify the physician of changes in the resident's condition...4. Except in medical emergencies, notifications will be made within twenty-four (24) hours of a change occurring in the resident's medical/mental condition or status..." 3.1-46(a)(1)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review, and	F 0695	**F 695**	08/12/2022

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	07/29/2022

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
	interview, the facility failed to ensure oxygen concentrator filters were applied and maintained for 2 of 3 residents reviewed for respiratory care. (Residents 48 and 112) Findings include: 1. During an observation of Resident 48's Oxygen (O2) concentrator on 7/25/22 at 9:20 a.m., the filter in the back was missing. The resident was observed to be utilizing the oxygen continuously at this time. During an observation and interview, on 7/26/22 at 10:05 a.m., Resident 48's Oxygen concentrator filter in the back was missing and was observed to be lying on the floor. The resident was observed to be utilizing the oxygen continuously at this time. She indicated she was not experiencing any difficulties breathing or with the concentrator. During an observation of Resident 48's Oxygen concentrator on 7/27/22 at 11:00 a.m., the filter in the back was missing and was observed to be lying on the floor. The resident was observed to be utilizing the oxygen continuously at this time. During an observation of Resident 48's Oxygen concentrator on 7/28/22 at 11:20 a.m., the filter in the back was missing and was observed to be lying on the floor. Resident was observed to be utilizing the oxygen continuously at this time. The clinical record for Resident 48 was reviewed on 7/27/222 at 8:59 a.m. The diagnoses included, but were not limited to, asthma, obstructive sleep apnea, congestive heart failure, seasonal allergic rhinitis and chronic obstructive pulmonary disease (COPD).		**Respiratory/Tracheostomy Care and Suctioning** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** The facility failed to ensure oxygen concentrator filters were applied and maintained. Residents 48 and 112 have had their concentrators checked for proper placement and cleanliness of filters. Neither resident suffered any ill effects from this deficient practice. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** Residents residing at Lincoln Hills of New Albany have the potential to be affected by this deficient practice. An audit of all residents with O2 orders has been completed to ensure all concentrators are clean and filters are placed properly. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.**	

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	07/29/2022

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
	A nurses note, dated 7/16/22 at 4:55 p.m., indicated the resident had complained of shortness of breath and required her oxygen to be titrated to 3L (liters). The Minimum Data Set (MDS) assessment, dated 5/30/22, indicated the resident was alert and oriented and cognitively intact. A care plan, dated 2/24/22, indicated the resident had the potential for respiratory distress related to COPD and asthma. The interventions included, but were not limited to, administer medications per MD order, administer oxygen per MD order, report signs of respiratory distress (restlessness, wheezing, dyspnea, difficulty with expectoration, diaphoresis, crackles, bubbling, tachycardia, cyanosis, decreased breath sounds). The physician's orders included the following: - albuterol sulfate aerosol inhaler; 90 mcg (micrograms)/actuation; amt (amount): 2 puffs inhalation; Special Instructions: start 5-30 minutes before activities 6 times per day as needed dated 7/21/22. - Claritin (loratadine) 10 mg (milligrams)1 tablet daily dated 7/21/22. - Oxygen 2 liter/min (minute) continuous per nasal cannula every shift dated 2/19/22. During an interview with the Respiratory Therapist on 7/29/22 at 10:45 a.m., she indicated she came in every Friday and cleaned and wiped down the concentrators, the filters, humidifier bottle and would replace the filters as needed if they became flimsy after so many washes. She further indicated she had just given the resident a		Nursing staff have been re-educated on appropriate placement and cleaning requirements for concentrators. Checking the equipment for placement and cleanliness has been added to care sheets. **IV. The facility will monitor the corrective action by implementing the following measures.** Director of nursing or designee will audit 5 residents with O2 orders to ensure oxygen concentrator filters are applied and clean per week for four weeks and continue weekly for no less than two additional months to ensure behavioral care plans and interventions are in place. 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. Care Plan to be updated as indicated. **V. Plan of Correction completion date.** Plan of Completion date is August 12, 2022.	

