

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155616	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/13/2016
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NAME OF PROVIDER OR SUPPLIER NEW ALBANY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 201 E ELM ST NEW ALBANY, IN 47150
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00203544.</p> <p>Complaint IN00203544 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Unrelated deficiencies are cited.</p> <p>Survey dates: July 12 and 13, 2016</p> <p>Facility number: 001145 Provider number: 155616 AIM number: 200120200</p> <p>Census bed type: SNF/NF: 80 Residential: 12 Total: 92</p> <p>Census payor type: Medicare: 5 Medicaid: 61 Other: 14 Total: 80</p> <p>Sample: 3</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

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F 0157 SS=D Bldg. 00	<p>Quality review completed by 34233 on July 19, 2016.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (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).</p> <p>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.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p>			

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	<p>Based on interview and record review, the facility failed to ensure the physician was aware of a critical lab (Resident #C) for 1 of 3 residents reviewed for physician notification.</p> <p>Findings include:</p> <p>During an interview on 7/12/16 at 1:30 p.m., Resident #C indicated, prior to his/her hospital transfer on 7/5/16, he/she had the shakes for a couple of days and told the nurse he/she wanted to go to the hospital.</p> <p>The clinical record for Resident #C was reviewed on 7/12/13 at 1:45 p.m. Diagnosis included, but was not limited to, hyperkalemia. The initial MDS (Minimum Data Set) assessment, dated 6/9/16, indicated Resident #C had a BIMS (Brief Interview of Mental Status) score of 15, which signified intact cognition.</p> <p>The nurses note, dated 7/4/16 at 1:30 p.m., included, but was not limited to, the following: "NO [New Order]: STAT [immediate] BMP [basic metabolic panel] [sic] CBC [complete blood count], valproic acid levels @ [at] this time. Pt [patient] is having slight jerky movements in the upper exts [extremities]. No pain. Pt [patient] A/O</p>	F 0157	<p>1 The Resident that was affected did not return to our facility She chose to return to the facility she resided at prior to her stay with us</p> <p>2 All Resident Labs were reviewed from July 1st to present No other Residents were found to be affected</p> <p>3 The Policy was reviewed and the Nurses were in-serviced immediately on the importance of immediate Physician notification of a Resident change in condition which may affect the well-being of the Resident including but not limited to Critical Lab Results The notification must be made by phone The Resident and/or Responsible party must also be contacted and informed of any change in the Resident or the treatment of Lab Log Books were placed at each Nurses Station which all labs ordered will be logged and follow up documentation including but not limited to Physician notification & Orders (Lab Log will be submitted)</p> <p>4 The DON and/or ADON will audit Lab Logs daily x4 weeks then weekly x4 then monthly x4 then quarterly as an on-going QA Focus Any areas of concern will be addressed immediately and brought to the Administrator The Logs will be reviewed monthly by the QA Committee to ensure on-going compliance and assess for the need of policy revision and/or further staff education</p>	08/12/2016			

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	<p>[alert and oriented] x [times] 3 [sic] able to make needs known. Sister states [sic] "last time she had shakes she had to be sent to hospital and get a transfusion. MD [medical doctor] made aware. Labs ordered...."</p> <p>The physician order, dated 7/4/16 at 1:30 p.m., indicated to obtain a BMP, CBC and Valproic Acid level.</p> <p>The BMP, dated 7/4/16 at 6:10 p.m., included, but was not limited to, the following: "...Potassium...7.6 (C) [critical]...Range [normal range]...3.5-5.2...."</p> <p>The nurses note, dated 7/4/16 at 7:00 p.m. indicated there were no new orders from the physician related to the critical potassium level.</p> <p>On 7/12/16 at 4:00 p.m., during an interview with Resident #C's attending physician, he indicated that he only received notification regarding a low Valproic Acid level. The physician also indicated he would have done something had he received the critical potassium lab value.</p> <p>On 7/13/16 at 1:40 p.m., during an interview with LPN (Licensed Practical Nurse) #3, she indicated when a resident</p>			

