STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155616	A. BUILDING 00 B. WING	04/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW ALBANY NURSING AND REHABILITATION CENTER	201 E ELM ST NEW ALBANY, IN 47150

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00348755, IN00351388, and IN00351834. Complaint IN00348755 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00351388- Substantiated. Federal/State deficiencies related to the allegations are cited at F550 and F600. Complaint IN00351834 - Substantiated. Federal/State deficiencies related to the allegations is cited at F689. Survey dates: April 20 and 21, 2021 Facility number: 001145 Provider number: 155616 AIM number: 200120200 Census Bed Type: SNF/NF: 59 Residential: 5 Total: 64 Census Payor Type: Medicare: 4 Medicaid: 54 Other: 1 Total: 59 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on April 23, 2021.	F 0000		

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

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F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his			

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	or her rights as required under this subpart. Based on observation, interview, and record review, the facility failed to ensure a resident's (Resident B) refusal of care was honored for 1 of 3 residents reviewed for resident rights. Findings include: The clinical record for Resident D was reviewed on 4/20/21 at 2:48 p.m. Diagnoses included, but were not limited to, Parkinson's disease, anxiety, and schizoaffective disorder of the bipolar type. The quarterly MDS (Minimum Data Set) assessment, dated 3/19/21, indicated the resident's cognition was intact. The incident report, dated 4/11/21 at 6:01 p.m., indicated the resident reported a staff member squeezed his left hand and his two outer digits hurt. The care plan, dated 2/18/19, indicated the resident refused care and to encourage him to vent his feelings and frustrations. The progress note, dated 4/12/21 at 12:17 a.m., indicated the resident complained of pain to the left hand and around the knuckles. The physician was notified of the resident's pain and an x-ray ordered. The progress note, dated 4/12/21 at 10:14 a.m., indicated the resident's left hand, 4th and 5th digits, appeared to be swollen and bruised. The radiology report, dated 4/12/21 at 12:11 p.m., indicated a fifth proximal phalanx bony fragment, possibly a fracture and the age of the fracture was unclear.	F 0550	F-550 Resident Rights Resident “D” continues to reside at facility. Resident “D” wears only pull ups, care plans have been updated to state only pull ups per resident’s request. CAN assignment sheets have been updated that resident is to wear only pull ups. Staff have been in serviced on resident rights, and abuse by Nursing Administration on April 28th and April 29th2021. All new hired staff will be educated on resident rights during orientation. On going resident rights inservices will be conducted no less than yearly. Residents have the right to refuse care if they do not want it. A questionnaire will be compiled and all interveiwable residents with a Bims score 10 or greater will be interviewed by DON or her designee to validate that all requests are being followed. Any findings will immediately be fixed, and care plan updated. Questionnaire will be done with each quarterly assessment by activities director. Audits will be completed with 5 residents per week to be interviewed weekly times 2 months, then 5 residents every other week times 2 months, then 5 residents monthly times 2 months, then quarterly when MDS is due. All findings will be brought to QAPI till 100% compliance	05/06/2021

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	The progress note, dated 4/12/21 at 3:26 p.m., indicated a new order was received to send the resident to the emergency department related to the x-ray results. The progress note, dated 4/12/21 at 6:28 p.m., indicated the resident returned from the hospital. The report showed a fracture of the fifth digit of the left hand, which was splinted and wrapped. On 4/20/21 at 3:35 p.m., the resident was observed sitting up in his chair in his room. His left pinky finger was observed with brown bruising. He indicated the aide was trying to change him. He did not want a brief on, he wanted a pull up. The aide continued to put a brief on him and he was trying to take it off. He wanted a pull up on, not a brief. He told her to stop and tried to keep her from putting it on him. She squeezed his left hand and broke his little finger. He could not recall the aide's name. During an interview on 4/21/21 at 12:04 p.m., CNA (Certified Nursing Aide) 3 indicated the resident needed to be changed because he had soaked through his brief. She went in to change him and he started swinging his arms and fighting her. He had a blue brief on with a pull up over it because he is a heavy wetter. He did not like the blue brief. She hollered out for help, but no one came. She did not want to leave him wet, so she put on his brief and pull up, dressed him, and transferred him to his wheelchair at which time the resident continued swinging. She did not stop and walk away at the beginning due to the way he was acting. She did not want him to get up on his own and hurt himself because he had an unsteady gait. She just wanted to get him cleaned, up, and		obtained. Audits to be completed by DON or her designee. Facility alleges compliance May 6, 2021	

