

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155400	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/05/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LIBERTY VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 4600 E JACKSON ST MUNCIE, IN 47303
---	--

(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 a Recertification and State Licensure Survey.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00196842.</p> <p>Survey dates: 3/30, 4/1, 2, 3, 4, 5, 2016</p> <p>Facility number: 000269 Provider number: 155400 AIM number: 100267720</p> <p>Census bed type: SNF/NF: N/A SNF: 7 NF: 58 Total: 65</p> <p>Census payor type: Medicare: 7 Medicaid: 58 Other: N/A Total: 65</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>QR completed on April 6, 2016 by 17934.</p>	F 0000	Submission of this Plan of Correction does not constitute an admission to or an agreement with facts alleged on the survey report. Submission of this Plan of Correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. The Plan of Correction is prepared and submitted because of requirements under State and Federal law. Please accept this Plan of Correction as our credible allegation of compliance.	

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155400	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/05/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER LIBERTY VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 4600 E JACKSON ST MUNCIE, IN 47303
---	--

(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 0282 SS=D Bldg. 00	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview and record review, the facility failed to complete a full assessment which identified and addressed the residents physical/medical need for the use of full side rails before applying or obtaining orders for full side rails for 1 of 3 residents reviewed for potential restraints (Resident #27).</p> <p>Findings include:</p> <p>Resident #27 was observed in bed with full side rails raised on both sides on the bed during the following dates and times: 3/30/16 at 2:02 p.m. (prior to the order for full side rails), 4/1/16 at 10:12 a.m., 4/1/16 at 12:11 p.m., 4/1/16 at 2:16 p.m. and 4/4/16 at 8:41 a.m.</p>	F 0282	Resident #27 did not experience any negative outcomes related to this alleged deficient practice. A full assessment has been completed for side rail use for Resident #27 and the resident's care plan has been updated to reflect the resident's current status related to side rail use. All residents utilizing side rails have the potential to be affected. Each resident's side rails screen has been reviewed and updated if indicated to ensure a full assessment for side rail use has been completed. Each resident's care plan has been updated to reflect their current status related to side rail use. The facility's policy for side rail use has been reviewed and no changes are indicated at this time. The nurses have been re-educated on the policy with a special focus on completing a full assessment for side rail use. A monitoring form has been implemented.	04/18/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155400		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/05/2016	
NAME OF PROVIDER OR SUPPLIER LIBERTY VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 4600 E JACKSON ST MUNCIE, IN 47303			
(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			
	<p>During a 3/30/16, 2:38 p.m., interview, Unit Manager #1 indicated, Resident #27 had physician's orders for 3/4 side rails to both sides of the bed. Unit Manager #1 reviewed Resident #27's chart at that time and indicated his current orders were for 3/4 side rails. In addition the Unit Manager indicated Resident #27 had not fallen in the past 30 days.</p> <p>During a 3/30/16, 2:46 p.m., observation and interview, the RN Consultant observed Resident #27 in bed with side rails up. At that time, she indicated the resident had full side rails in place and raised.</p> <p>Resident #27's clinical record was reviewed on 4/4/16 at 2:23 p.m. Resident #27's diagnoses included, but were not limited to, chronic kidney disease, multiple sclerosis and hypertension.</p> <p>Resident #27 had a ,3/30/16, 3:30 p.m., physician's order to: discontinue 3/4 side rails and begin 2 full side rails up when in bed to provide tactile bed boundaries related to multiple</p>		<p>The DON or designee will be responsible for reviewing siderail screens on 10 residents to ensure a full assessment was completed asfollows: weekly for 4 weeks, monthly fortwo months, then quarterly thereafter. Should a concern be found, immediate corrective action will occur. Results of these reviews and any correctivactions will be reviewed during the facility's monthly QA meetings and the planadjusted accordingly if indicated.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155400	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/05/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER LIBERTY VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 4600 E JACKSON ST MUNCIE, IN 47303
---	--

