

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155768	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/24/2014
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NAME OF PROVIDER OR SUPPLIER EVANSVILLE PROTESTANT HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3701 WASHINGTON AVE EVANSVILLE, IN 47714
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F000000	<p>This visit was for the Investigation of Complaint IN00142668.</p> <p>Complaint IN00142668 - Substantiated, Federal/State deficiencies related to the allegations are cited at F224, F225, and F226.</p> <p>Survey dates: January 23 and 24, 2014</p> <p>Facility number: 001125 Provider number: 155768 AIM number: N/A</p> <p>Survey team: Anne Marie Crays RN, TC Amy Winger RN</p> <p>Census bed type: SNF: 30 Residential: 62 NCC: 15 Total: 107</p> <p>Census payor type: Medicare: 5 Other: 102 Total: 107</p> <p>Sample: 4 Residential sample: 1</p>	F000000	Please accept this plan of correction as our credible allegation of compliance. This plan of correction is submitted as part of the regulatory required response and is not to be construed as agreement with deficiencies cited.	
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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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	<p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on January 27, 2014, by Jodi Meyer, RN</p>			

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F000224 SS=D	<p>483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROP RIATN 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 ensure a resident's pain medication was not removed and taken from the locked medication cart without authorization, for 1 of 3 residents reviewed for misappropriation of property, in a sample of 4. Resident A</p> <p>Findings include:</p> <p>1. On 1/23/14 at 10:40 A.M., LPN # 1 indicated Resident A had been a resident in the residential section of the facility, and was transferred to the skilled section of the facility for a</p>	F000224	<p>F-224 1. What corrective action will be accomplished for resident found to be affected by deficient practice? Resident A has suffered no ill effects. The medication was replaced at the time of discovery and at no time did the resident request the medication and it was not available. 2. How other residents potentially affected will be identified and corrective actions taken? DON or designee shall audit all current pain medication orders for congruency with medication cart availability for all residents who do not self-administer based on current orders received by physician and placed on the MAR at the time of admission or transfer. Any discrepancies shall be corrected</p>	02/23/2014

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	<p>few weeks. LPN # 1 indicated that when Resident A transferred back to the residential side, it was discovered that the resident's Tramadol [pain medication] medication card and sign out sheet was missing.</p> <p>On 1/23/14 at 12:00 P.M., during interview with the Administrator, she indicated the missing Tramadol was not reported to the ISDH (Indiana State Department of Health) or to the police, because the medication "was not a narcotic."</p> <p>On 1/23/14 at 1:45 P.M., during interview with the Director of Nursing (DON), she indicated Resident A was living in the apartments, or residential, and went to "nursing," or skilled, on 11/22/13. The DON indicated during that transfer, LPN # 2 and LPN # 3 counted 16 Tramadol. The DON indicated when the resident was ready to return to the apartments, on 12/12/13, the staff noticed the medication was missing. The DON indicated both the sign out sheet and the medication card which contained the 16 Tramadol was missing. The DON indicated she found out about it on a Monday morning. The DON indicated she did not report the</p>		<p>immediately through replacement and or clarification of physician orders and reported as misappropriation using unusual occurrence procedures and regulatory guidelines. 3. What measures will be put in place or systemic changes made to ensure the deficient practice does not recur? In addition to routine shift to shift narcotic count the DON or designee is responsible to ensure implementation of Narcotic Count Verification sheet related to pain medication is performed per shift. Narcotic count sheet verification audits ensure the count sheet has not been removed from the cart. Management Narcotic Sheet audits ensure the medication is in the lock box, the count sheet is in place, medication given was documented. Drug destruction disposition shall be copied to DON or designee by medical records or designee to ensure pain medication is disposed of properly. Pharmacy protocol has been updated to include approval by Administrator only for replacement of all medications at facility expense due to reorder. Any discrepancy shall be corrected immediately through replacement and or clarification of physician orders and reported as misappropriation using unusual occurrence procedures and regulatory guidelines. 4. How the corrective actions will be monitored to ensure the deficient</p>		

