STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155614	A. Building B. Wing	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lincoln Hills of New Albany	326 Country Club Drive New Albany, IN 47150

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure residents' meal trays were removed in a timely manner for 6 of 7 residents reviewed for dignity. (Residents 38, 43, 104, 122, 109, and 74)Findings include: 1. During an observation and interview, on 12/1/25 at 10:00 a.m., Resident 38 was sitting up in her wheelchair with her breakfast tray sitting in front of her on the bedside table. She had not eaten any of her breakfast. She held a butter knife in her hand and indicated she was trying to get started eating her breakfast. During an interview, on 12/3/25 at 10:05 a.m., Resident 38 indicated the staff normally left the breakfast tray on her bedside table. She was asleep when they brought it. They would let her know it was there. The resident had not yet eaten any of her breakfast. She indicated she was going to eat it soon. During an observation, on 12/03/2025 12:02 p.m., Resident 38 received her lunch. As Certified Nurse Aide (CNA) 4 left the resident's room, she indicated the resident had just started eating her breakfast. Upon entering the resident's room, she was finishing her breakfast, eating the last few bites of French toast. The resident indicated she would eat her lunch afterwards, because she was paying for it. The lunch tray had been set on the bed next to the resident's bed with the plate cover over the meal. During an observation, on 12/3/25 at 12:39 p.m., the resident was pulling the bedside table up to her chair at bedside with the lunch tray on it. She sat down in front of the tray but didn't start eating. She was watching the television. She then rose from her chair and started to straighten up her bed. During an observation, on 12/3/25 at 1:29 p.m., the resident was observed eating her lunch received at 12:02 p.m. During an observation, on 12/4/25 at 9:35 a.m., the resident was starting to drink coffee from her breakfast tray. The tray was on the bedside table pushed against the opposite wall away from her bed and chair. She was standing at the tray, and she turned and sat down in the chair. She indicated she did not know what was on her tray for breakfast. She then got up from the chair and checked the meal under the plate cover. It was a breakfast sandwich with an egg, bacon, and cheese on a biscuit. She went back to her chair and sat down. The physician's order, dated 12/25/24, indicated the resident received a regular diet. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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.

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The record for Resident 38 was reviewed on 12/3/25 at 1:43 p.m. The diagnoses included, but were not limited to, memory deficit following cerebrovascular disease, lack of coordination, difficulty in walking, moderate protein-calorie malnutrition, vitamin deficiency, alcohol dependence with alcohol-induced persisting dementia, encephalopathy, gastro-esophageal reflux disease, altered mental status. The Comprehensive Minimum Data Set (MDS) assessment, dated 10/30/25, indicated the resident was moderately cognitively impaired. The resident required setup or clean-up assistance with eating. During an interview, on 12/5/25 at 10:40 a.m., Licensed Practical Nurse (LPN) 5 indicated the resident slept late. She would take a while to eat her meals. The staff checked the trays in the rooms all the time. After 35 to 40 minutes, the meal trays would be removed from the resident's room. 2. During an observation, on 12/1/25 at 9:55 a.m., Resident 43 was lying in her bed leaning toward her left side. The bedside table was in front of her with her breakfast tray in front of her on the table. The breakfast tray had not been touched. The resident was attempting to remove the lid from her apple juice without success. The resident's breakfast had not been consumed. During an observation, on 12/3/25 at 12:00 p.m., the Activities Assistant 6 was overheard asking Resident 43 if she needed help cutting up her meat as she placed the meal tray on the bedside table in front of the resident. When the staff left, the resident just sat in her wheelchair without touching her meal. The meal was uncovered, and the drink cup had a lid on it. The lunch meal was a Salisbury steak, mashed potatoes, green beans were on the plate. A cupcake or roll was in a bag on the tray. The resident just looked at the tray. During an observation, on 12/4/25 at 9:35 a.m., the resident was in her room, sitting in bed with the bedside table