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	09/01/2016

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 the Investigation of Complaint IN00205663. Complaint IN00205663 - Substantiated. Federal/State deficiencies related to the allegations are cited at F309 and 9999. Survey dates: August 31 and September 1, 2016 Facility number: 000321 Provider number: 155614 AIM number: 100286130 Census bed type: SNF/NF: 129 SNF: 9 Total: 138 Census payor type: Medicare: 15 Medicaid: 94 Other: 29 Total: 138 Sample: 5 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	Preparation and execution of this response and plan ofcorrection does not constitute an admission or agreement by the provider of thetruth of the facts alleged or conclusions set forth in the statement ofdeficiencies. The plan of correction is preparedand/or executed solely because it is required by the provisions of federal andstate law. For purpose of any allegationthat the facility is not in substantial compliance with federal requirements ofparticipation, the response and plan of correction constitutes Lincoln HillsHealth Center's allegation of compliance in accordance with Section 7305 in theState 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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	Quality review completed by 34233 on September 8, 2016.			
F 0309 SS=G Bldg. 00	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on interview and record review, the facility failed to ensure treatment was not delayed on two residents (Resident #E and #G) with confirmed hip fractures secondary to falls for 2 of 3 residents reviewed for accidents. Findings include: 1. The clinical record for Resident #G was reviewed on 9/1/16 at 10:15 a.m. Diagnosis included, but was not limited to, left femur fracture. The nurses note, dated 5/24/16 at 3:37 a.m., included, but was not limited to, the following: "resident [sic] walking back to...room and was found sitting in a	F 0309	The facility will continue to provide the necessary care andservices to attain or maintain the highest practicable physical, mental, andpsychosocial well-being, in accordance with the comprehensive assessment andplan of care. Resident G and Resident E have discharged from the facility. All residents who sustain a fall exhibiting complaints ofpain or injury have the potential to be affected by the alleged deficientpractice. Procedure regarding administration of prn pain medication forresidents complaining of pain after a fall has been reviewed by licensednursing	09/18/2016

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	straight up position in hallway [sic] nurse asked what happened [sic] "i [sic] sat down bc [sic] [because] i [sic] was getting weak" [sic] quoted [sic] resident [sic] gripper socks were on floor [sic] dry [sic] nothing in area that may have contributed to fall [sic] resident said [he/she] did not hit [his/her] head and no noticeable [sic] [noticeable] injuries noted...assisted to a standing position and assisted to room..." The nurses note, dated 5/24/16 at 11:23 a.m., included, but was not limited to, the following: "Resident was in...room resting in bed. This nurse had just left room about 30 minutes before. Housekeeper was down there and alerted staff that resident was on the fllor [sic] [floor]. [He/She] was found on...left side by...bed. Nurse from another hall assessed resident and no injurys [sic] [injuries] noted. Neuro [neurological] checks [assessment used for head injury] started r/t [related to] fall was unwitnessed. Resident brought up in w/c [wheelchair] to TV [television] lounge and will have MD [medical doctor] review meds [medications]..." The MAR (Medication Administration Record) for May, 2016, indicated, on 5/24/16 at 12:00 p.m., Resident #G received a Percocet 5/325mg		staff members to include administration of prn pain medication when aresident complains of onset of new or increased pain even if routine painmedication has been previously administered. Facility policy regarding obtaining x-rays and follow toresults has been updated. Licensednursing staff members have been in-serviced regarding timely ordering of x-raysand frequent follow-up regarding x-ray results. Resident E noted to be resting quietly with no distress atthe time transport was arranged. Facility will continue to arrange transportation through services thatare consistent with resident condition. However, facility procedure has been modified to include that allresidents exhibiting a fall with complaints of pain or subsequent complaints ofpain that could be attributed to a fall will be immediately sent out to theemergency room via 911 for evaluation. Licensed nursing staff members have been in-serviced on this change infacility procedure. Nursing managers will review the medical record of allresidents sustaining a fall to ensure facility policy and procedures arefollowed. These audits will be completeddaily as each fall occurs for a period of three months.	

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	[milligrams] [pain medication] orally. The nurses note, dated 5/24/16 at 1:23 p.m., included, but was not limited to, the following: "Resident c/o [complained of] of [sic] pain to left groin/hip/pelvic area. Resident frequently c/o [complains of] of [sic] paibn [sic] [pain] to the area but as precaution will get stat X-ray to left hip/pelvic area..." The nurses note, dated 5/24/16 at 4:47 p.m., included, but was not limited to, the following: "F/U [follow up] to being found on floor x [times] 2 today. This [sic] first time occurred early am [sic] [a.m.] and [he/she] stated [he/she] sat down purposefully as [he/she] felt weak. This is likely turi [sic] [true] as [he/she] has been witnessed numerous times sitting down or crawling on floor purposefully. [He/She] is being treated for Pneumonia and [he/she] may feel weaker than usual. The second time [sic] unsure if [he/she] tried to get up or rolled off the bed. The bed is low and [he/she] has mat to floor for safety...Are awaiting hip x-ray result r/t [related to] discomfort in hip..." The radiology report, dated 5/24/16 at 4:50 p.m., included, but was not limited to, the following: "Patient...[Resident #G's name]...Results...Acute		Nursing will review the medical record of all residentsreceiving an order for an x-ray related to complaints of pain or suspectedinjury to ensure facility policy and procedures are followed. These audits will completed daily as x-raysare ordered for a period of three months. Results of these audits will be reported to the DON. DON will ensure that additional trainingand/or counseling is provided as necessary. A summary of the findings will be reported to the QAACommittee. The QAA Committee will reviewresults and determine necessity of continuation of audits. DON and Administrator to monitor.	