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	<p>missing medication, because it was a PRN (as needed) medication, and it was not a narcotic. The DON indicated she called the pharmacy and had it replaced. She indicated she spoke to both LPN # 2 and LPN # 3 about the incident. She did not indicate she spoke to any other staff about the incident. The DON acknowledged a medication theft occurred from the facility Emergency Drug Kit around the same time, on 12/2/13.</p> <p>On 1/23/14 at 2:25 P.M., LPN # 3 was interviewed. He indicated he was working on 11/22/13 when Resident A was moved to his unit. He indicated he and LPN # 2 counted the resident's medications, including the Tramadol. He indicated approximately 3-4 weeks later, the resident was transferred back to the apartments. He indicated there was not a narcotic sheet, nor the medication. He indicated the Tramadol was a prn drug, and he had never given it to the resident, and so didn't realize it was missing during the few weeks the resident was on the nursing side. LPN # 3 indicated he immediately reported it to the DON or to the Unit Manager.</p> <p>On 1/23/14 at 2:25 P.M., LPN # 2</p>		<p>practice will not recur? Pain medication count audits completed for admissions and transfers shall be reviewed in quality assurance committee for completion and effectiveness of misappropriation deterrence. Pain Medication Count Audits shall be completed on admissions and transfers within 24 hours by Don or designee. Drug disposition records shall be reviewed by DON or designee for accurate documentation, destruction and adherence to policy, these audits shall be turned into quality assurance committee for review of completion and effectiveness of misappropriation deterrence. Monthly pharmacy bill shall be reviewed in quality assurance to ensure notification and authorization of Administrator occurred and reporting requirements followed for potential misappropriation of pain medication. Pharmacy bills shall be reviewed indefinitely for compliance with unusual occurrence reporting and regulatory guidelines. Audits shall occur with each admission transfer and discharge for 3 months. After 3 months if 100% compliance is achieved will perform monthly audits thereafter.</p>				

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	<p>was interviewed. She indicated she was the Unit Manager on Residential South. She indicated she transferred Resident A to the nursing side, and her and LPN # 3 counted 16 Tramadol. She indicated her and LPN # 3 both signed the narcotic sign out card. LPN # 3 indicated when Resident A moved back to the apartments, all of the medications and drug sheets were sent except the Tramadol. She indicated she asked LPN # 3 where the Tramadol was, and he looked through the medication carts, thinking it could have been misplaced. LPN # 2 indicated when they could not find the missing medication, they immediately reported it to the DON.</p> <p>On 1/23/14 at 2:45 P.M., the DON provided a written statement from LPN # 2 and LPN # 3. She indicated she had both of the nurses write statements on 1/23/14, as she must have lost their previous statements regarding the missing Tramadol. A notation on a copy of the resident's drug disposition document indicated, "Back to Apts - missing 16 Tramadol. [LPN # 1] counted all other narcs [narcotics] [and] Tramadol accounted for...Call [pharmacy] - bill facility."</p>			

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	<p>On 1/24/14 at 9:30 A.M., Pharmacist # 1 was interviewed. He indicated he was aware of a resident missing Tramadol, but that the pharmacy didn't report this, as it was the resident's property. Pharmacist # 1 indicated the pharmacy did report medication thefts from the facility's general Emergency Drug Kit to the Drug Enforcement Agency and State Board.</p> <p>O 1/24/14 at 10:00 A.M., the clinical record of Resident A was reviewed.</p> <p>Physician orders, dated 11/22/13, included, "Ultram [Tramadol] 50 mg [one] tablet po [by mouth] q [every] 4 [hours] PRN pain...."</p> <p>A Drug Disposition Record, dated 11/22/13, indicated, "Tramadol 50 mg, Quantity 16," and was signed by LPN # 2 and LPN # 3. The "Method of Disposition" indicated, "Moved to nursing."</p> <p>Documentation indicated the resident did not receive the Tramadol while on the skilled side of the building.</p> <p>A Physician's order, dated 12/11/13, indicated, "May transfer resident to residential [with] current medication</p>			

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	<p>orders on 12/12/13."</p> <p>"Post Discharge Instructions," dated 12/12/13, indicated, "Medicaitons/Treatments...Ultram 50 mg [one] tab po q 4[hours] PRN pain...."</p> <p>2. On 1/24/14 at 10:00 A.M., the Administrator provided the current facility policy on "Policy and Procedure for Reporting of Inappropriate/Improper Behavior/Potential Abuse/Missing Property and Grievances," undated. The policy included: "...The Elder Justice Act under the Patient Protection and Affordable care Act of 2010 shall be utilized for any reports of the reasonable suspicion of a crime against a resident of this facility and the reports must be made to the Indicana State Departament of Health and local law enforcement entity within 2 hours if there is a serious bodily injury. If events causing the suspicion do no [sic] result in the serious bodily injury, it must be reported within 24 hours after forming the suspicion...Definition of Abuse:...Material/Financial abuse (theft) misuse, misappropriation, and/or exploitation of an older adult's material and/or monetary</p>			
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	<p>assets...Procedure:...All staff members associated with/near the incident will be interviewed and written statements obtained in a timely manner...A report will be submitted to the appropriate state authority...Incident/complaints involving alleged resident abuse will be directed to the Administrator, Director of Nursing, and Social Services Director and investigated immediately."</p> <p>This Federal tag relates to Complaint IN00142668.</p> <p>3.1-28(a)</p>			

