STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165612	A. BUILDING _____ B. WING _____	C 05/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY CENTER AT LUTHER PARK	1555 HULL AVENUE DES MOINES, IA 50316

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F 000	INITIAL COMMENTS The following information relates to investigation of Facility Reported Incident #97074. Facility Reported Incident # 97074-I was substantiated. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 684 SS=J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff and physician interviews, facility policy review and review of online reference sources, the facility failed to intervene following receipt of a critical Potassium laboratory value for 1 of 4 sampled (Resident #1) for assessment and intervention. On 4/21/21 at 8:15 p.m., Staff A (Licensed Practical Nurse) received a phone call from laboratory informing him of Resident #1's critically high potassium level. Staff A failed to document the call and failed to notify Resident #1's physician of the critical value. Staff A reported the information to Staff B (Registered Nurse) who directed staff on all floors to check for faxed receipt of the lab results. Staff B reported he did	F 684	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 05/24/2021

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 684	Continued From page 1 not know the lab or its value, so did not report to physician. On 4/22/21 at 8:50 a.m., the staff found Resident #1 unresponsive and without a pulse and initiated Cardiopulmonary Resuscitation and called for Emergency Medical Services. The Death Certificate listed Resident #1's immediate cause of death as acute kidney failure due to hyperkalemia The facility reported a census of 97 residents. Findings include: According to the Minimum Data Set (MDS) assessment dated 2/5/21, Resident #1 had diagnoses that included renal failure/insufficiency, diabetes mellitus, congestive heart failure and high blood pressure. The assessment did not document any special treatments or procedures while at the facility. The resident had severely impaired memory and cognitive abilities, based on a Brief Interview for Mental Status score of 7. Resident #1 entered the facility on 1/29/21. The Advanced Registered Nurse Practitioner (ARNP) Progress Note dated 4/20/21 documented she was asked to see Resident #1 due to increased weakness and nausea. The resident appeared in pain during the visit, which she took Narco (an opioid pain medication) for, but the Narco made her nauseated. The patient's appetite has been poor and she was weak and pale during the visit. The resident informed the ARNP she felt nauseated in the morning, making it hard for her to eat. The ARNP offered transfer to the hospital, but Resident #1 declined, stating they won't do anything. The ARNP voiced concerns to the resident and Resident #1 agreed to have laboratory (lab) work done. The ARNP's	F 684		

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F 684	Continued From page 2 plan included to ask family members about a Hospice consult due to Failure to Thrive in an adult and orders to obtain lab samples. The ARNP ordered measurement of the resident's CBC (Complete Blood Count), CMP (Comprehensive Metabolic Panel), A1C (to measure her blood glucose history) and a Vitamin D level. The Nurse's Note dated 4/21/21 at 5:31 a.m. documented Resident #1 slept well and the ordered lab tests were drawn without difficulty. Results of the CMP dated 4/21/21 showed the test as obtained at 6 a.m. and resulted at 8:14 p.m. The resident's potassium level measured 8.7 mmol/L (minimoles per liter) and a reference range for potassium as 3.5 - 5.1 mmol/L. The comments section documented repeat of the test to verify the result. A lab technician called Staff A (Licensed Practical Nurse) to inform him of the result at 8:13 p.m. and Staff A read back the result to the lab technician. Review of Progress Notes from 4/21/21 2:56 p.m. to 4/22/21 at 9:52 a.m. revealed no documentation regarding the resident's critically high potassium level. According the Mayo Clinic web article dated 11/14/20, potassium is a chemical that is critical to the function of nerve and muscle cells, including those of the heart. A potassium level higher than 6.0 mmol/L can be dangerous and usually requires immediate treatment. If you have symptoms of high potassium, particularly with kidney disease, high potassium can cause muscle fatigue, weakness, paralysis, abnormal heart rhythms and/or nausea.	F 684		

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F 684	Continued From page 3 The Nurse's Note dated 4/22/21 at 8:50 a.m. documented Staff A went to Resident #1's room to give medications and insulin. The resident was not responsive and had no pulse. Staff initiated CPR (Cardio Pulmonary Resuscitation). At 8:58, the Assistant Director of Nursing (ADON) documented Resident #1 experienced lethargy, nausea and vomiting for the past several days; the resident did not want to eat or drink. The resident wished to stay in bed for breakfast. Labs have been requested from the lab draw done yesterday but have not been received at this time. The floor nurse (Staff A) notified the ADON he found Resident #1 unresponsive, assessed her and found the resident to be without a pulse. The resident was a full code, staff initiated CPR and called 911. Paramedics arrived and transported Resident #1 to the hospital. At 12:30 p.m., the DON documented the resident's physician called the facility and reported Resident #1 passed away. Review of Resident #1's Emergency Department (ED) record revealed she arrived in the ED on 4/22/21 at 9:40 a.m. with presentation of pulseless electrical activity (PEA, which results in electrical activity in the heart muscle, but no pulse). The note documented the resident as last seen at 8:30 a.m. (normal) and found unresponsive without a blood pressure at 8:55 a.m.; bystander CPR started at the facility. Staff note the resident as in the process of Hospice enrollment but no DNR (Do Not Resuscitate) yet. Medics noted PEA with pacer spikes (on the electrocardiogram), did multiple rounds of Advanced Cardiac Life Support with 3 mg (milligrams) of epinephrine. Resident #1 had received approximately 45 minutes of CPR prior	F 684		