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	<p>had a critical lab value, the lab will call and notify the facility, and the facility, then, would call the physician.</p> <p>On 7/13/16 at 2:00 p.m., during a telephone interview with LPN #2, she indicated due to shift change LPN #3 texted the labs to the physician, and she wrote the nurses note that indicated no new orders. LPN #2 also indicated she notified the DON (Director of Nursing).</p> <p>On 7/13/16 at 2:10 p.m., during an interview with the DON, she indicated LPN #2 did not notify her of the critical labs. The DON indicated LPN #3 told her, as she was walking out the door, that there were labs sent to the physician and they were waiting on a response. The DON indicated she was not told the labs were critical. The DON also indicated there were problems with staff notifying her of lab results.</p> <p>On 7/13/16 at 2:15 p.m., during an interview with LPN #3, she indicated she texted the physician, at 6:28 p.m., pictures of the labs and asked for any new orders. LPN #3 indicated the physician responded at 6:44 p.m., indicating no new orders. She showed the text response from the physician to LPN #2, who then documented in the nurses notes.</p>			

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	<p>The clinical record lacked documentation that the lab values were texted to the physician when the labs were sent/called to the facility.</p> <p>On 7/13/16 at 4:15 p.m., the Administrator provided a current copy of the document titled, "Physician Notification, Change in Condition". It included, but was not limited to, the following: "...Purpose...The purpose of this procedure is to assure each resident's physician is notified immediately in [sic] if there is a crucial/significant change in the resident's condition...Procedure...1. Each resident's physician will be contacted immediately when he/she experiences a significant change in condition...Change in condition includes [sic] but is not limited to:...B. A change in resident's physical...status...This may include [sic] but not limited to [sic] deterioration in health...status in life threatening conditions or clinical complications...2. When there is notification to physician of a change in condition the nurse will document in the nurses notes the times notification was made and the names of the person(s) to whom you spoke...."</p> <p>3.1-5(a)(2)(3)(4)</p>			

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F 0309 SS=G Bldg. 00	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>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.</p> <p>Based on interview and record review, the facility failed to ensure the physician was aware of a critical lab for a resident (Resident #C) which resulted in a delay of hospitalization for 1 of 3 residents reviewed for hospital transfers.</p> <p>Findings include:</p> <p>During an interview on 7/12/16 at 1:30 p.m., Resident #C indicated, prior to his/her hospital transfer on 7/5/16, he/she had the shakes for a couple of days and told the nurse he/she wanted to go to the hospital. Resident #C also indicated the nurse told him/her she would have to get an order from the physician and the physician did not like getting phone calls. Resident #C indicated the nurse did call the physician and obtained an order to send him/her to the hospital.</p> <p>The clinical record for Resident #C was reviewed on 7/12/13 at 1:45 p.m. Diagnosis included, but was not limited to, hyperkalemia. The initial MDS</p>	F 0309	<p>1 The Resident affected did not return to our facility She chose to return to the facility she was residing at prior to her stay with us 2 All Resident Labs were reviewed from July 1st to present No other Residents were found to be affected 3 The Policy was reviewed and the Nurses were in-serviced immediately on the importance of immediate Physician notification of a Resident change in condition which may affect the well-being of the Resident including but not limited to Critical Lab Results The notification must be made by phone The Resident and/or Responsible party must also be informed of any change in condition or the treatment of Lab Log books were placed at each Nursing Station which all labs ordered will be logged and follow up documentation including but not limited to Physician notification & Orders (Lab Log will be submitted)</p> <p>4 The DON and/or ADON will audit Lab Logs daily x4 weeks then weekly x4 weeks then monthly x4 then quarterly as a QA</p>	08/12/2016

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	<p>(Minimum Data Set) assessment, dated 6/9/16, indicated Resident #C had a BIMS (Brief Interview of Mental Status) score of 15, which signified intact cognition.</p> <p>The nurses note, dated 7/4/16 at 1:30 p.m., included, but was not limited to, the following: "NO [New Order]: STAT [immediate] BMP [basic metabolic panel] [sic] CBC [complete blood count], valproic acid levels @ [at] this time. Pt [patient] is having slight jerky movements in the upper exts [extremities]. No pain. Pt [patient] A/O [alert and oriented] x [times] 3 [sic] able to make needs known. Sister states [sic] "last time she had shakes she had to be sent to hospital and get a transfusion. MD [medical doctor] made aware. Labs ordered...."</p> <p>The physician order, dated 7/4/16 at 1:30 p.m., indicated to obtain a BMP, CBC and Valproic Acid level.</p> <p>The BMP, dated 7/4/16 at 6:10 p.m., included, but was not limited to, the following: "...Potassium...7.6 (C) [critical]...Range [normal range]...3.5-5.2...."</p> <p>The nurses note, dated 7/4/16 at 7:00 p.m., included the following: "No N.O's</p>		<p>Focus to ensure compliance Any areas of concern will be addressed immediately and reported to the Administrator. The Logs will be reviewed by the QA Committee monthly to ensure on-going compliance and assess the need for policy revision and further staff education.</p>	