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	safe. She did not lay her hands on him and blocked his swings with her forearms. During an interview on 4/21/21 at 3:10 p.m., the Director of Nursing indicated CNA 3 should have walked away when the resident became combative and was refusing care. On 4/21/21 at 1:25 p.m., the Director of Nursing provided a current copy of the document titled "Resident Rights" dated 2014. It included, but was not limited to, "The right to be treated with dignity and respect ...Another right residents have when living in a long-term care facility is the right to be treated with dignity and respect ...residents are entitled to care that promotes their physical ...social well-being ...." On 4/21/21 at 3:05 p.m., the Director of Nursing provided a current copy of the document titled "Refusal of Treatment" dated December 2006. It included, but was not limited to, "Our facility shall honor a resident's request not to receive ...treatment ...as well as care routines outlined on the resident's ...plan of care This Federal tag relates to Complaint IN00351388 3.1-3(t)			
F 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or			

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	chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on interview and record review, the facility failed to ensure resident to resident abuse did not occur for 3 of 4 resident's reviewed for abuse. (Residents E, F, and G) Findings include: 1. a. The clinical record for Resident E was reviewed on 4/21/21 at 11:11 a.m. Diagnosis included, but was not limited to, dementia with behavioral disturbance. The admission MDS (Minimum Data Set) assessment, dated 2/4/21, indicated the resident's cognition was severely impaired. The resident had physical behaviors which occurred 1 to 3 days, and she had wandering behaviors 1 to 3 days. The incident report, dated 2/22/21 at 10:01 p.m., indicated Resident E was found in Resident F's room after staff heard Resident F hollering. Resident E had her hand on Resident F's stomach. Resident F reported she was hit in the chest by the resident along with multiple times in the stomach. The progress note, dated 2/22/21 at 8:43 p.m., indicated at 7:20 p.m., Resident E was found in another residents' room. The resident reported that Resident E hit her in her chest and stomach. She reported that Resident E tried to push her and kept on hitting her. The resident was heard screaming which prompted staff to enter the	F 0600	Residents' "E', "F", and "G" all continue to reside at facility. Psych services is in the facility weekly and sees residents as needed for behaviors or medication reviews. There has been no additional resident to resident altercations involving resident "E", "F", and "G". Activities department has increased activities on Memory care unit, to keep residents occupied and interested. In services were completed on abuse and monitoring residents upon return from Behavior Units by Nursing Administration on 4/28 and 4/29/2021. A monitoring/observation tool has been initiated for all residents Admitted or readmitted from a behavior unit. This tool can also be initiated at any time a resident starts exhibiting behaviors or aggression. All monitoring tools will be brought to morning meeting to be reviewed by the IDT team to determine all needs are being met for the resident. This process will be put into place and will be ongoing. All monitoring sheets will be audited 3 times a week for 2	05/06/2021

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	room. Resident E was redirected and placed one on one. The social services note, 2/23/21 at 10:03 a.m., indicated the Resident E wandered into another residents room last night and began to hit the resident. Resident F pushed Resident E away, but she came back and hit on her again. Resident E was placed one on one with staff due to her dementia, wandering, and combative behavior. Resident E started to display combative behaviors when she was living at home with her family member which was why he was unable to provide 24 hour care for her. The progress note dated 2/23/21 at 2:04 p.m., indicated the resident was directly admitted to the hospital behavior unit. The progress note, dated 3/2/21 at 4:30 p.m., indicated the resident was readmitted to the facility, ambulatory on the unit, and wandered in and out of rooms. The resident was easily redirected. The resident was discharged to the hospital on 3/4/21 due to a syncope (fainting) episode and readmitted on 3/6/21. The incident report, dated 3/7/21 at 5:01 p.m., indicated Resident E wandered into Resident G's room and slapped her in the face which caused a scratch to Resident G's lip. The progress note, dated 3/7/21 at 4:38 p.m., indicated the resident was having continuous behaviors, constantly wandered around the unit touching people, and was redirected numerous times. At 4:30 p.m., the resident walked over to		months, then 2 times a week every other week for 2 months, then 1 time a month for 2 months. PRN audits can be done at any time. All findings will be brought to QAPI until 100% compliance is reached. Audits will be completed by DON or her designee. Facility alleges compliance May 6,2021	

