

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155535	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/21/2016
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NAME OF PROVIDER OR SUPPLIER WILLOW CROSSING HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3550 CENTRAL AVE COLUMBUS, IN 47203
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00204163.</p> <p>This visit was in conjunction with the PSR to Complaint IN00201580 completed on 6/30/2016.</p> <p>Complaint IN00204163 - Substantiated. Federal/State deficiencies related to the allegation are cited at F225 and F226.</p> <p>Survey date: July 21, 2016</p> <p>Facility number: 000572 Provider number: 155535 AIM number: 100267710</p> <p>Census bed type: SNF/NF: 59 Total: 59</p> <p>Census payor type: Medicare: 5 Medicaid: 52 Other: 2 Total: 59</p> <p>Sample: 4</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC</p>	F 0000	<p>Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under and state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey. Due to the low scope and severity of the survey finding, please find the sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance. Should additional information be necessary to confirm said compliance, feel free to contact me.</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 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 0225 SS=D Bldg. 00	<p>16.2-3.1.</p> <p>Quality review completed by 34233 on July 25, 2016.</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his</p>			

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	<p>designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on interview and record review, the facility failed to ensure a resident's narcotic pain medication was free from medication diversion and failed to follow their policy/procedure for narcotic count/disposal for 1 of 4 residents reviewed for misappropriation of resident property. (Resident #B)</p> <p>Findings include:</p> <p>The ISDH reportable, dated 7/2/16 at 5:30 p.m., included, but was not limited to, the following: "...Residents Involved... [Resident #B's name]...Staff Involved... [LPN (Licensed Practical Nurse) #6's name]...[LPN #7's name]...[RN (Registered Nurse) #8's name]...[LPN #9's name]...[LPN #10's name]...Brief Description of Incident...Description added -- 7/2/2016 [LPN #6's name] discovered that resident [Resident #B's name] was short in her number of Oxycodone 5/325mg [milligrams] [narcotic pain medication] from the medication cart locked controlled medication box. She notified [DON's (Director of Nursing) name], who went to</p>	F 0225	F225 Requires the facility to ensure resident's narcotic pain medication is free from medication diversion and to follow their policy/procedure for narcotic count. 1. Resident #B narcotic count sheet was reconciled with no further concerns noted. 2. All residents have the potential to be affected. All residents narcotic count sheets were reconciled. No concerns were noted. See below for corrective measures. 3. The narcotic count/disposal policy and procedure was reviewed with no changes made. (See attachment A) The staff was inserviced on the above procedure. 4. The DON or her designee will audit to ensure the nurses are signing the narcotic count sheets. The audits will consist to ensure that the ongoing and outgoing nurse sign the narcotic counts confirming the correct is correct and both signatures documented on the narcotic count sheet verifying the count is completed per policy. The DON or her designee will utilize the nursing monitoring tool daily times for weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained	07/25/2016

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	<p>the facility to investigate. Upon investigation, it was discovered that [Resident #B's name] was 72 pills short of the medication. After checking the medication reconciliation invoices and speaking with [name of pharmacy], it was discovered that there were pill cards and count sheets unaccounted for and had become missing at some point between 6/24/16 and 6/26/16. The above listed nurses had all had responsibility for the medications during this time frame. This Administrator was notified of the incident by phone. [name of police department] was notified. [Resident #B's name] physician was notified, as well as her family of the incident and informed that an investigation was taking place...Immediate Action Taken...Director of Nursing currently having all nurses listed complete urine drug screen. Director of Nursing completing an audit of all facility controlled meds [medications]...Preventative Measures Taken...Director of Nursing will continue to audit pharmacy invoices, orders and controlled medications to prevent diversion...Follow up...7/7/16 Audits of all controlled medications performed by the Director of Nursing. Urine drug screens were performed on all staff who had access to the medication cart in question. All staff had negative drug</p>		<p>and maintained. (See attachment B) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly. 5. The above corrective measures will be completed on or before July 25, 2016.</p>	