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	<p>[new orders] R/T [related to] results of STAT BMP, CBC, and Valporic [sic] Acid levels per [physician name]...."</p> <p>The SBAR (Situation, Background, Appearance, Review and Notify), dated 7/5/16 at 9:00 a.m., included, but was not limited to, the following: "...Situation...The change in condition, symptoms, or signs observed and evaluated is/are...Irregular labs...K+ [potassium]...7.6...This started on 07/04/16...Appearance...Resident was noted on 07/04/16 to have noticeable jerky movement in bilat [bilateral] upper arms/hands. M.D. notified [plus sign] [and] stat labs taken; MD notified of results [c with line over it] [with] no N.O given; resident requested to be sent to hospital...Review and Notify...[physician name]...Date...07/04/16...1900 [7:00 p.m.]...Resident Evaluation...6. Abdominal/GI [gastrointestinal] Evaluation...Nausea...10. Neurological Evaluation...Other neurological symptoms...Noticeable shakiness in bilateral hands...."</p> <p>The physician order, dated 7/5/16 at 9:00 a.m., indicated the following: "May send to [name of hospital] for evaluation [plus sign] [and] treatment...."</p> <p>The hospital discharge summary, dated</p>			

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	<p>7/11/16 at 7:15 p.m., included, but was not limited to, the following: "...Admit Date: 07/05/2016 11:21 [11:21 a.m.]...Admitting Diagnosis...muscle spasms...elevated K [potassium]...Hospital Course...female came to ER [emergency room] with active complaint of muscle spasms since yesterday, patient underwent workup at ECF [extended care facility] which showed elevated K, [sic] following [sic] this patient was transferred to ER and we were asked to see the patient for further care...patient was...found to have elevated K greater than 7...Patient received IV [intravenous] fluids...Lasix IV x [times] 1 today to promote potassium excretion...."</p> <p>The hospital lab for Resident #C, dated 7/5/16, included, but was not limited to, the following: "...Routine Chemistry...Potassium...Range [normal range]...3.6-5.1...* [indicates critical] 7.0...."</p> <p>During an interview on 7/12/16 at 4:00 p.m., Resident #C's attending physician indicated he only received notification regarding a low Valproic Acid level. The physician also indicated he would have done something had he received the critical potassium lab value on 7/4/2016.</p> <p>During an interview on 7/13/16 at 1:40</p>						

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	<p>p.m., LPN (Licensed Practical Nurse) #3 indicated, when a resident has critical lab values, the lab will call and notify the facility and the facility, then, would call the physician.</p> <p>During a telephone interview on 7/13/16 at 2:00 p.m., LPN #2 indicated LPN #3 texted the labs to the physician and she wrote the nurses note due to it was change of shift. LPN #2 also indicated she notified the DON (Director of Nursing).</p> <p>During an interview on 7/13/16 at 2:10 p.m., the DON indicated LPN #2 did not notify her of the critical labs. The DON indicated LPN #3 advised her, as she was walking out the door, that there were labs sent to the physician and they were waiting on a response. The DON indicated she was not told the labs were critical. The DON also indicated there were problems with staff notifying her of lab results.</p> <p>During an interview on 7/13/16 at 2:15 p.m., LPN #3 indicated she texted the physician, on 7/4/16 at 6:28 p.m., pictures of the labs and asked for any new orders. LPN #3 indicated the physician responded at 6:44 p.m., indicating no new orders. She showed the text response from the physician to LPN</p>			

