STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155432		07/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBANY HEALTH CARE & REHABILITATION CENTER	910 W WALNUT ST ALBANY, IN 47320

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: 7/6/16, 7/7/16, 7/8/16, 7/11/16, 7/12/16 and 7/13/16 Facility number: 000309 Provider number: 155432 AIM number: 100288960 Census bed type: SNF/NF: 64 Total: 64 Census payor type: Medicare: 9 Medicaid: 45 Other: 10 Total: 64 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. QR completed by 11474 on July 15, 2016.	F 0000	The following Plan ofCorrection constitutes ourwritten allegation ofcompliance for the deficienciescited. Submission of the Planof Correction is not anadmission that a deficiencyexists or that one was citedcorrectly. This Plan ofCorrection is submitted tomeet the requirementsestablished by state andfederal law. We formallyrequest Paper Compliance forthis survey.	
F 0157 SS=D	483.10(b)(11) NOTIFY OF CHANGES			

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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Bldg. 00	(INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.			
	Based on record review and interview, the facility failed to ensure the physician was notified of blood pressure results in accordance with his orders for 1 of 5 residents reviewed for unnecessary medications. (Resident #22)	F 0157	**F157 Notification of Changes** 1. What corrective action(s) will be accomplishedfor those residents found to have been affected by the deficient practice? The Physician was notified of Resident #22's bloodpressure results. 2. How other	08/12/2016

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	Findings include: The clinical record for Resident #22 was reviewed on 7/11/16 at 9:51 a.m. Diagnoses for Resident #22 included, but were not limited to, hypertension, bipolar disorder, and anemia. Resident #22 had current, physician's orders for the following: a. Lisinopril (a blood pressure medication) 20 mg by mouth every day. The original date of this order was 10/5/11. b. Check blood pressure and pulse weekly. Notify physician of systolic blood pressure below 110 or above 180, and for a pulse below 60. The original date of this order was 4/26/14. Resident #22 had a health care plan, dated 12/11/14, with a focus of hypertension. One of the interventions for this focus was to "have my blood pressure taken as ordered and they [the blood pressure results] will be observed for any pattern changes." Review of the July, 2016, Medication Administration Record (MAR) indicated Resident #22's blood pressure was 104/54 on 7/2/16, and 103/56 on 7/9/16.		residents having the potential to beaffected by the same deficient practice will be identified and what correctiveaction(s) will be taken? All residents with blood pressure readings outsideof the physician call parameters have the potential to be affected. An audit was completed of all blood pressures obtained overthe past 2 weeks to ensure call parameters were followed. 3. What measures will be put into place or whatsystemic changes will be made to ensure that deficient practice does not recur? An in-service was provided to nursing staff onPhysician/Family/Responsible Party Notification for Change in Condition Policy. 1:1 education was provided to the staff members whofailed to notify the physician/family. Daily (to exclude weekends and holidays), DON/designeewill complete an audit of the Vitals Summary report to ensure all relevantblood pressures were reported and documented. 4. How will the corrective action(s) be monitoredto ensure the deficient practice will not recur? ie: what QA program will be put into place and bywhat date will they be completed. **All audits/findings will bereviewed monthly by QA team x 3 months then quarterly x 3.** 5. By what date will the systematic changes becompleted? **August 12, 2016**	

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	Review of the nurses notes from 7/2/16 to 7/10/16 lacked any documentation of the physician having been notified of Resident#22's blood pressure on 7/2/16 or 7/9/16. During an interview on 7/12/16 at 1:25 p.m. the Acting Director of Nursing indicated the physician had not been notified of Resident #22's blood pressure results on 7/2/16 and 7/9/16. Review of the current facility policy, revised 8/2013, titled "PHYSICIAN/FAMILY/RESPONSIBLE PARTY NOTIFICATION FOR CHANGE IN CONDITION", provided by the DON on 7/12/16 at 3:40 p.m., included, but was not limited to, the following: "Purpose: To ensure that medical care problems are communicated to the attending physician and family/responsible party in a timely, efficient,, and effective manner.... ...1. Physician and family/responsible party notification is to include, but is not limited to: ...Significant change in/or unstable vital signs... ...Change in condition that may warrant a			