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	07/29/2022

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
	new filter last Friday (7/22/22) when she was here. The filters served as a means of protecting the equipment from getting all dusty. The dust on the filter would not compromise the resident receiving his/her oxygen. 2. During an observation of Resident 112's oxygen concentrator on 7/25/22 at 10:00 a.m., the filter on the right side had white fuzzy dust pieces on it. The resident was observed to be utilizing the oxygen continuously at this time. During an observation and interview on 7/26/22 at 10:00 a.m., Resident 112's oxygen concentrator right sided filter had white fuzzy dust pieces on it. The resident was observed to be utilizing the oxygen continuously at this time. The resident indicated at this time she had no problems with her oxygen other than the tubing would not stay in her nose. During an observation of Resident 112's oxygen concentrator on 7/27/22 at 11:05 a.m., the right sided filter had white fuzzy dust pieces on it. Resident was observed to be utilizing the oxygen continuously at this time. The clinical record for Resident 112 was reviewed on 7/27/22 at 9:21 a.m. The diagnoses included, but were not limited to, cerebral palsy and chronic pulmonary edema. 7/11/22 The Quarterly MDS assessment, dated 7/11/22, indicated the resident was moderately impaired. A care plan, dated 3/14/22, indicated the resident was at risk for impaired gas exchange and required oxygen therapy related to Pneumonia. The interventions included, but were not limited to,			

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	07/29/2022

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
	administer oxygen as ordered; monitor lung sounds as needed; position resident in preferred position for optimal breathing, elevate head of bed to alleviate shortness of breath while lying flat; and report signs of hypoxia (cyanosis, tachypnea, dyspnea, confusion, restlessness, nasal flaring, elevated blood pressure, increased respirations, increased pulse). The physician's orders indicated the following: - Oxygen 3 liter/min) continuous per nasal cannula every shift dated 3/14/22. - 3/14/22 Change and date oxygen tubing, humidifier bottle and nebulizer tubing. Special Instructions: Change weekly per the respiratory company on Thursday. During an interview with the Director of Nursing (DON) on 7/28/22 at 4:30 p.m., she indicated there was a company who came out every week to clean the machine filters and checked the machines to be sure they were working properly. The DON also presented a copy of the facility's current policy from the oxygen company titled Selection of Oxygen Source which indicated, "... Maintenance - Clean external filter once per week..." 3.1-47(a)(6)			
F 0740 SS=D Bldg. 00	483.40 Behavioral Health Services §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and			

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	07/29/2022

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
	psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. Based on record review and interview, the facility failed to ensure appropriate care planning and interventions were in place for a resident with a history of resident to resident aggression for 1 of 3 residents reviewed for behavioral services. (Resident 84) Findings include: The clinical record for Resident 84 was reviewed on 7/26/22 at 1:00 p.m. The diagnoses included, but were not limited to, unspecified dementia with behavioral disturbance, Alzheimer's disease with late onset, mood disorder due to known physiological condition with major depressive-like episode, brief psychotic disorder, unspecified mood affective disorder, anxiety disorder, and attention and concentration deficit. The nurse's note, dated 11/19/21 at 10:00 a.m., indicated the resident was aggressive towards his family member and he was placed on 1 on 1 care (one staff to one resident continuous observations) and referred out to a behavioral health facility. The nurse's note, dated 11/23/21 at 3:23 p.m., indicated the resident was sent to a behavioral unit due to being found on top of his family member choking her and yelling that he was going to k**l her. He showed no aggression toward other residents or staff.	F 0740	**F 740 Behavioral Health Services** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** The facility failed to ensure appropriate care planning and interventions were in place for a resident with a history of resident to resident aggression. Resident 84's care plan has been updated with appropriate interventions in place. Psychosocial support provided with no changes in mood or behavior noted. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** Residents residing at Lincoln Hills of New Albany have the potential to be affected by this deficient practice. An audit of all residents has been completed with care plans and interventions updated as needed.	08/12/2022