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	<p>screen results..."</p> <p>The Administrator provided a copy of a timeline of the incident, dated 7/2/16, which included the following: "Incident 7/2/2016...11:30 a.m. - [LPN #6's name], LPN called [DON's name], RN DON and stated the pharmacy would not send a refill for [Resident #B's name] oxycodone because she would have not more by 7/4/16.. [sic] The pharmacy stated that it was too early to send the medication...2pm-[DON's name], DON came in to investigate the problem. Upon auditing the meds [medications] and comparing to the narcotic sign off sheets, it became apparent that 72 oxycodones were unaccounted for. The sign off sheets were also missing and that it took place between 6/24/16 and 6/26/16. [DON's last name] notified the administrator at this time. Facility and med room were searched for the missing items. All narcotics in the facility were reconciled and audited. No other discrepancies were noted...4pm...All nurses that had responsibility of the med cart during the period were call in and given urine drug screens ([LPN #5's name], [LPN #9's name], [RN #8's name], [LPN #10's name], [LPN #6's name]). All nurses passed the urine drug screens. No other employees had access to the narcotics during this period..."</p>			

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	<p>The physician order, dated 3/15/16 and untimed, indicated to discontinue the as needed Oxycodone order and start Oxycodone 5/325 mg, 2 tablets by mouth every 4 hours routinely.</p> <p>During an interview on 7/21/16 at 4:02 p.m., Corporate Nurse (CN) #4 indicated, because Resident #B had taken the pain medication so often, the order was changed to routinely.</p> <p>On 7/21/16 at 4:30 p.m., CN #2 provided a copy of the narcotic count sheets, dated 6/17/16 - 7/2/16, for Resident #B's Oxycodone. The narcotic count sheet, dated 6/10/16, indicated the last dose given to Resident #B was on 6/24/16 at 4:00 p.m. The narcotic count sheet, which indicated page 2 of 2, dated 6/23/16, indicated the next dose given to Resident #B was on 6/26/16 at 8:00 a.m.</p> <p>The narcotic count sheets lacked documentation of administration of the Oxycodone to Resident #B, between 6/24/16 at 8:00 p.m. through 6/26/16 at 4:00 a.m.</p> <p>The June 2016 MAR (Medication Administration Record) indicated, between 6/24/16 at 8:00 p.m. and 6/26/16 at 4:00 a.m., Resident #B received the</p>			

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	<p>narcotic pain medication.</p> <p>During an interview on 7/21/16 at 3:48 p.m., RN #5 indicated, at the beginning of shift change, the off going nurse, using the controlled drug record, will tell the oncoming nurse how many narcotics should be left. RN #5 indicated the oncoming nurse will verify the number was correct by counting how may narcotics are left in the cards or bottles. RN #5 indicated, when the narcotic count was correct, both nurses sign the narcotic count record. RN #5 also indicated, if the narcotic count was not correct, the narcotic count record was not signed and the Director of Nursing was notified.</p> <p>The narcotic count record for March 2016, on 3rd shift, lacked a signature 21 out of 31 days.</p> <p>The narcotic count record for April 2016, on 3rd shift, lacked a signature 7 out of 30 days.</p> <p>The narcotic count sheet for June 2016, on 3rd shift, lacked a signature 11 out of 30 days, which included 6/25/16 and 6/26/16.</p> <p>During an interview on 7/21/16 at 4:32 p.m., CN #2 indicated, due to the upcoming holiday, LPN #6 called the</p>			

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	<p>pharmacy to make sure Resident #B did not run out of her pain medication. CN #2 indicated Resident #B had enough pain medication on hand to last through 7/4/16 at 4:00 a.m., however, the resident should have had enough to last through 7/10/16. CN #2 indicated pharmacy told LPN #6 it was too early to order and could not send again until 7/10/16. CN #2 indicated LPN #6 notified the DON, who then came to the facility to find out why the pain medication could not be sent. CN #2 indicated, when the DON pulled the narcotics, she realized the narcotic count sheets went from 6/24/16 at 4:00 p.m. to 6/26/16 at 8:00 a.m. CN #2 further indicated, after looking into the incident, they realized 72 pills were missing.</p> <p>During an interview on 7/21/16 at 4:40 p.m., the DON indicated page 1 of 2 of the narcotic count sheet was unaccounted for.</p> <p>During an interview on 7/21/16 at 4:45 p.m., the Administrator, CN #2, and CN #4 indicated they felt it was an employee who took the medication, but have no evidence since all the drug screens came back with negative results.</p> <p>During an interview on 7/21/16 at 4:50 p.m., CN #4 indicated it was facility</p>			

