

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

PRINTED: 02/05/2019

FORM APPROVED

OMB NO. 0938-039

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 01/24/2019	
NAME OF PROVIDER OR SUPPLIER NEW ALBANY NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP COD 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
F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaints IN00284331 and IN00284768.</p> <p>Complaint IN00284331 - Substantiated. Federal/State deficiencies related to the allegations are cited at F689.</p> <p>Complaint IN00284768 - Unsubstantiated due to lack of sufficient evidence.</p> <p>Survey dates: January 23 and 24, 2019</p> <p>Facility number: 001145 Provider number: 155616 AIM number: 200120200</p> <p>Census Bed Type: SNF/NF: 85 Residential: 12 Total: 97</p> <p>Census Payor Type: Medicare: 6 Medicaid: 63 Other: 16 Total: 85</p> <p>This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on January 28, 2019.</p>			F 0000	<p>F 000</p> <p>Preparation and or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and or executed solely as required. The facility requests the plan of correction be considered the allegation of compliance effective 2-7-2019.</p>		
F 0689 SS=G Bldg. 00	<p>483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that -</p>						

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 other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclosed 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.

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

PRINTED: 02/05/2019
FORM APPROVED
OMB NO. 0938-039

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 01/24/2019	
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			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
	<p>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and</p> <p>§483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident's (Resident B) bed side rail fit appropriately which resulted in the entrapment of the right leg and a fracture of the left greater trochanteric at the pubic ramus (part of the pelvis) for 1 of 3 residents reviewed for accident hazards.</p> <p>Findings include:</p> <p>The clinical record for Resident B was reviewed on 1/23/19 at 1:30 p.m. Diagnoses included, but were not limited to, dementia with behavioral disturbance, anxiety, and Parkinson's disease.</p> <p>The bed rail assessment for Resident B, dated 12/20/18, indicated quarter length bed rails would be used for the resident's safety.</p> <p>The SBAR (Situation, Background, Appearance, Review) form, dated 1/14/19, indicated LPN (Licensed Practical Nurse) 4 was called to Resident B's room. The resident was found face down on the floor mat with his right leg caught between the bed rail and mattress.</p> <p>The interdisciplinary post-fall assessment, dated 1/14/19 at 7:00 a.m., indicated the resident rolled out of bed, had his right leg caught between the bed rail and mattress, and the mattress was moved to free the resident's right leg. The resident was sent to the emergency room for evaluation.</p>			F 0689	<p>F 689</p> <p>Resident B was assessed for the use of bed side rails and they were determined to be no longer necessary. Resident B's MDS and care plan were updated to reflect the resident's current bed mobility needs.</p> <p>All unoccupied beds were inspected and if side rails were present they were removed. A side rail assessment was completed on all residents with bed side rails. Side rails were removed if no longer needed. Resident representatives were notified, physician orders obtained, and all residents' MDSs and care plans were updated to reflect resident current bed mobility needs. Of the remaining residents with bed side rails, maintenance inspected the side rails to ensure proper fit, installation and function.</p> <p>To prevent reoccurrence of the deficient practice: "Check fit, installation and function of bed side rails" was added to the medication administration record (EMAR) and nursing will monitor</p>		02/07/2019

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

PRINTED: 02/05/2019

FORM APPROVED

OMB NO. 0938-039

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 01/24/2019	
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			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
	<p>The hospital x-ray report, dated 1/14/19, indicated there was no fracture to the right leg but there was a fracture of the left greater trochanteric at the pubic ramus.</p> <p>On 1/23/19 at 2:08 p.m., Resident B's bed was observed against the wall with a side rail in place to the right side of the bed. The side rail was parallel to the mattress and loose. The side rail moved freely back and forth away from the mattress.</p> <p>During an interview on 1/23/19 at 2:40 p.m., the Director of Nursing (DON) indicated the side rail looked broken and after the incident, no one looked to see if there was an issue with the bed rail. The staff informed the DON on 1/24/19 that Resident B pushes and pulls on the side rail frequently while in bed. The DON indicated she was unaware of the resident's behavior prior to 1/24/19.</p> <p>During an interview on 1/23/19 at 2:48 p.m., the Maintenance Director indicated he was not notified of any issues with the side rail after the incident and the side rail was not broken, but just needed to be tightened up. The gap between the mattress and side rail measured two and three quarter inches.</p> <p>During an interview on 1/24/19 at 10:13 a.m., LPN 4 indicated at the time of the fall the resident's side rail was parallel to the mattress, the bed was in the low position, and Resident B's right leg was caught between the bed rail and mattress.</p> <p>This Federal tag relates to Complaint IN00284331</p> <p>3.1-45(a)(1)</p>				<p>daily ongoing. Fit, installation and function of bed side rails has been added to the preventative maintenance task list and will be checked weekly by maintenance personnel ongoing. All staff will be inserviced on proper fit, installation and function of bed side rails (utilizing hands-on demonstration and return demonstration) and reporting needed repairs or replacement immediately to the Administrator or Nursing Administration in his/her absence.</p> <p>To monitor compliance: the director of nursing, housekeeping designee and maintenance personnel will audit bed side rail fit, installation and function weekly for two months; housekeeping and maintenance will continue auditing weekly for two months; and maintenance will continue auditing weekly for two months and ongoing. If a bed side rail fails the minimum fit, installation inspection, and function test it will be repaired or replaced immediately. All audits will be documented accordingly as well as any necessary repair or replacement activities. Results of the monitoring will be reviewed during the monthly QAPI Committee meeting overseen by Administrator and reviewed by Corporate risk management team. If threshold of 100% compliance is not achieved an</p>		

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

PRINTED: 02/05/2019
FORM APPROVED
OMB NO. 0938-039

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 01/24/2019	
NAME OF PROVIDER OR SUPPLIER NEW ALBANY NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP COD 201 E ELM ST NEW ALBANY, IN 47150			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
					action plan will be developed to ensure compliance.		