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	change in current treatment.... ...2. Physician and Family/Responsible Party notification will be documented in the progress notes, it should contain information regarding the resident condition, physician notification, and any physician orders obtained...." 3.1-5(a)(3)			
F 0333 SS=D Bldg. 00	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. Based on observation, record review and interview, the facility failed to administer a psychoactive medication as ordered by the physician, resulting in a significant medication error for 1 of 5 residents reviewed for unnecessary medications. (Resident #6) Findings include: The clinical record for Resident #6 was reviewed on 7/8/16 at 10:19 a.m. Diagnoses for Resident #6 included, but was not limited to, metabolic	F 0333	**F333 RESIDENTS FREE OF SIGNIFICANT MED ERRORS** 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Upon review of Resident #6's medication dosage, a call was placed to the facility Pharmacist to discuss recommendations of method to decrease or discontinue medication to avoid adverse side effects or withdrawal. Information was received at this time from the facility Pharmacist regarding side effects to monitor Resident#6 for. Director of Nursing completed an	08/12/2016

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	encephalopathy, dementia without behaviors, hypertension, atrial fibrillation, hypo-osmolatity and hyponatremia. Resident #6 had a current, physician's order for Haldol (an antipsychotic medication) 2.5 mg by mouth at bedtime. The original date of this order was 6/17/16. Prior to the 6/17/16 order, Resident #6 had been receiving Haldol 0.5 mg by mouth at bedtime. Resident #6 had a health care plan dated 6/15/16, and revised on 6/19/16 which indicated Resident #6 had the focus of being admitted to the facility having been receiving Haldol for insomnia. One of the interventions for this focus was "I receive medications as ordered" dated 7/9/16. Review of a pharmacy "Consultation Report", dated 6/10/16, indicated Resident #6 "receives an antipsychotic, HALDOL 0.5 MG HS." Recommendations from the pharmacist included, but were not limited to, "REDUCE THE DOSE SLOWLY WHILE MONITORING to 0.25 mg HS [bedtime] x [for] 7 days..." The respond to the recommendation was "IDT [Interdisciplinary Team] recommends to decrease the Haldol to 0.25 mg hs. Res.		assessment of Resident #6 by speaking with therapy staff, floor staff, reviewing nurses notes, hospital notes, and Nephrologist's progress notes. A new Abnormal Involuntary Movement assessment was completed. Resident #6's physician was updated with all information including resident's assessment findings, Haldol dose, and Pharmacist recommendations. A physician order was received to decrease Resident#6's Haldol to 0.25mg daily times seven days, then discontinue. Pharmacy was notified of the new order. Current Haldol supply was removed from the medication cart and destroyed per facility policy. A Transcription Error Report was completed. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All Residents receiving Pharmacy recommendations to change a medication dosage have the potential to be affected. An audit was completed for Pharmacy recommendations received in May and June of 2016 to ensure transcription accuracy. 3. What measures will be put into place or what systemic changes will be made to ensure that deficient practice does not recur? An in-service was provided to nursing staff on Physician Orders Policy and Procedure. Following the physician's review of	

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	[resident] & family report that she has been taking it for insomnia for over 20 years There is no hx [history] of other significant mental illness. IDT rec.s [recommends] to eventually discontinue the Haldol & if she has insomnia sx's [symptoms], IDT recommends to use a hypnotic or antidepressant that's appropriate for insomnia symptom as well." The pharmacy report as signed by the physician on 6/16/16. Review of the June, 2016, and July, 2016, Medication Administration Records indicated Resident #6 had received Haldol 2.5 mg by mouth at bedtime, instead of 0.25 mg by mouth at bedtime, from 6/17/16 to 7/7/16. This resulted in the resident having received a total of 21 incorrect Haldol doses, 2.25 mg more than the ordered dose each time the medication was given. A "Interdisciplinary Psychopharmacological Review" note for Resident #6, dated 6/19/16, indicated the Interdisciplinary Team failed to identify the resident had the incorrect dose of Haldol ordered on 6/17/16. Review of a nurses note for Resident #6, dated 7/8/16 at 3:58 p.m., indicated "Reviewed current Haldol dose with pharmacist with new recommendation for		Pharmacy recommendations, DON/designee will review to identify receipt of a physician's order. The identified pharmacy recommendations will be distributed to the appropriate licensed nurse for order entry. Daily (to exclude weekends and holidays) the EMR Coordinator/designee will print all written orders for review during clinical meeting, at which time the DON/designee will complete an audit of applicable orders against the physician's written order to ensure accuracy. 4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur? ie: what QA program will be put into place and by what date will they be completed. **All audits/findings will be reviewed monthly by QA team x 3 months then quarterly x 3.** 5. By what date will the systematic changes be completed? **August 12, 2016**	