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	Resident G, whom asked her to get away. The resident proceeded to slap Resident G and scratched her top lip in the process. The resident was removed from the area and placed one on one. During an interview on 4/21/21 at 3:10 p.m., the Director of Nursing indicated the staff were told to monitor the resident but there was no documentation of that. b. The clinical record for Resident F was reviewed on 4/21/21 at 11:45 a.m. Diagnoses included, but were not limited to, dementia with behavioral disturbance and bilateral lower leg amputations. The significant change MDS assessment, dated 3/17/21, indicated severely impaired cognition. The incident report, dated 2/22/21 at 10:01 p.m., indicated Resident E was found in Resident F's room after staff heard Resident F hollering. Resident E had her hand on Resident F's stomach. Resident F reported she was hit in the chest and multiple times in the stomach. c. The clinical record for Resident G was reviewed on 4/21/21 at 12:12 p.m. Diagnosis included, but was not limited to, dementia with behavioral disturbance. The quarterly MDS assessment, dated 4/9/21, indicated severely impaired cognition. The incident report, dated 3/7/21 at 5:01 p.m., indicated Resident E wandered into Resident G's room and slapped her in the face which caused a scratch to Resident G's lip. On 4/20/21 at 12:06 p.m., the Executive Director			

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	provided a current copy of the document titled "Abuse & Neglect" dated 11/19/18. It included, but was not limited to, "Policy...Each resident has the right to be free from abuse..."Physical abuse" included hitting...." According to the National Institute of Aging website found at www.nia.nih.gov/health/elder-abuse#effect, " ...Any type of mistreatment can leave the abused person feeling fearful and depressed. Sometimes, the victim thinks the abuse is his or her fault ...." This Federal tag relates to Complaint IN00351388 3.1-27(a)(1)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review, the facility failed to ensure adequate supervision was in place when a resident (Resident B) broke into an unsupervised medication cart and took and ingested another resident's medications. Findings include: The clinical record for Resident B was reviewed on 4/20/21 at 12:16 p.m. Diagnoses included, but were not limited to, anxiety, bipolar, dementia with	F 0689	F-689 Free of Accident Hazards/Supervision/Devices Resident “B” discharged from facility. Residents’ son lives in Eastern Kentucky and he wanted his father closer to him so he could visit him more. Resident discharged from Hospital with no adverse effects from accidental overdose.	05/06/2021

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	behavioral disturbance, and major depressive disorder. The quarterly MDS (Minimum Data Set) assessment, dated 4/9/21, indicated the resident cognition was intact. The incident report, dated 4/16/21 at 10:01 a.m., indicated the resident was found to have six blister packs (medication cards) in his room that belonged to another resident and had ingested them. The resident was sent to the ER for evaluation. The behavior note, dated 3/29/21 at 6:35 p.m., indicated the resident had been medication seeking during shift change, pacing back and forth to each medication cart asking for anything that would help him sleep. He was informed it was not time for his medications and was then observed to pull of medication cart drawers to see if they would open. He was instructed not to touch the medication carts and then continued to pace back and forth. The health status note, dated 3/30/21 at 2:24 a.m., indicated the resident continued to go the nurse's station looking for meds. He has been witnessed to try and open medication carts that are locked, trying to get to anyone's medications. He has been instructed not to touch medication carts and was non-compliant with the instructions. The progress note, dated 4/2/21 at 12:11 p.m., indicated the resident was pacing around the medication cart prior to breakfast and was redirected back to his room to wait for his medications. The progress note, dated 4/6/21 at 6:05 a.m., indicated the resident continued to circle the		Medication carts were immediately locked in medication room when not in use. All nurses and qma's were in serviced on medication carts and proper storage effective immediately, by Nursing Administration on 4/28 and 4/29/2021. Keys to the medication room has been placed on all medication cart keys. Staff have been in service on residents exhibiting behaviors that are increasingly agitated, anxious, persistently repetitive, and different from residents' usual behaviors. Residents must have increased supervision and monitoring. A monitoring/observation tool has been implemented to be used when resident requires additional observation. Residents MD and RP will be notified if monitoring/observation tool has been initiated. Social Services Director will be notified to check for any psychosocial needs. Audits will be done 3 times a week times 2 months, then 2 times every other week times 2 months, then 1 time per month for 2 months. All findings will be brought to QAPI till 100% compliance has been obtained. DON or her designee will do audits. Facility alleges compliance May 6, 2021.	

