

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365379	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/26/2024
NAME OF PROVIDER OR SUPPLIER  The Laurels of Walden Park		STREET ADDRESS, CITY, STATE, ZIP CODE  5700 Karl Road Columbus, OH 43229	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43064</b></p> <p>Based on closed medical record review, hospital record review, review of facility policy and interview, the facility failed to ensure Resident #215 received adequate, timely and necessary care and services to prevent an acute change in condition related to hypokalemia (decreased potassium) level.</p> <p>Actual Harm occurred beginning on 10/25/24 at 3:33 P.M. when Resident #215's laboratory results reflected a low potassium level of 3.0 mmol/L (normal range 3.5 -5.0) (indicative of hypokalemia) which went unreviewed and unaddressed by facility staff. On 10/28/24 Resident #215 began to experience shortness of breath and required supplemental oxygen. On 10/30/24 Resident #215's heart rate was noted to be between 41 and 46 beats per minute (low/bradycardic) and the resident informed staff his automated implanted cardioverter defibrillator (AICD) had alarmed. On 10/31/24 at 7:30 A.M. Resident #215 was noted to have a change in condition including a new irregular pulse with a listed heart rate of 46 (bradycardic), generalized weakness, and signs of delirium. Resident #215 was sent to a local emergency department where he was assessed to have chest pain with an abnormal heart rhythm of Ventricular Tachycardia (VT) and required multiple defibrillations to return to a normal heart rate and rhythm. The hospital records indicated Resident #215's VT was likely precipitated by his significant hypokalemia (low blood potassium) which was listed as 2.6 mmol/ml upon arrival to the emergency department. Resident #215 was subsequently admitted to the hospital and did not return to the facility.</p> <p>This affected one resident (#215) of three residents reviewed for quality of care/emergency care. The facility census was 215.</p> <p>Findings include:</p> <p>Review of the closed medical record for Resident #215 revealed an admitted [DATE]. Medical diagnoses included chronic systolic and diastolic heart failure, chronic obstructive pulmonary disease, type two diabetes, chronic respiratory failure, chronic kidney disease, paroxysmal atrial fibrillation, and encounter for adjustment and management of automatic implantable cardiac defibrillator. Resident #215 was transferred to a local hospital on 10/31/24 and did not return to the facility.</p> <p>Review of Resident #215's hospital discharge notes dated 10/22/24 revealed the resident had a scheduled visit with the cardiologist on 11/06/24. The hospital indicated he had recommended outpatient testing which included obtaining a Basic Metabolic Panel (BMP) and magnesium level in three to five days.</p> <p>(continued on next page)</p>

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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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #215's physician orders dated 10/24/24 revealed an order to draw a BMP on 10/25/24 and fax the results to the resident's cardiologist. A fax number for the provider was included in the order.</p> <p>Review of Resident #215's BMP result dated 10/25/24 revealed the laboratory specimen was collected that day at 10:20 A.M. The results were reported on 10/25/24 at 3:33 P.M. and revealed his potassium level was low at 3.0 mmol/L.</p> <p>Review of Resident #215's progress notes dated 10/25/24 to 10/31/24 revealed no evidence the physician was notified of the lab results.</p> <p>Review of Certified Nurse Practitioner (CNP) #304's progress note dated 10/29/24 revealed no evidence she was aware of Resident #215's 10/25/24 laboratory result. CNP #304's note referenced labs from the hospital on 10/22/24. The note included Resident #215 had an episode of his defibrillator firing; she suggested an appointment with cardiology and the resident agreed.</p> <p>Review of Resident #215's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had intact cognition.</p> <p>Review of Resident #215's progress notes dated 10/30/24 revealed the residents heart rate that morning had been ranging from 41 to 46 beats per minute (BPM), cardiology was contacted, and a message was left. The resident reported to the nurse that his defibrillator had alarmed and needed to be inspected. The nurse placed another call to the resident's cardiologist and an appointment was scheduled for the following day (10/31/24). The physician and resident were informed, and Resident #215 stated he had been feeling better.</p> <p>Review of a change of condition progress note dated 10/31/24 revealed the resident had a new irregular pulse with a listed heart rate of 46, generalized weakness, and signs of delirium. The progress note indicated the provider had been contacted and ordered Resident #215 to be transferred to a local emergency department.</p> <p>Review of Resident #215's hospital record dated 10/31/24 revealed upon arrival to the emergency department, the resident was found to have chest pain with VT and required multiple defibrillations to return to a normal heart rate and rhythm. The hospital records indicated they were able to interrogate the resident's AICD which reflected the resident was defibrillated six times the night prior (10/30/24) for VT. Resident #215's VT was likely precipitated by his significant hypokalemia which was listed as 2.6 mmol/ml upon arrival to the emergency department. Resident #215 was administered potassium supplements and was subsequently admitted to the hospital for laboratory monitoring and cardiology consultation. Resident #215 did not return to the facility.</p> <p>Interview on 11/26/24 at 9:38 A.M. with Registered Nurse (RN) #300 revealed abnormal laboratory results should be reported to the physician. The laboratory only notified the nurses of critical labs, otherwise, nursing needed to check for results.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 11/26/24 at 10:22 A.M. and 11:41 A.M. with Unit Manager #305 revealed the CNP or physician should be notified of all lab results. She reported she spoke to the nurse who put the order for the BMP and the nurse could not recall where the order came from and did not think it was the facility physician. The nurse was also unsure why the results needed to be faxed to the cardiologist. Unit Manager #305 stated she thought the order came from the hospital when he admitted , so the in-house provider did not know to look for results. Unit Manager #305 verified there was no indication anybody reviewed the results or faxed them to the cardiologist.</p> <p>Interview on 11/26/24 at 11:49 A.M., 12:25 P.M., and 2:05 P.M. with the Director of Nursing (DON) revealed she believed Resident #215's BMP was to be completed in preparation for his cardiology appointment on 11/07/24. She verified there was no evidence his BMP was reviewed in the facility and was aware his 10/31/24 hospitalization involved a low potassium level (hypokalemia). The DON verified as far as nursing staff were aware, as of 10/29/24, the resident's defibrillator only went off once so an appointment with cardiology was made. However, the night of 10/30/24 into the morning of 10/31/24 it went off multiple times, so the night nurse called the on-call physician who agreed to send the resident to the hospital.</p> <p>Review of the facility policy 'Notification of change' dated 02/14/24 revealed the facility must inform the resident, consult with the resident's practitioner, and notify the representative when there is a change in status. A change in status included a need to alter treatment significantly or a significant change in the resident's physical, mental, or psychosocial status.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00159685.</p>		