in front of her. Her breakfast tray was in front of her and she was picking at the food. After a few minutes, she stopped eating. The record for Resident 43 was reviewed on 12/3/25 at 2:24 p.m. The resident's diagnoses included, but were not limited to, dementia with psychotic disturbance, chronic systolic congestive heart failure, atrial fibrillation, limitation of activities due to disability, mild vascular dementia with mood disturbance, anxiety and behavioral disturbance, unsteadiness on feet, history of transient ischemic attack (TIA), and cerebral infarction without residual deficits, age-related physical debility, Transient cerebral ischemic attack, lack of coordination, and the need for assistance with personal care. The Quarterly MDS assessment, dated 10/3/25, indicated the resident was severely cognitively impaired. She required setup or clean-up assistance with eating. The care plan, dated 7/18/25 and revised 11/12/25, indicated the resident was at nutritional risk related to advanced age, impaired cognition related to dementia, heart failure, debility, major depressive disorder, vitamin D deficiency, history of dehydration, hypertension, hyperlipidemia, generalized anxiety disorder, dysphagia, paranoid schizophrenia, weakness, varied appetite and complaints of pain. The interventions, dated 7/18/25, included, but were not limited to, explain the potential negative outcome of weight loss, honor the resident's food preferences, involve family in the plan of care, monitor the resident's weight, notify the physician of any significant weight changes, record meal and fluid consumption, serve the diet per physician order, and supplements as ordered. The resident's weight, on 6/2/25 at 7:09 p.m., was 173.4 pounds. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident's current weight, on 12/1/25 at 2:39 p.m., was 163.4 pounds. The current physician's order indicated the resident received a regular diet. 3. During an observation, on 12/3/25 at 12:13 p.m., Resident 104's lunch meal tray was brought into the resident's room and placed on the bedside table. The resident was asleep and snoring. The curtain was partially closed. The plate cover was left on the resident's plate. During an observation, on 12/3/25 at 12:38 p.m., the resident was still asleep. The privacy curtain had been pulled the entire length of the bed. The meal tray was sitting on the bedside table, still covered. The resident was snoring. During an observation, on 12/3/25 at 1:28 p.m., the resident's lunch meal tray was still on the bedside table. The resident was asleep. The meal was still covered. Residents in the dining room had completed their meals and had been taken to an activity. The record for Resident 104 was reviewed, on 12/4/25 12:27 p.m. The resident's diagnoses included, but were not limited to, Parkinson's disease with dyskinesia with fluctuations, disturbances of salivary secretion, pain, palliative care, severe dementia, severe with anxiety, lack of coordination, diabetes mellitus due to underlying condition with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (NKHHC), restlessness and agitation, limitation of activities due to disability, memory deficit following cerebral infarction, memory deficit following cerebrovascular disease, stage 3 chronic kidney disease, and need for assistance with personal care. The Quarterly MDS assessment, dated 6/24/25, indicated the resident was moderately cognitively impaired. He required setup or clean-up assistance with eating. The resident's weight, on 3/27/25 at 5:10 p.m. was 185 pounds. The care plan, dated 8/21/25 and revised 11/25/25, indicated the resident was at nutritional risk related to advanced age, Parkinson's, dementia, weakness, chronic kidney disease, hypertension, hyperlipidemia, gastro-esophageal reflux disease, diabetes, and hypotension. The interventions, dated 8/21/25, included, but were not limited to, explain the potential negative outcome of weight loss, honor the resident's food preferences, involve family in the plan of care, monitor the resident's weight, notify the physician of any significant weight changes, record meal and fluid consumption, serve diet per physician's order, and supplements as ordered. The physician's order, dated 10/28/25, indicated the resident received a regular diet. The resident's last weight, on 11/1/25 at 4:21 p.m., was 170.8 pounds. The nurse's note, dated 11/24/25 at 9:19 a.m., indicated the resident was up in his wheelchair eating breakfast with staff. The physician's order, dated 12/1/25, indicated the resident was to receive a nutritional supplement three times daily upon rising between 7:00 a.m. and 8:00 