(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
	<p>sclerosis.</p> <p>Resident #27 had a ,12/31/15, quarterly, Minimum Data Set (MDS) assessment which indicated the resident was total dependent for all activities of daily living including bed mobility and did not stand or walk. .</p> <p>Resident #27 had a, 3/30/16, "Side Rail Screen" which indicated the resident needed 2 (both side) 3/4 rails for "bed parameters." No where on the assessment did it indicate why full side rails (the most restrictive side rail) as opposed to 1/2 or 3/4 side rails best met the resident's need for bed parameters.</p> <p>Resident #27 had a, 4/1/16 "Side Rail Screen" (completed after the full side rails were ordered) which indicated the resident needed 2 (both side) 3/4 rails for "bed parameters." No where on the assessment did it indicate why full side rails (the most restrictive side rail) as opposed to 1/2 or 3/4 side rails best met the resident's need for bed parameters.</p> <p>Resident #27's clinical record lacked any type of assessment or</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155400	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/05/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER LIBERTY VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 4600 E JACKSON ST MUNCIE, IN 47303
---	--

(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
	<p>statement of change in condition which addressed the resident's need for full side rails (the most restrictive side rail) to provide bed parameters.</p> <p>Resident #27's clinical record lack indications he had fallen from bed, had additional difficulties being turned in bed or had a change in bed mobility during the 30 days prior to the 3/30/16 full bed rail order.</p> <p>During a 4/5/16, 8:20 a.m., interview, the Administrator was questioned if the facility had any form of assessment for Resident #27's need for full side rails as opposed to any other device to establish bed parameters.</p> <p>During a 4/5/16, 1:20 p.m., interview, the Director of Nursing indicated an assessment for full side rails had not been completed for Resident #27 prior to obtaining full side rail orders.</p> <p>A current ,10/2014 facility policy, titled "SIDE RAIL USE", provided by the Administrator on 4/5/16 at 9:48 a.m., indicated:</p> <p>"Side rails are used, as indicated by resident or per physician's order, as</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155400	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/05/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER LIBERTY VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 4600 E JACKSON ST MUNCIE, IN 47303
---	--

(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 0309 SS=D Bldg. 00	<p>needed to enable the resident to turn and reposition while in bed. The use of side rails may be ordered by a physician for a dependent resident whose medical symptoms would warrant their use.... A side rail screen will be completed upon admission, quarterly, with significant change in condition and as deemed necessary by license nursing personnel."</p> <p>3.1-35(g)(2)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to obtain a physician's order for an in and out catheter to obtain a urine specimen for 1 of 5 residents reviewed for unnecessary medications. (Resident #14)</p> <p>Findings include:</p> <p>The clinical record for Resident #14 was reviewed on 4/1/16 at 12:16 p.m. Diagnoses for Resident #14 included, but</p>	F 0309	Resident #14 did not experience any negative outcome related to this alleged deficient practice. The clinical record has been reviewed and orders are present for all noted lab procedures including in and out catheter orders for urine specimens if indicated. All residents have the potential to be affected. Their clinical records have been reviewed orders are present for all noted lab procedures including in and out catheter orders for urine	04/18/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155400		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/05/2016	
NAME OF PROVIDER OR SUPPLIER LIBERTY VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 4600 E JACKSON ST MUNCIE, IN 47303			
(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			
	<p>were not limited to, delirium, hypertension, and heart failure.</p> <p>A telephone order, dated 3/5/16, indicated a urinalysis and a urine culture and sensitivity, one time, now for increased confusion and altered mental status.</p> <p>A nurses note, dated 3/5/16, indicated the urine specimen for the physician ordered urine laboratory tests was obtained by an in and out catheter.</p> <p>The March 2016 Medication Administration Record (MAR) indicated on 3/5/16 "U/A [urinalysis] C&S [culture and sensitivity] x [times] 1 now."</p> <p>During an interview on 4/5/16 at 1:46 p.m., the Director of Nursing indicated Resident #14 did not have an order for an in and out catheter on 3/5/16.</p> <p>Review of the current facility policy, dated 10/2014, titled "LABORATORY ORDERS, TIMELY DRAWS", provided by the Director of Nursing on 4/5/16 at 1:58 p.m., included, but was not limited to, the following:</p> <p>"PURPOSE: Laboratory testing shall be conducted in a timely manner per physician's orders...."</p>		<p>specimens if indicated. The nurses have been educated on physician's orders with aspecial focus on obtaining in and out catheter orders for urine specimens ifindicated. A monitoring tool has beenimplemented. The DON or designee will be responsible for reviewing MDorders daily on scheduled work days to ensure orders are obtained to utilize anin and out catheter for urine specimens if indicated. Should a concern be found, immediatecorrective action will occur. Results ofthese reviews and any corrective actions will be discussed during thefacility's monthly QA meetings and the plan adjusted if indicated.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155400	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/05/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER LIBERTY VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 4600 E JACKSON ST MUNCIE, IN 47303
---	--