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	medication cart looking for whatever medications he could take. The progress note, dated 4/12/21 at 6:35 p.m., indicated the resident had been ambulating in circles around the nurse's station since shift change gleaming at staff repeating when could he have his medications. The progress note, dated 4/13/21 at 5:00 a.m., indicated the resident continued to stalk the nurse related to his medications. He went around checking the medication carts to see what he could grab and run. This nurse and other staff nurses continued to monitor him for this behavior. The progress note, dated 4/15/21 at 11:48 a.m., indicated the resident had been ambulating around the nurse's station asking for Tylenol. The progress note, dated 4/15/21 at 6:07 p.m., indicated the resident kept coming to medication cart asking for medications. He was informed it was not time for his medications and kept pacing back and forth. The progress note, dated 4/16/21 at 5:49 p.m., indicated at 8:30 a.m. this morning, the nurse on the hall was heard asking Resident B where he had gotten the medications and was observed holding the resident up. The nurse stated when she gave the resident his crushed medications, she noticed that he had quickly pushed the bottom drawer of his nightstand closed. The nurse indicated she had seen what looked like a blister pack. When she opened the drawer, she saw six blister packs, three were empty and three had medication in them. Resident B said he had taken them because he wanted to feel better. He was			

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	asked what he had taken and he said ten or so of the blue pills, four or so of the yellow pills, and was not sure how many he took of the other ones. When asked where he got them, he said out of the cart. Staff were instructed to call 911 for a possible overdose. When asked how he got in the cart, he avoided the question and said he just did. The resident had become increasingly unsteady, his speech had started to slow, and he remained very anxious. When asked if he was trying to hurt himself, he said no but just needed to take pills so he could feel better. The hospital emergency note, dated 4/16/21 at 9:56 a.m., indicated the resident came from nursing home. He had grabbed various medications off the nursing medication cart which included ten Cardura (antihypertensive medication) 1 mg (milligram) tabs, three Neurontin (anti-convulsant) 800 mg tabs, eight Prilosec (heart burn medication) 20 mg tabs, two Zoloft (anti-depressant)100 mg tabs, and an unknown amount of 5 mg Abilify (antipsychotic) tablets. When asked, the patient stated he took the medications because his stomach hurt. Poison Control was updated and the biggest concern at this point was the Cardura overdose which has the potential to cause hypotension and tachycardia. During an interview on 4/20/21 at 1:29 p.m., LPN (Licensed Practical Nurse) 4 indicated she came in at 6:00 a.m. that day (4/16/21). The medication carts were up at the nurse's station. She had both Hall 1 and Hall 2 medication carts. She went down Hall 2 first to pass medications and check blood sugars. The Hall 1 cart was up at the nurses station the whole time and there were multiple staff passing trays up around the nurses. She went to Hall 1 with the medication cart and parked it at			

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NEW ALBANY NURSING AND REHABILITATION CENTER	201 E ELM ST 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
	the end of the hall close to the DON's (Director of Nursing) office. It was between 7:45 a.m. and 8:00 a.m. when she got to Resident H's medications, who was Resident B's roommate. She noticed that Resident H had medications missing and thought maybe they were waiting on them from pharmacy. She recalled when she opened the drawer of the medication cart that it acted funny when she opened it. She didn't really think anything about it. She went in with Resident B's medications and administered them and noticed he shut the bottom drawer of his bedside table quickly. She thought she saw a bubble pack. She asked him what that was, and he got nervous, which was nothing new when you asked him questions. She opened the drawer and found multiple pill packs that belonged to his roommate. Before she could call anyone, he came to the doorway, very unsteady on his feet, and had to hold him up. She called for help, at which time the DON came out of her office, she told her what she had found, and 911 was called. His vital signs were good while here and he just acted somewhat loopy. After he went to the hospital, she noticed the slide on the front of the cart was broken. They went back and checked the drawers again and found a small tool kit. She was not sure where the resident had gotten it. 4/21/21 at 3:10 p.m., the Director of Nursing indicated they estimated the resident broke into the medication cart between 5 and 6 a.m. The night shift nurse would have been doing last minute treatments and blood sugar checks and the aides would have been assisting other residents. She believed the tool kit was sent to the resident by his family member, but the investigation was still ongoing.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155616	A. BUILDING 00 B. WING	04/21/2021

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	This Federal tag relates to Complaint IN00351834 3.1-45(a)(2)			