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	intertrochanteric fracture of the proximal left femur...Conclusion...Acute fracture..." The nurses note, dated 5/24/16 at 10:07 p.m., included, but was not limited to, the following: "this [sic] nurse was notified of f/u [follow up] fall this evening. resident [sic] sitting in chair in mdr [main dining room], complaing [sic] [complaining] of pain to left hip. when [sic] it was time to have xray [sic] [x-ray] taken, took two assist to transfers [sic] [transfer] resident to wheelchair, being that [he/she] was not able to bare [sic] [bear] weight on the left leg at this time. received [sic] results from xray [sic] to left hip/ pelvis& [sic] results show acute fracture to left hip. md [sic] notified of results & requested that we send the resident to the emergency [sic] to be tx [treated]. this nurse notified 2nd contact of results, r/t [related to] the 1st contact being unreachable...dtr [sic] [family member] return [sic] [returned] call, was not aware that [resident] had fallen..." During an interview on 9/1/16 at 4:20 p.m., the Director of Nursing indicated, it appeared, according to the nurses note on 5/24/16 at 10:07 p.m., the fax regarding the x-ray result, was received when the note was documented.			

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	During an interview on 9/1/16 at 4:38 p.m., the Account Manager for the radiology facility, indicated the x-ray was ordered at 12:56 p.m., completed at 4:24 p.m., and results were sent to the facility's east hall at 4:52 p.m. On 9/1/16 at 5:28 p.m., the Administrator provided a copy of the document titled, "Resident Status History List". It included, but was not limited to, the following: "...[Resident #G's name]...D [discharge]...5/24/16...7:40 p.m..." 2. The clinical record for Resident #E was reviewed on 9/1/16 at 10:15 a.m. Diagnosis included, but was not limited to, right hip fracture. The nurses note, dated 6/4/16 at 10:14 a.m., included, but was not limited to, the following: "Late entry for 6/4/16 @ [at] 7:am CNA [Certified Nursing Assistant] entered room after hearing resident yell out [sic] CNA called for nurse. This nurse entered room and resident was lying in front of bathroom door [sic] it was open [sic] on...back with...legs out straight. Resident disoriented [sic] unable to answer simple questions at this time. There was urine on the floor and the resident had...pants down around...ankles. Resident assisted to bathroom and then to bed with 2 assist. Resident began to c/o			

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	[complain of] bilat [bilateral] hip pain and hold onto [sic] [on to] [his/her] right leg with [his/her] hand. Resident able to move legs independently...Supervisor informed...MD [medical doctor] informed [sic] new order to x-ray righ [sic] hip [sic] x-ray left hip stat [immediate]. Call placed to [name of radiology facility] [sic] x-rays ordered stat..." The nurses note, dated 6/4/16 at 10:33 a.m, included, but was not limited to, the following: "Late entry for 6-4-16 @ [at] 8:45am [name of radiology facility] here for x-ray..." The radiology report, dated 6/4/16 at 10:03 a.m., included, but was not limited to, the following: "...Patient: [name of Resident #E]...Results...There is an acute angulated fracture at the junction of the right femoral neck and the intertrochanteric region...Conclusion...Acute fracture right hip..." The nurses note, dated 6/4/16 at 10:36 a.m., included, but was not limited to, the following: X-ray results here [sic] left hip intact [sic] right hip noted with acute fracture. Report viewed by Supervisor. MD notifed [sic] new order received and noted to send resident to [initials of			

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	hospital] ER [emergency room] for eval [evaluation] and treatment..." The nurses note, dated 6/4/16 at 11:17 a.m., included, but was not limited to, the following: "Transportation made through [name of transportation service]. Report callled [sic] [called] to [initials of hospital] ER..." The nurses note, dated 6/4/16 at 1:26 p.m., included the following: "[name of transportation service] transported resident via [by] stretcher and 2 attendants to [initials of hospital]." During an interview on 5/24/16 at 4:20 p.m., the Director of Nursing indicated Resident #E was not in any distress or pain and it just took that long for the transportation service to get there. The Director of Nursing also indicated they generally do not call 911 unless there is an emergency because the fire department comes when 911 is called. This Federal tag relates to Complaint IN00205663 3.1-37(a)			
F 9999 Bldg. 00				