a.m., afternoon between 11:00 a.m. and 12:00 p.m., dinner between 4:00 p.m. and 5:00 p.m. The nurse's note, dated 12/1/25 at 9:41 a.m., indicated the hospice company ordered Ensure (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	supplemental drinks, three times daily, with meals. The nurse's note, dated 12/1/25 at 2:36 p.m., indicated the resident did not eat any lunch and was unable to understand how to open his mouth. The nutritional drink was given, and the resident drank all the drink with assistance of the nurse. The nurse's note, dated 12/2/25 at 10:39 a.m., indicated the resident was more awake this morning, but was keeping his eyes closed most of the time. The hospice nurse was at the facility at this time and was informed the resident was not taking much food in at all. He was drinking nutritional drinks with assistance of staff. The resident did eat a few bites of breakfast on this date, but it was hard to get the resident to understand how to open his mouth. 4. During an observation, on 12/3/25 at 12:14 p.m., Resident 122's lunch meal tray was sitting on his bedside table. It had a plate cover over the food and the resident was asleep. During an observation, on 12/3/25 at 12:43 p.m., the resident was still asleep, and his lunch meal tray was sitting on his bedside table covered. The food had not been touched. During an observation, on 12/3/25 at 1:32 p.m., the resident's lunch meal tray had been removed from the bedside table. The resident was still asleep in his bed and had not moved from the same position. During an observation, on 12/4/25 at 9:35 a.m., the resident arrived to his room from the dining room. He had eaten breakfast in the dining room. The record for Resident 122 was reviewed on 12/4/25 at 2:08 p.m. The resident's diagnoses included, but were not limited to, schizoaffective disorder, bipolar type, seizures, speech and language deficits following other cerebrovascular disease, dysphagia following cerebrovascular disease, restlessness and agitation, severe dementia with mood disturbance, Alzheimer's disease, protein-calorie malnutrition, hypokalemia, pain, symptoms and signs involving cognitive functions and awareness, symptoms and signs involving the musculoskeletal system. The Quarterly MDS assessment, dated 9/24/25, indicated the resident was severely cognitively impaired. The resident required setup or clean-up assistance for eating. The resident's weight, on 6/2/25 at 7:13 p.m., was 157.2 pounds. The care plan, dated 7/30/25, indicated the resident was at nutritional risk related to mechanically altered diet, advanced age, dementia, schizoaffective disorder, Alzheimer's, major depressive disorder, protein calorie malnutrition, dysphagia, iron deficiency anemia, vitamin deficiency, hypertension, pain, and diarrhea. The resident was on hospice and at risk for unavoidable weight loss related to terminal illness and end of life. The interventions, dated 7/30/25, included but were not limited to, provide assistance and encouragement as indicated for eating. The care plan, dated 11/11/25, indicated unavoidable weight loss related to terminal illness and end of life. The interventions, dated 11/11/25, included, but were not limited to diet as ordered, offer snacks between meals as tolerated, and pleasure foods as requested and tolerated. The physician's order, dated 10/23/25, indicated the resident received a mechanical soft, ground meat diet. Ice cream with lunch and dinner, 2 scrambled eggs and toast for breakfast and lunch per (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	speech therapy, the resident could have grilled cheese sandwiches at meals. The physician's order, dated 10/31/25, indicated the resident was to receive 120 milliliters (mL) of Med Pass three times a day upon rising 7:00 a.m. to 11 a.m., afternoon 3:00 p.m. to 5:00 p.m., before bedtime 7:00 p.m. to 11:00 p.m. The nurse's note, dated 11/28/25 at 12:44 p.m., indicated the resident was in bed. He refused to go to the dining room to eat. The nurse's note, dated 11/2/25 at 1:26 p.m., indicated the resident was in the dining area and was not in his room for all meals. Staff had fed and cued the resident while he was eating meals. The resident's last weight, on 12/2/25 at 9:24 a.m., was 151 pounds. During an interview, on 12/4/25 at 9:41 a.m., CNA 7 indicated she was not sure how long the food trays could be left in a resident's room. During an interview, on 12/4/25 at 9:45 a.m., the DON indicated the food could sit in resident's rooms for as long as necessary. There was no time limit. If the resident hadn't touched the food, staff would ask if they could take it away. If the resident was not done