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<p>F 0773</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43064</p> <p>Based on record review, staff interview, and policy review, the facility failed to ensure timely notification to the physician or Certified Nurse Practitioner (CNP) of abnormal laboratory values for Resident #37. This affected one (Resident #37) of three residents reviewed for quality of care. The facility census was 215.</p> <p>Findings include:</p> <p>Review of the closed medical record for Resident #215 revealed an admitted [DATE]. Medical diagnoses included chronic systolic and diastolic heart failure, chronic obstructive pulmonary disease, type two diabetes, chronic respiratory failure, chronic kidney disease, paroxysmal atrial fibrillation, and encounter for adjustment and management of automatic implantable cardiac defibrillator.</p> <p>Review of Resident #215's hospital discharge notes dated 10/22/24 revealed the resident had a scheduled visit with the cardiologist on 11/06/24. The hospital indicated he had recommended outpatient testing which included obtaining a Basic Metabolic Panel (BMP) and magnesium level in three to five days.</p> <p>Review of Resident #215's physician orders dated 10/24/24 revealed an order to draw a BMP on 10/25/24 and fax the results to the resident's cardiologist. A fax number for the provider was included in the order.</p> <p>Review of Resident #215's BMP result dated 10/25/24 revealed the laboratory specimen was collected that day at 10:20 A.M. The results were reported on 10/25/24 at 3:33 P.M. and revealed his potassium level was low at 3.0 mmol/L.</p> <p>Review of Resident #215's progress notes dated 10/25/24 to 10/31/24 revealed no evidence the physician was notified of the lab results.</p> <p>Interview on 11/26/24 at 9:38 A.M. with Registered Nurse (RN) #300 revealed abnormal laboratory results should be reported to the physician. The laboratory only notified the nurses of critical labs, otherwise, nursing needed to check for results.</p> <p>Interview on 11/26/24 at 10:22 A.M. and 11:41 A.M. with Unit Manager #305 revealed the CNP or physician should be notified of all lab results. She reported she spoke to the nurse who put the order for the BMP and the nurse could not recall where the order came from and did not think it was the facility physician. Unit Manager #305 stated she thought the order came from the hospital when he admitted, so the in-house provider did not know to look for results. Unit Manager #305 verified there was no indication anybody reviewed the results or faxed them to the cardiologist.</p> <p>Interview on 11/26/24 at 11:49 A.M., 12:25 P.M., and 2:05 P.M. with the Director of Nursing (DON) revealed she believed Resident #215's BMP was to be completed in preparation for an upcoming cardiology appointment. She verified there was no evidence his laboratory report was reviewed in the facility.</p> <p>(continued on next page)</p>		

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