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	<p>policy to complete a narcotic count between the off going nurse and the oncoming nurse. CN #4 also indicated the nurses signature on the narcotic count record indicated the narcotic count was correct.</p> <p>During an interview on 7/21/16 at 5:01 p.m., LPN #5 indicated, when the narcotic medication for Resident #B came in on 6/23/16, she locked the medication in the narcotic box. LPN #5 indicated the narcotic count was correct when she left on 6/23/16 and she did not work again until 6/27/16.</p> <p>On 7/21/16 at 11:52 a.m., the Administrator provided a current copy of the document titled "ABUSE PROHIBITION". It included, but was not limited to, the following: "...Policy: It is the policy of this facility [sic] allegations of abuse will be commuted to, and thoroughly investigated by, the correct authority...1. This facility will not permit residents to be subjected to abuse by anyone...Misappropriation of Resident Property...The deliberate misplacement, exploitation or wrongful, temporary or permanent us of a resident's belongings or money without the resident's consent..."</p> <p>On 7/21/16 at 5:00 p.m., CN #2 provided</p>			

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F 0226 SS=D Bldg. 00	<p>a copy of the document titled "Narcotic Count/Disposal, dated October 2014. It included, but was not limited to, the following: "...Purpose...To deter potential drug diversion through ongoing accountability of narcotic use...Policy...This facility will reconcile Schedule II narcotics each shift...Procedure...7. At the end of each shift, the oncoming nurse and the off going nurse will count the medications and reconcile them with the count sheets..."</p> <p>This Federal tag relates to Complaint IN00204163</p> <p>3.1-28(d)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review, the facility failed to implement their abuse policy/procedure and conduct a thorough investigation when missing narcotic pain medication was identified for 1 of 4 residents reviewed for misappropriation of resident property. (Resident #B)</p>	F 0226	<p>F226 Requires the facility to implement their abusepolicy/procedure and conduct a thorough investigation when narcotics painmedication.</p> <ol style="list-style-type: none"> Resident#B narcotic count was reconciled with no further concerns noted. All residents have the 	07/25/2016

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	<p>Findings include:</p> <p>The clinical record for Resident #B was reviewed on 7/21/16 at 3:00 p.m. Diagnoses included, but were not limited to neuropathy and chronic pain.</p> <p>The ISDH reportable, dated 7/2/16 at 5:30 p.m., included, but was not limited to, the following: "...Residents Involved... [Resident #B's name]...Staff Involved... [LPN (Licensed Practical Nurse) #6's name]...[LPN #7's name]...[RN (Registered Nurse) #8's name]...[LPN #9's name]...[LPN #10's name]...Brief Description of Incident...Description added -- 7/2/2016 [LPN #6's name] discovered that resident [Resident #B's name] was short in her number of Oxycodone 5/325mg [milligrams] from the medication cart locked controlled medication box. She notified [DON's (Director of Nursing) name], who went to the facility to investigate. Upon investigation, it was discovered that [Resident #B's name] was 72 pills short of the medication. After checking the medication reconciliation invoices and speaking with [name of pharmacy], it was discovered that there were pill cards and count sheets unaccounted for and had become missing at some point between 6/24/16 and 6/26/16. The above listed</p>		<p>potential to beaffected. All residents narcotic countsheets were reconciled. No concerns were noted. See below for corrective measures.</p> <p>3. The Abuse Prohibition policy and procedure wasreviewed with no changes made. (See attachment C) The staff was inserviced on the aboveprocedure.</p> <p>4. The administrator will ensure that with all incidentsa written investigation is completed including written statements from staff toensure the investigation is complete per policy. Upon the facility completing theinvestigation, the nurse consultant will review the incident investigation toensure investigation is complete as well. The administrator or his designee will utilize the nursing monitoringtool daily times for weeks, then weekly times four weeks, then every two weekstimes two months, then quarterly thereafter until 100% compliance is obtainedand maintained. (See attachment B) Theaudits will be reviewed during the facility's quarterly quality assurancemeetings and the plan of correction will be adjusted accordingly.</p> <p>5. The above corrective measures will be completedon or before July 25, 2016.</p>	

