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	12/14/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00213244 and IN00216379. Complaint IN00213244 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00216379 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: December 7, 8, 9, 12, 13 and 14, 2016. Facility number: 000321 Provider number: 155614 AIM number: 100286130 Census bed type: SNF: 10 SNF/NF: 124 Total: 134 Census payor type: Medicare: 13 Medicaid: 90 Other: 31 Total: 134	F 0000	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For purpose of any allegation that the facility is not in substantial compliance with federal requirements of participation, the response and plan of correction constitutes Lincoln Hills Health Center's allegation of compliance in accordance with Section 7305 in the State Operations Manual.	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Sample: 5 This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed by 34233 on December 18, 2016.			
F 0176 SS=D Bldg. 00	483.10(c)(7) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE (c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, record review and interview, the facility failed to ensure a resident had a physician's order to keep medications at the bedside and was assessed to self administer medications. This deficient practice affected 1 of 40 residents observed for medications left at bedside. (Resident 14) Findings include: Upon entering Resident 14's room on 12/8/16 at 9:10 a.m. to interview the resident, a medication cup was observed on the bedside table next to the resident who was in her bed. There were two pills observed in this medication cup.	F 0176	The facility will continue to observe the resident's right to self-administer medications if the interdisciplinary team has determined that the practice is clinically appropriate. For resident number 14: Medications were removed from the resident room and destroyed. Physician notified. Order was received to administer medications at the time they were found. No ill effect noted to resident. All residents have the potential to be affected by this alleged deficient practice.	12/29/2016

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	At 9:13 a.m., RN [Registered Nurse] 1 indicated she was unsure what the medications were in the cup, "the resident requested that staff just leave them and when she was ready, she would take them. Staff really weren't supposed to leave them, but they just did." The resident had been in the facility for years and that she always took her medication whenever she was ready. The Nurse then proceeded to leave the room and left them at bedside in order to get the nurse assigned to the hall. At 9:20 a.m., LPN [Licensed Practical Nurse] 1 came onto the unit and was also shown the medications in a cup left at bedside. She identified them as Levothyroxine (for hypothyroidism) and Neurontin (for pain) and voiced that the third shift RN 2 gave them to the resident; they were the resident's 6:00 a.m. pills. The LPN indicated "I would not leave them at bedside because sometimes the resident would take them and sometimes she (the resident) would fall back asleep and forget." At 9:45 a.m., The DON (Director of Nursing) indicated "It is not protocol for medications to be left at bedside and that the issue would be addressed with the nurse along with a general inservice with nursing about this. The medications were		The nurse responsible for the medications found in resident number 14's room was educated on 12/8/16 regarding proper medication procedure which included that the nurse must witness the resident taking the medication and cannot leave the medication at bedside. All licensed staff and QMA's were reeducated regarding the policy and procedure for LICENSED NURSE AND QMA PROCEDURE- ADMINISTRATION OF MEDICATIONS ORAL and policy and procedure for SELF-ADMINISTRATION OF MEDICATION. Rounds will be conducted by nursing managers on all units. Rounds will be conducted weekly times four weeks and then monthly. During rounds nursing managers will observe for any medications left at bedside. If medications are found they will be removed immediately unless it has been determined by the interdisciplinary team that the resident is clinically appropriate to self-administer medications. The results of these rounds will be reported to the DON and	

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	destroyed and the MD was notified who indicated it was okay to give the medicine now. The resident is strong willed and will try to get you to leave them - others have tried it too, but it is something that should not occur. It is okay to place them on bedside and watch while not letting her know you are watching but the medications must be removed before the nurse leaves that room." Review of the clinical record for Resident 14, on 12/9/16 at 10:00 a.m., indicated the resident had Physician orders for Gabapentin (Neurontin) 300 mg (milligrams) - 1 tablet TID (3 times a day) dated 3/31/16 and Levothyroxine 25 mcg (micrograms)1 tablet qd (every day) dated 9/24/14. There was no self administration nursing assessment or a physician order for the medications to be left at bedside. On 12/8/16 at 10:20 a.m., the DON presented a copy of the facility's current policy titled "Licensed Nurse and QMA (Qualified Medication Aide) Procedure - Administration of Medications Oral". Review of this policy at this time included, but was not limited to: "Purpose: To safely administer medications as		Administrator. The DON and Administrator will ensure that additional training and/or counseling is provided as necessary. A summary of the audits above will be reported to the QAA committee. The QAA committee will review results of all audits. Audits will be ongoing until 100% compliance has been achieved and maintained for one quarter. DON and Administrator to monitor.	

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	prescribed...Procedure:...8. Administer oral medication and remain with resident while he/she takes the medication. Rationale/Amplification: Never leave a drug in resident's room..." 3.1-11(a)			