eating after a while, the staff would ask if they could get them a fresh meal. If the meal was still with the resident and it was a half hour before the next meal arrived, staff should ask the resident if they wanted a snack. Staff should check on the resident after the meal, there was no specific time. After maybe 30 minutes, staff could remind the resident that they had the meal in their room. If the resident had fallen asleep, staff should wake the resident up and remind them of their food being present. During an interview, on 12/4/25 at 10:00 a.m., CNA 8 indicated the meal trays stay with a resident. She woke them and set them up in bed. Breakfast meals would not stay with a resident longer than an hour. During an interview, on 12/4/25 at 10:13 a.m., CNA 9 indicated she would leave a meal tray with the resident, for as long as it took them to eat. She would wake them up and set them up in bed to let them know the food was there to eat, otherwise they would go back to sleep. She would never leave the tray with them until the next meal came. She would wake them up to ask if they were going to eat or if they wanted the food warmed up. During an interview, on 12/5/25 at 10:50 a.m., the Clinical Specialist indicated the facility had no policy on how long food could be left sitting out in a resident's room. 5. During an observation, on 12/1/25 at 9:45 a.m., Resident 109 was lying in her bed. Her breakfast tray was sitting on her bedside table beside her bed. The breakfast had not been set up for the resident, and she had not eaten any of her breakfast. During a second observation, on 12/1/25 at 11:20 a.m., Resident 109 remained in her bed. Her breakfast was still sitting on her bedside table untouched. The resident had not eaten any of her breakfast. The record for Resident 109 was reviewed on 12/3/25 at 1:53 p.m. The resident's diagnoses included, but were not limited to, wedge compression fracture of the first lumbar vertebra, difficulty walking, (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	memory deficit, attention and concentration deficit, Alzheimer's disease, anemia, and severe protein-calorie malnutrition. The admission MDS, dated [DATE], indicated the resident required assistance with setting up her meals. The resident was moderately cognitively impaired. The care plan, dated 11/6/25, indicated Resident 109 was at nutritional risk related to her advanced age, underweight, Alzheimer's, dementia, enterocolitis, anxiety disorder, severe protein calorie malnutrition, nausea, and iron deficiency anemia. The interventions included, but were not limited to, involve the family in the resident's care plan, explain the potential negative outcome of weight loss, honor the resident's food preference, supplements as needed, monitor weight and record meal and fluid consumption. During an interview, on 12/1/25 at 11:30 a.m., the Dietary Aide 11 indicated the breakfast meal was served between 7:30 a.m., and 8:00 a.m., on 12/1/25. 6. During an observation, on 12/1/25 at 9:50 a.m., Resident 74 was lying in her bed. Her breakfast tray was sitting on her bedside table. The breakfast had not been set up for the resident, and she had not eaten any of her breakfast. When an unknown CNA entered the room and asked the resident if she was going to eat her breakfast the resident indicated she wanted to eat her breakfast. The record for Resident 74 was reviewed on 12/4/25 at 5:17 p.m. The resident's diagnoses included, but were not limited to, dementia, limitations of activities, memory deficit, dysphagia, chronic pain and tremors. The admission Minimum Data Set (MDS), dated [DATE], indicated the resident required assistance with setting up her meals. The resident was severely cognitively impaired. The care plan, dated 6/27/27, indicated the resident was at nutritional risk related to mechanically altered diet, advanced age, dementia, dysphagia, depression, and anxiety disorder. The interventions included, but were not limited to, the resident would tolerate a (mechanically altered/therapeutic diet) without significant weight loss, aid and encouragement as indicated for eating, provide assistive devices as needed, monitor and report difficulties with eating, chewing and swallowing to the physician, monitor and record meal intake. During an interview, on 12/4/25 at 9:45 a.m., CNA 12 indicated staff would assist the residents if they needed assistance with eating. Once the resident received the meal tray staff should check on the resident 15 to 20 minutes later to make sure the resident was eating or needed assistance. The Resident Rights policy, dated 6/6/19, included, but was not limited to, .It is our policy that residents shall be treated with kindness, respect and dignity by associates, volunteers, contractors and visitors. 