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	<p>nurses had all had responsibility for the medications during this time frame. This Administrator was notified of the incident by phone. [name of police department] was notified. [Resident #B's name] physician was notified, as well as her family of the incident and informed that an investigation was taking place...Immediate Action Taken...Director of Nursing currently having all nurses listed complete urine drug screen. Director of Nursing completing an audit of all facility controlled meds [medications]...Preventative Measures Taken...Director of Nursing will continue to audit pharmacy invoices, orders and controlled medications to prevent diversion...Follow up...7/7/16 Audits of all controlled medications performed by the Director of Nursing. Urine drug screens were performed on all staff who had access to the medication cart in question. All staff had negative drug screen results..."</p> <p>The Administrator provided a copy of a timeline of the incident, dated 7/2/16, which included the following: "Incident 7/2/2016...11:30 a.m. - [LPN #6's name], LPN called [DON's name], RN DON and stated the pharmacy would not send a refill for [Resident #B's name] oxycodone because she would have not</p>			

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	<p>more by 7/4/16.. [sic] The pharmacy stated that it was too early to send the medication...2pm-[DON's name], DON came in to investigate the problem. Upon auditing the meds [medications] and comparing to the narcotic sign off sheets, it became apparent that 72 oxycodones were unaccounted for. The sign off sheets were also missing and that it took place between 6/24/16 and 6/26/16. [DON's last name] notified the administrator at this time. Facility and med room were searched for the missing items. All narcotics in the facility were reconciled and audited. No other discrepancies were noted...4pm...All nurses that had responsibility of the med cart during the period were call in and given urine drug screens ([LPN #5's name], [LPN #9's name], [RN #8's name], [LPN #10's name], [LPN #6's name]). All nurses passed the urine drug screens. No other employees had access to the narcotics during this period..."</p> <p>On 7/21/16 at 5:30 p.m., the DON provided the following typed statement: "On 7/2/16 after discovering the missing narcotics [sic] I immediately reconciled all narcotics in facility. I implemented the narcotic card count form that nurses would need to sign with off going nurse when taking over the med cart. No other missing narcotics were noted. Count was</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155535	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/21/2016
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NAME OF PROVIDER OR SUPPLIER WILLOW CROSSING HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3550 CENTRAL AVE COLUMBUS, IN 47203
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	<p>accurate...[DON's typed name with signature]..."</p> <p>The facility could not provide any documentation with regards to the narcotic count audits that were completed on 7/2/16.</p> <p>During an interview on 7/21/16 at 4:58 p.m., the Administrator indicated interviews were conducted upon staff coming in for the urine drug screens. The Administrator also indicated there were no written statements from staff regarding the medication diversion.</p> <p>During an interview on 7/21/16 at 5:30 p.m., the Administrator indicated there were no inservices completed related to the misappropriation of resident property after the incident occurred. The Administrator also indicated staff inservices probably should have been completed.</p> <p>On 7/21/16 at 11:52 a.m., the Administrator provided a current copy of the document titled "ABUSE PROHIBITION". It included, but was not limited to, the following: "...Policy: It is the policy of this facility [sic] allegations of abuse will be commuted to, and thoroughly investigated by, the correct authority...1. This facility will not permit</p>			

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	<p>residents to be subjected to abuse by anyone...Misappropriation of Resident Property...The deliberate misplacement, exploitation or wrongful, temporary or permanent us of a resident's belongings or money without the resident's consent...8. The facility Administrator is designated as the individual responsible for coordinating all efforts in investigation of abuse allegations and for assuring all policies and procedures are followed...13. A comprehensive record of any abuse investigation is to be compiled and maintained by the facility, including [sic] but not limited to...statements from witnesses and others involved, reports, communication and all other relevant information...If resident abuse, or suspicion of abuse, is reported...10. Resident will be questioned...and their statements placed in writing...12. Statements will be taken, including, but not limited to...facts and observations by involved employees...facts and observations by the licensed nurse or individual to whom the initial report was made...13. Follow-up assessments will be completed...15. The Administrator is responsible to coordinate the investigation, assure an accurate and complete written record of the incident and investigation..."</p> <p>This Federal tag relates to Complaint</p>			

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