(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 0329 SS=D Bldg. 00	<p>...5. Should orders be received for a [sic] urinalysis and sensitivity and the resident is unable to complete a clean catch midstream sample, and I/O [in and out] catheter procedure will be used to obtain the urine."</p> <p>3.1-37(a)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155400	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/05/2016
NAME OF PROVIDER OR SUPPLIER LIBERTY VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 4600 E JACKSON ST MUNCIE, IN 47303		
(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	
	<p>Based on observation, interview and record review, the facility failed to ensure psychoactive medication was used to treat an identified behavioral/emotional symptom for 1 of 5 residents reviewed for psychoactive medication use (Resident #76).</p> <p>Findings include:</p> <p>Resident #76's clinical record was reviewed on 4/1/16 at 2:14 p.m. Resident #76's diagnoses included, but were not limited to, anxiety and history of cerebrovascular accident.</p> <p>Resident #76 had a current, 12/14/15, physician's order for: Xanax 0.25 mg- 1 tablet 3 times daily for anxiety.</p> <p>Resident #76's clinical record lacked any indication of how the resident's behavioral/emotional symptom related to anxiety displayed itself. Resident #76 Nursing Notes for January 2016 to April 1, 2016 had no documented symptoms of anxiety.</p> <p>During a 4/5/16, 9:17 a.m., interview, the Social Service Designee indicated the facility did</p>	F 0329	<p>Resident #76 did not experience any negative outcome related to this alleged deficient practice. Review of the resident's clinical record indicated the resident complains of "feeling anxious". The resident's behavior log and care plan have been updated to reflect the identified behavior/emotional symptom. All residents receiving psychotropic medications have the potential to be affected. Their clinical records have been reviewed. The behavior logs and care plans have been updated to reflect any identified behavioral/emotional symptoms if indicated. The facility's policies for behavior management and use of psychopharmacological medications have been reviewed and no changes are indicated at this time. The Social Service Director has been re-educated on the policies with a special focus on identifying specific behavioral/emotional symptoms. A monitoring tool has been implemented. The SSD or designee will be responsible for reviewing the clinical record of 5 residents receiving psychoactive medications to ensure there are specific behavioral/emotional symptoms listed on the care plan and behavior logs. These reviews will occur on scheduled work days as follows: daily for two weeks, weekly for two weeks, then monthly thereafter.</p>	04/18/2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155400	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/05/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER LIBERTY VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 4600 E JACKSON ST MUNCIE, IN 47303
---	--