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F 0505 SS=D Bldg. 00	<p>#2, who then documented physician notification in the nurses notes.</p> <p>3.1-37(a)</p> <p>483.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS</p> <p>The facility must promptly notify the attending physician of the findings. Based on interview and record review, the facility failed to follow the lab reporting policy/protocol when a resident's (Resident #C) lab values were at a critical level for 1 of 3 residents reviewed for labs.</p> <p>Findings include:</p> <p>The clinical record for Resident #C was reviewed on 7/12/13 at 1:45 p.m. Diagnosis included, but was not limited to, hyperkalemia.</p> <p>The nurses note, dated 7/4/16 at 1:30 p.m., indicated new orders were received for stat (immediate) labs, which included a BMP (basic metabolic panel), CBC (complete blood count), and a valproic acid level. The nurses not also indicated Resident #C was having slight jerky movements in the upper extremities and family indicated the last time Resident #C had the shakes, he/she had to be sent to hospital to get a transfusion.</p>	F 0505	<p>1 The Resident affected did not return to our facility She chose to return to the facility she resided at prior to her stay with us 2 All Resident Labs were reviewed from July 1st to present No other Residents were found to be affected 3 The Policy was reviewed and the Nurses were in-serviced immediately on the importance of immediate Physician notification of a Resident change in condition which may affect the well-being of the Resident including but not limited to Critical Lab Results. The notification must be made by phone. The Resident and/or Responsible party must be informed of any change in condition or the treatment of. Lab Log books were placed at each Nurses Station which all labs ordered will be logged and follow up documentation including but not limited to Physician notification & Orders (Lab Log will be submitted) 4 The DON and/or ADON will audit Lab Logs daily x4 weeks then weekly x4 weeks then monthly x4 then quarterly as a QA</p>	08/12/2016

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	<p>The physician order, dated 7/4/16 at 1:30 p.m., indicated to obtain a BMP, CBC and Valproic Acid level.</p> <p>The BMP, dated 7/4/16 at 6:10 p.m., included, but was not limited to, the following: "...Potassium...7.6 (C) [critical]...Range [normal range]...3.5-5.2...."</p> <p>The nurses note, dated 7/4/16 at 7:00 p.m. indicated there were no new orders from the physician related to the critical potassium level.</p> <p>On 7/12/16 at 4:00 p.m., during an interview with Resident #C's attending physician, he indicated that he only received notification regarding a low Valproic Acid level on 7/4/16.</p> <p>On 7/13/16 at 1:40 p.m., during an interview with LPN (Licensed Practical Nurse) #3, she indicated when a resident has critical lab values, the lab will call and notify the facility and the facility, then, would call the physician.</p> <p>On 7/13/16 at 2:00 p.m., during a telephone interview with LPN #2, she indicated LPN #3 texted the labs to the physician and she wrote the nurses note, that indicated no new orders, due to it</p>		<p>Focus to ensure on-going compliance Any areas of concern will be addressed immediately and reported to the Administrator. The Lab Logs will be reviewed monthly by the QA Committee to ensure compliance and assess for the need of Policy Revision and/or further staff education</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155616	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/13/2016
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NAME OF PROVIDER OR SUPPLIER NEW ALBANY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 201 E ELM ST NEW ALBANY, IN 47150
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	<p>was change of shift.</p> <p>On 7/13/16 at 2:10 p.m., during an interview, the DON (Director of Nursing) indicated she was not notified of Resident #C's critical labs. The DON indicated LPN #3 told her, as she was walking out the door, that there were labs sent to the physician and they were waiting on a response from the physician.</p> <p>On 7/13/16 at 2:15 p.m., during an interview with LPN #3, she indicated she texted the physician, on 7/4/16 at 6:28 p.m., pictures of the labs and asked for any new orders. LPN #3 indicated the physician responded at 6:44 p.m., indicating no new orders. She showed the text response from the physician to LPN #2, who then documented in the nurses notes.</p> <p>The clinical record lacked documentation that the physician was called with regards to the critical lab values for Resident #C.</p> <p>On 7/13/16 at 3:20 p.m., the Administrator provided a current copy of the document titled, "Lab Reporting Policy/Protocol". It included, but was not limited to, the following: "...1. Critical Labs are to be called...5. Completion of [sic] and accurate response to [sic] is critical to the wellbeing of our</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER NEW ALBANY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 201 E ELM ST NEW ALBANY, IN 47150		
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	residents...." 3.1-49(f)(2)				