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F 684	Continued From page 4 to arrival. ED staff attempted one more round of epinephrine with bicarbonate without response and pronounced Resident #1 dead at 9:46 a.m. Resident #1's Certificate of Death documented she expired on 4/22/21 at 9:46 a.m. The certificate listed her immediate cause of death as acute kidney failure due to hyperkalemia (high blood potassium). During interview at the facility on 4/26/21 at 10:50 a.m., the DON stated Staff A failed to document the call or the lab results. Staff A passed the information to the next nurse and said he waited for the faxed copy of the lab results to arrive before notifying the physician. During a telephone interview on 4/26/21 at 11:21 a.m., Staff A stated lab staff called him with Resident #1's lab results on 4/21/21, but lab staff did not fax (send a facsimile) a copy of the results. Staff A stated he knew Resident #1 had more results coming than a potassium level, so that's why he waited. The morning of 4/22/21 around 7 a.m., Staff A stated the resident seemed fine and when Staff A went back after breakfast, the resident had passed away. Staff A got the ADON and they started CPR. When asked to recall the critical lab number, Staff A replied 8.0 something. Staff A did not write it down because he waited for the fax before calling the doctor. Staff A stated he knew 8.0 was a very high potassium level, but he did not call because he didn't have all the resident's lab information. Staff A stated he reported to the oncoming nurse (Staff C) that Resident #1 had critical labs, but not which lab or the value. When asked what a critical value meant for a resident, Staff A stated it meant emergency and in looking back, he should	F 684		

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F 684	Continued From page 5 have called. Staff A also stated he called another nurse after his shift (Staff B) and asked him to remind Staff C to look for Resident #1's faxed lab results. Staff A thought he left the facility on 4/21/21 around 9:15 p.m. During a phone interview on 4/26/21 at 11:54 a.m., Staff B, (Registered Nurse) stated he remembered the call from Staff A on 4/21/21. Staff A told him Resident #1 had a critical potassium level and asked him to remind Staff C look for the fax results; Staff C already knew to do so. Staff B said he learned what to with lab values (like calling the doctor) during orientation and critical values would have been called to the doctor. During a phone interview on 4/26/21 at 1:40 p.m., Staff C (Registered Nurse) stated he worked evening and night shifts on 4/21/21. During evening shift change on 4/21/21, Staff A informed Staff C he had a call from the lab about a critical lab for Resident #1, but did not say what the value measured and that a fax would come. Staff A told him he'd forgotten the lab test or the value. Staff C did not call the lab as it was closed and asked staff on other halls to watch for the faxed report; no one had them. Staff C stated he called Staff A to check the lab and value, but Staff A did not answer the phone. Staff C thought about calling the doctor but he did not have the lab or its value and did not call; he did not inform the DON. Staff C stated he could not remember receiving facility training about calling physicians for lab values and the facility had on-call doctors available. Staff C stated if he had known the results of the resident's potassium level, he would have called the doctor immediately.	F 684		

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F 684	Continued From page 6 During an interview on 5/4/21 at 2:00 p.m., the Assistant Director of Nurses (ADON) stated the facility uses a dual fax system for lab results and she audited the results daily since the incident with Resident #1. When asked to comment on Staff A's actions, the ADON stated if further lab results had not arrived by fax after an hour of the verbal report of a critical value, Staff A should have called the physician to report. The ADON was not notified of any of this at the time. Staff had been talking with the ARNP about the resident's overall decline and whether Hospice should be initiated. The labs were ordered to check the resident's overall condition. During an interview on 5/4/21 at 2:20 p.m., Resident #1's Physician stated if a nurse received a report of a resident's critical lab value, they should have picked up the phone and called; they call for everything else. Staff A was a good nurse. However, staff shouldn't wait to report a critical lab value. Resident #1 could not have been treated either in or out of house; she had End Stage Renal Disease (ESRD or kidney failure) and dialysis would have been the only treatment. During an interview on 5/4/21 at 2:37 p.m., the Administrator and DON revealed lots of things went wrong. The resident's physician told staff that critical lab values should be called to report. The Administrator stated that conversations with staff revealed that some staff needed understanding of the meaning of critical test results and that RNs and LPNs showed some difference in perception/training regarding lab values. The facility's Clinical Protocol on Lab and Diagnostic Test Results, revised 3/6/20,	F 684		

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F 684	Continued From page 7 instructed that a nurse will identify the urgency of communicating with the Attending Physician based in part, on the seriousness of any abnormality. Nursing staff will consider whether the result should be conveyed to a physician regardless of other circumstances (that is, the abnormal result is problematic regardless of any other factors). The facility's Nursing Home Medical Director Agreement, dated 10/1/14, documented that appropriate physician coverage is provided to patients 365 days per year and 24 hours per day, and that patient consultations are provided in a timely manner on a mutually agreed upon schedule. The scenario detailed above resulted in a past-noncompliance Immediate Jeopardy situation for facility residents. On 4/22/21, the facility initiated measures to correct the Immediate Jeopardy situation. A Self-Identification and Correction Form dated 4/22/21 and titled Reporting and Documentation of Critical Lab Values identified all nursing staff present in the building were educated immediately as to the Policy Procedure on 4/22/21. Nurses coming onto shifts were educated prior to starting their shift and all other nurses would continue to be educated prior to starting their nursing shift. The policy directed that staff would notify the physician/ARNP in a timely manner regarding critical lab values. The policy documented: a. Critical labs that are called to us from lab need to be documented in the progress notes and reported to the physician within one hour of	F 684		

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F 684	Continued From page 8 receiving test values. b. Do not wait for faxed lab values before you call. Call within one hour of receiving the value. c. If we do not receive faxed lab values by the end of your scheduled shift, call back the lab and request them again and then document in the progress notes that you have done so. d. If the lab is closed for the night, call the hospital and ask to speak with the lab. Once you talk to lab staff, make sure they are looking for lab results under "pathology lab". The Education Sign-In Sheet documented the facility began educating nursing staff on 4/22/21 and completed the education on 4/26/21.	F 684		