3.1-3(a)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, record review and interview, the facility failed to ensure the kitchen was maintained in a clean and sanitary condition and the disposal of expired food. This deficient practice had the potential to affect 120 of 120 residents residing in the facility.Findings Include:During an observation of the facility kitchen, on 12/1/25 at 9:30 a.m., the following was observed: - Fifty small condiments containers were observed with ranch dressing in them. The expiration date on the containers was 11/18/25. - The kitchen floor had several black and brown dried substances on the floor tile (the floor appeared greasy) and food debris was scattered on the floor. - The knob to the oven door was missing and the Dietary Manager located it underneath the oven. the Dietary Manager indicated the knob was loose and frequently fell off. - There was a brown greasy streak running down the full length of the oven door and onto the floor. During a second observation of the facility kitchen, on 12/3/25 the following was observed: - The kitchen floor had several black and brown dried substances on the floor tile (the floor appeared greasy) and food debris was scattered on the floor. - The knob to the oven door was missing. -There was a brown greasy streak running down the full length of the oven door and onto the floor. The review of the kitchen cleaning scheduled for the month of November was reviewed. The log documentation indicated 20 out of 30 days the cleaning was not completed. During an interview, on 1/12/25 at 9:30 a.m., the Dietary Manager indicated if there were blank holes in the cleaning schedule that meant the cleaning was not done. She indicated leftover food should be disposed of after three days. 3.1-21(i)(l)(3)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, record review and interview, the facility failed to ensure a resident's plan of care was revised for 1 of 3 residents reviewed for dementia care. (Resident 121)Findings include:During an observation on 12/5/25 at 11:30 a.m., the resident was seen in the hallway propelling his wheelchair to the activities room from C Hall which was not a locked unit. The resident indicated that he felt good today and was ready to be out of his room.The record for Resident 121 was reviewed on 12/2/25 at 8:30 a.m. The resident's diagnoses included, but were not limited to, personal history of traumatic brain injury, bipolar disorder, memory deficit following other cerebrovascular disease, history of falls, and chronic obstructive pulmonary disease.A care plan, dated 4/12/24, indicated the resident had a diagnosis of dementia, that negatively impacts the resident's cognition and judgement, causing the resident to require a locked, structured unit. The goal, dated 2/14/26, was for the resident to remain on locked unit until their clinical and psychosocial needs no longer required a specialized unit. The interventions, dated 4/12/24, included but were not limited to, educate the resident's family of disease process; and the resident will be encouraged to participate in activities of interest; staff to provide cues and reminders to the resident as necessary.A physician's order, dated 5/8/24, indicated the resident may reside on the secured memory unit.The resident's clinical record lacked an updated care plan and/or interventions related to the resident's improved cognition, judgement and behaviors. The resident resided on the memory unit starting on 4/11/24 and was transferred to the skilled nursing hallway on 12/27/24.The Social Service note, dated 12/30/24 at 4:27 p.m., indicated the resident was visited to follow up with his new room on the skilled nursing hall.The Quarterly Minimum Data Set (MDS) assessment, dated 10/23/25, indicated the resident's cognition was cognitively intact.During an interview, on 12/4/25 at 10:30 a.m., Certified Nurse Aide (CNA) 13 indicated that the resident did not have behaviors throughout the day when she was here. He refused care sometimes but did not attempt to wander or elope from the facility.During an interview, on 12/5/25 at 10:00a.m., the Director of Nursing indicated that changes to care plans and orders were made by the Interdisciplinary (IDT) team after a change in condition had been addressed in a resident.During an interview, on 12/5/25 at 11:00 p.m., The Clinical Specialist indicated that there were no policies on care plans or care plan revisions. The facility followed the Resident Assessment Instrument (RAI) manual for care plans.3.1-35(c)(1)