(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
	<p>not have an identified symptom for Resident #76's anxiety because her condition was stable. When questioned, the Social Services Designee indicated she did not know what Resident #76's symptoms were prior to receiving antianxiety medication.</p> <p>During a 4/1/16, 10:11 a.m., observation, Resident #76 was walking calmly in her room. During a 4/1/16, 2:17 p.m., observation, Resident #76 was calmly watching TV in her room. During a 4/4/16, 8:41 a.m., observation, Resident #76 was walking calmly in her room.</p> <p>A current, 10/2014, facility policy, titled "USE AND TAPERING OF PSYCHOPHARMACOLOGICAL MEDICATIONS (OTHER THAN ANTIPSYCHOTICS AND SEDATIVE HYPNOTICS)", provided by the RN Consult on 4/5/16 at 10:27 a.m., indicated: "Each resident's medication regimen must be free from unnecessary medication. An unnecessary medication is any mediation when used... without adequate indications for its use; or..."</p> <p>3.1-48(a)(4)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155400		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 04/05/2016	
NAME OF PROVIDER OR SUPPLIER LIBERTY VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 4600 E JACKSON ST MUNCIE, IN 47303			
(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 0425 SS=D Bldg. 00	<p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on interview and record review, the facility failed to ensure resident medication was readily available for 1 of 6 residents reviewed for availability of medication (Resident #9).</p> <p>Findings Include:</p> <p>During a 3/31/16, 10:09 a.m., interview, Resident #9 indicated the facility had ran out of her medications a number of times. She indicated she had recently gone 3 to 4 days without Nortriptyline to help her sleep. She additionally</p>	F 0425	Resident #9 experienced no negative outcomes related to this alleged deficient practice and at no time did the resident complain of not being able to sleep during the period of March 25-28. The facility informed the resident's physician on March 25 of the medication that was not going to be available and the physician ordered to hold the medication until available from the pharmacy. All residents have the potential to be affected. The clinical records were reviewed and if medications were found to not be available, the physician was contacted for further orders. The facility's policy for ordering	04/25/2016			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155400		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/05/2016	
NAME OF PROVIDER OR SUPPLIER LIBERTY VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 4600 E JACKSON ST MUNCIE, IN 47303			
(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			
	<p>indicated she had trouble sleeping without her medication.</p> <p>Resident #9's clinical record was reviewed on 4/1/16 at 1:25 p.m. Resident #9's diagnoses included, but were not limited to, depression, insomnia and hypertension.</p> <p>Resident #9 had a, current, 1/27/16, physician's order for: Nortriptyline HCL 75 mg- 1 daily at bed time for insomnia.</p> <p>Resident #9's March 2016 Medication Administration Record indicated the resident did not receive Nortriptyline HCL 75 mg for 4 days in March (3/25/16, 3/26/16, 3/27/16 and 3/28/16) due to lack of availability.</p> <p>Resident #9 had a 3/25/16, 8:00 p.m., physician's order to hold Nortriptyline HCL 75 mg until available from the pharmacy.</p> <p>A 3/25/15, "Re-order Medication Form" indicated Resident #9's Nortriptyline HCL 75 mg was re-ordered. The order was placed the day the resident's record indicated she was out of the medication.</p>		<p>and receiving medications was reviewed and no changes are indicated at this time. The nurses have been educated on the policy with a special focus on receiving ordered medications in a timely manner. A monitoring tool has been implemented. The DON or designee will be responsible for reviewing medication administration records and treatment administration records to ensure medications are treatments are available in a timely manner for the residents. These reviews will be completed on scheduled work days as follows: daily for two weeks, 2 times weekly for two weeks, then weekly thereafter. Should a concern be found, immediate corrective action will occur. Results of these reviews and any corrective actions will be discussed during the facility's monthly QA meetings and the plan adjusted if indicated.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155400	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/05/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER LIBERTY VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 4600 E JACKSON ST MUNCIE, IN 47303
---	--

(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
	<p>Resident #9 had a current, 2/25/16, care plan problem regarding insomnia. Approaches to this problem included, but was not limited to, administer medications as ordered.</p> <p>During a 4/5/16, 10:00 a.m., interview, the Director of Nursing indicated the facility was unable to determine why nursing did not re-order Resident #9's medication before it ran out nor why pharmacy did not deliver the medication promptly.</p> <p>A current, undated, facility policy, titled "ORDER AND RECEIPT OF DRUGS FROM PHARMACY", provided by the Director of Nursing on 4/1/16 at 3:10 p.m., indicated: "Prescriptions can be re-ordered when there is a four (4) day supply remaining. To re-order, remove the side re-order label and attach it to the pharmacy sheet titled Re-Order Medication Form."</p> <p>3.1-25(g)(2) 3.1-25(g)(3)</p>			