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	3.1-13 (g) The administrator is responsible for the overall management of the facility but shall not function as a departmental supervisor, for example, director of nursing or food service supervisor, during the same hours. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Immediately informing the division by telephone followed by written notice within twenty-four (24) hours, of unusual occurrences that directly threaten the welfare, safety, or health of the resident or residents, including, but not limited to, any: (D) major accidents Based on interview and record review, the facility failed to ensure falls, which resulted in fractures, were reported to the Indiana State Department of Health (ISDH) for 3 of 4 residents reviewed for falls with significant injury. (Resident #C, E, and G) Findings include: 1. The clinical record for Resident #C was reviewed on 8/31/16 at 3:20 p.m. Diagnosis included, but was not limited to, fracture of left femur. The nurses note, dated 8/4/16 at 4:28	F 9999	The facility will ensure that any major accidents, i. e.falls resulting in fractures will be reported to the Indiana State Departmentof Health (ISDH) within twenty-four (24) hours. Policy has been updated regarding reportable incidentreporting policy adopting changes made effective 7/15/15. Licensed nursing staff members have been in-servicedregarding report of any residents sustaining a fracture to Administrator/DON/NursingManagement immediately. Administrator, Assistant Administrator, DON, ADONs and allnursing managers have been in-serviced regarding update to this policy. DON will complete an audit of all major accidents resultingin a fracture weekly to ensure that all fractures were reported to the ISDH ina timely manner for a minimum of one quarter. Results of these audits will be reported tothe Administrator. DON/Administratorwill ensure additional training and/or counseling is provided as necessary. A summary of the findings will be reported to the QAACommittee. The QAA Committee will	09/18/2016

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	a.m., indicated the following: Resident #C was found on the floor. Resident #C was ambulating to the bathroom and lost his/her balance and fell. Resident #C was assisted to bed and an assessment was completed after he/she was placed back in bed. The nurses note also indicated Resident #C complained of pain to his/her left hip, leg, and knee area. Resident #C was sent to the emergency department and diagnosed with a left femur fracture. During an interview on 8/31/16 at 3:20 p.m., the Administrator and Director of Nursing indicated Resident #C's fracture was not reported to ISDH because it did not fit the criteria of a reportable. The Administrator and Director of Nursing also indicated they had not received anything from ISDH with regards to changes and were unaware that all fractures had to be reported. On 8/31/16 at 4:15 p.m., the Administrator indicated she had found where the policy on reportable's had been changed on 7/15/2015. On 9/1/16 at 5:05 p.m., The Administrator indicated the facility follows the reporting guidelines provided by the Indiana State Department of Health.		reviewresults and determine necessity of continuation of audits. DON and Administrator to monitor.	

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	On 9/1/16 at 5:05 p.m., the Administrator provided a copy of the document titled "Indiana State Department of Health". It included, but was not limited to, the following: "...Date: March 13, 2006...Subject: Reportable Unusual Occurrences Policy & Procedure..." The Division of Long Term Care Reportable Incident Policy, dated 7/15/15, included, but was not limited to, the following: "...Effective Date: 07/15/15...Title: Incident Reporting Policy...Policy: Incidents required to be reported by federal and/or state law will be submitted to the Indiana State Department of Health...Procedure:..C. Types of incidents reportable under state rules...5. Major Accidents...Examples...ALL fractures..." 2. The clinical record for Resident #E was reviewed on 8/31/16 at 4:15 p.m. Diagnosis included, but was not limited to, right hip fracture. The nurses note, dated 6/4/16 at 10:14 a.m., included, but was not limited to, the following: "...resident was lying in front of bathroom door [sic] it was open on...back with her...out straight...MD [medical doctor] informed [sic] new order to x-ray righ [sic] [right] hip [sic]			

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	x-ray left hip stat [immediately]. Call placed to [name of radiology company] [sic] x-rays ordered stat..." The radiology report, dated 6/4/16 at 10:03 a.m., included, but was not limited to, the following: "...Results...There is an acute angulated fracture at the junction of the right femoral neck and the intertrochanteric region...Conclusion...Acute fracture right hip..." During an interview on 9/1/16 at 4:05 p.m., the Administrator indicated Resident #E's fracture was not reported to the Indiana State Department of Health. 3. The clinical record for Resident #G was reviewed on 9/1/16 at 10:15 a.m. Diagnosis included, but was not limited to, left femur fracture. The nurses note, dated 5/24/16 at 11:23 a.m., included, but was not limited to, the following: "...Housekeeper...alerted staff that resident was on the fllor [sic] [floor]...was found lying on...left side by...bed. Nurse from another hall assessed resident and not injurys [sic] [injuries] noted..." The nurses noted, dated 5/24/16 at 1:23 p.m., included, but was not limited to, the			

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	following: "...Resident c/o [complained of] of [sic] pain to left groin/hip/pelvic area. Resident frequently c/o [complains of] of [sic] paibn [pain] to the area [sic] but as precaution [sic] will get stat [immediate] X-ray..." The radiology report, dated 5/24/16 at 4:50 p.m., included, but was not limited to, the following" "...Results...Acute intertrochanteric fracture of the proximal left femur...Conclusion: Acute fracture..." During an interview on 9/1/16 at 4:05 p.m., the Administrator indicated Resident #G's fracture was not reported to the Indiana State Department of Health. This State tag relates to Complaint IN00205663			