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	07/29/2022

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
	The nurse's note, dated 12/13/21 at 6:59 p.m., indicated the resident returned to the facility. He had an agitated tone and had strong negative feelings toward his family member. The nurse's note, dated 12/20/21 at 6:42 a.m., indicated a confused resident made her way into the resident's room and he came out into the hallway, yelling aggressively and cursing at staff to get the resident out of his room. He had aggression directed at staff. The behaviors stopped when the other resident was removed from his room. The nurse's note, dated 12/22/21 at 6:26 p.m., indicated the resident's room was changed to his prior room, which was more familiar and closer to the nurse's station for monitoring. The nurse's note, dated 1/21/22 at 5:44 a.m., indicated yelling was heard in the hallway. Upon investigating, staff discovered the resident's roommate in the hallway, leaning up against the wall. Staff questioned his roommate as to what was wrong. The roommate indicated the resident had shoved him. Staff checked on the resident and he indicated to staff his roommate would not let him get any sleep because he kept turning the lights on, so he shoved him. His roommate's wrist was swollen and a bone appeared to be sticking up on the pinky side. The resident's were separated and placed on every 15 minute checks. The nurse's note, dated 3/8/22 at 9:16 a.m., indicated the resident had shoved another resident out of his room that morning. The other resident hit against the wall and was knocked unconscious. This resident immediately had one on one monitoring and was sent to a behavioral health unit for evaluation and monitoring.		**III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** IDT will review behavioral events during morning meeting and review care plans and intervention to ensure compliance. Staff have been re-educated regarding behavioral management and care plan interventions. **IV. The facility will monitor the corrective action by implementing the following measures.** Director of nursing or designee will audit 5 residents with behaviors per week for four weeks and continue weekly for no less than two additional months to ensure behavioral care plans and interventions are in place. 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. Care Plan to be updated as indicated.	

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	07/29/2022

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
	The nurse's note, dated 3/25/22 at 3:50 p.m., indicated a care meeting was held with the resident's family member. She had been staying away due to her triggering increased agitation with him. A stop sign was up across his door and was working to deter wandering residents The nurse's note, dated 4/26/22 at 11:01 p.m., indicated at 7:30 p.m. the resident was in his room and another resident was propelling towards his room door. Resident 84 went to the doorway and yelled out, and as staff approached him he swatted at the other resident's left upper arm. The resident was placed on every 15 minute checks. The nurse's note, dated 4/29/22 at 8:29 p.m., indicated due to every intervention that was attempted was not working and keeping wandering residents out of the resident's room. He was moved off the dementia unit to a private room with a private bath which was next to the nurse's station. The clinical record lacked documentation of any care plan, interventions, or behavior monitoring to address the resident's behavior of having resident to resident aggression. During an interview on 7/29/22 at 11:03 a.m., LPN (Licensed Practical Nurse) 15 indicated she was familiar with the resident. She knew he had a history of exit seeking, but she was not aware of him having any issues with other residents. She had not heard of any issues with other residents. She'd heard about altercations with staff before he moved over to the A Hall. There was nothing on his care plan for resident to resident aggression. The only thing anyone had ever told her was he had aggression toward staff. He did not have any		**V. Plan of Correction completion date.** Plan of Completion date is August 12, 2022	

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	07/29/2022

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
	orders to monitor for resident to resident aggression. During an interview on 7/29/22 at 12:26 p.m., CNA (Certified Nurse Aide) 16 indicated she was taking care of the resident. She was familiar with him but she was not aware of any behaviors the resident had or any history of behaviors. She had not heard anything about him having any altercations with other residents. The Behavioral management program Policy, dated 10/2013, provided on 7/29/22 at 2:00 p.m. by the CS (Clinical Support) included, but was not limited to, "... Some of our residents have medical disabilities that can lead to disruptive behaviors and these behaviors have the potential to create a negative effect on the resident, other residents, visitors and the staff. It is [Name of Corporation] policy that each community will have a behavior program that: identifies, monitors, manages and disseminates (whenever possible) all behavioral events by utilizing the least invasive approach based on the individual resident affected... [Name of corporation] believes in a person-centered care approach and tailors all considerations for the individual affected..." 3.1-37(a)			