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	0.25 mg daily for 7 days, then d/c [discontinue]. Resident continues to progress in her therapy services. Dr. [name of physician] updated and agrees with the recommendation. Written as ordered. No further orders received. Son, [name of son] aware. During an interview with the Acting Director of Nursing (DON) and the Nurse Consultant on 7/12/16 at 11:12 a.m., they indicated the medication error had been discovered when gathering and reviewing information for the surveyors. The DON indicated the decimal point had been in the wrong place when the Haldol went from 0.5 mg to 2.5 mg. She indicated two pharmacists, the physician and the family had been contacted as soon as they realized the error. Information from the pharmacists included recommendations of method to decrease or discontinue medication to avoid adverse side effects or withdrawal. The DON indicated the pharmacists also provided the side effects to monitor for Resident #6. The DON indicated Resident #6 was assessed by speaking with therapy staff, floor staff, review of nurses notes, hospital notes, and nephrologist progress notes. An Abnormal Involuntary Movement assessment was completed on 7/8/16, and the physician updated with all information regarding resident, Haldol			

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	dose, and pharmacist recommendations. Manufacturer's signs and symptoms of a Haldol overdose from the "Nursing 2014 Drug Handbook", indicated "Severe extrapyramidal reactions [included, but not limited to, tremors, slurred speech, anxiety, distress, and paranoia], hypotension, and sedation." On 7/7/16 at 7:51 a.m., Resident #6 was observed sitting in her room, eating breakfast without problems. On 7/7/16 at 9:13 a.m., Resident #6 was observed sitting in her room with her eyes closed. On 7/7/16 at 10:02 a.m., Resident #6 was observed sitting in her room talking with her family and staff. Resident #6's family was present for a care plan meeting. On 7/7/16 at 10:41 a.m., therapy staff was observed assisting Resident #6 out of the resident's room. On 7/7/16 at 2:45 p.m., Resident #6 was observed in an activity, participating to the best of her ability. On 7/8/16 at 10:18 a.m., Resident #6 was observed sitting in her room watching the television.			

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	During an interview on 7/13/16 at 8:09 a.m., Occupational Therapist #3 and Occupational Therapist Aide #4 indicated Resident #6 had received physical therapy, occupational therapy and speech therapy since 6/8/16. They indicated the resident had not shown any unusual behaviors, physical symptoms, or a change in cognition throughout therapy. During an interview on 7/13/16 at 12:30 p.m., RN #5 indicated she had worked with Resident #6 and familiar with her. She further indicated she had not observed any changes to the resident's behavior, or physical symptoms such as low blood pressure, slurred speech, and no changes in mental status. Review of Resident #6's blood pressures before and after the Haldol dose change with no concerns noted. The resident had been seen by the physician on 7/6/16 with "no acute distress" and "Patient stable" documented on physician progress note. During an interview on 7/13/16 at 12:52 p.m., the Social Services Director indicated during the IDT meetings the pharmacy recommendations are reviewed and the resident's current orders are not in front of them at the same time. She indicated she assumed the correct dose			

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	for Resident #6 had been ordered for the Haldol medication dose change on 6/16/17. She indicated she never looked at the pharmacy recommendation and the resident's physician order side by side or at the same time. Review of the current facility policy, revised 1/2012, titled "ADMINSITRATIVE PHYSICIAN'S ORDERS", provided by the DON on 7/12/16 at 3:40 p.m., included, but was not limited to, the following: "Purpose: To provide general guidelines when receiving, transcribing, notification, and care planning physician's orders.... ...a. Enter the order into the resident's chart under 'phys order' tab and according to the instructions for the type of order that is received.... ...Include: 1. Route 2. Dose 3. Times...." 3.1-48(c)(2)			