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F000225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>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 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>			

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	<p>Based on interview and record review, the facility failed to ensure a resident's theft of pain medication was investigated thoroughly and reported to the Indiana State Department of Health and local Police Department, for 1 of 3 residents reviewed for misappropriation of property, in a sample of 4. Resident A</p> <p>Findings include:</p> <p>1. On 1/23/14 at 10:40 A.M., LPN # 1 indicated Resident A had been a resident in the residential section of the facility, and was transferred to the skilled section of the facility for a few weeks. LPN # 1 indicated that when Resident A transferred back to the residential side, it was discovered that the resident's Tramadol [pain medication] medication card and sign out sheet was missing.</p> <p>On 1/23/14 at 12:00 P.M., during interview with the Administrator, she indicated the missing Tramadol was not reported to the ISDH (Indiana State Department of Health) or to the police, because the medication "was not a narcotic."</p> <p>On 1/23/14 at 1:45 P.M., during</p>	F000225	<p>F-225 1. What corrective action will be accomplished for resident found to be affected by deficient practice? Resident A has suffered no ill effects. ISDH is aware of misappropriation and facility has reported tramadol misappropriation to local police department and provided case #14-02049 2. How other residents potentially affected will be identified and corrective actions taken? Results of pain medication count audits shall be reviewed by Administrator or designee for investigation completion, including completion of grievance/missing property report and adherence to grievance/misappropriation guidelines. Misappropriation shall be reported to ISDH following unusual occurrence procedures and local police department for compliance with regulatory guidelines. 3. What measures will be put in place or systemic changes made to ensure the deficient practice does not recur? To enhance currently compliant operations all staff shall be in-serviced regarding misappropriation of pain medication as an unusual occurrence and proper procedures for reporting. Procedures shall include immediately informing supervisor and or Administrator, completion of unusual occurrence to ISDH and notification of local police department for misappropriation</p>	02/23/2014			

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	<p>interview with the Director of Nursing (DON), she indicated Resident A was living in the apartments, or residential, and went to "nursing," or skilled, on 11/22/13. The DON indicated during that transfer, LPN # 2 and LPN # 3 counted 16 Tramadol. The DON indicated when the resident was ready to return to the apartments, on Thursday, 12/12/13, the staff noticed the medication was missing. The DON indicated both the sign out sheet and the medication card which contained the 16 Tramadol was missing. The DON indicated she found out about it on a Monday morning. The DON indicated she did not report the missing medication, because it was a PRN (as needed) medication, and it was not a narcotic. The DON indicated she called the pharmacy and had it replaced. She indicated she spoke to both LPN # 2 and LPN # 3 about the incident. She did not indicate she spoke to any other staff about the incident. The DON acknowledged a medication theft occurred from the facility Emergency Drug Kit around the same time, on 12/2/13.</p> <p>On 1/23/14 at 2:25 P.M., LPN # 3 was interviewed. He indicated he</p>		<p>of pain medication. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur? Results of pain medication count audits shall be reviewed by Quality Assurance committee for investigation completion including completion of grievance/missing property report and adherence to grievance/misappropriation guidelines. Misappropriation shall be reported to ISDH following unusual occurrence procedures and local police department for compliance with regulatory guidelines.</p>				

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	<p>was working on 11/22/13 when Resident A was moved to his unit. He indicated he and LPN # 2 counted the resident's medications, including the Tramadol. He indicated approximately 3-4 weeks later, the resident was transferred back to the apartments. He indicated there was not a narcotic sheet, nor the medication. He indicated the Tramadol was a prn drug, and he had never given it to the resident, and so didn't realize it was missing during the few weeks the resident was on the nursing side. LPN # 3 indicated he immediately reported it to the DON or to the Unit Manager.</p> <p>On 1/23/14 at 2:25 P.M., LPN # 2 was interviewed. She indicated she was the Unit Manager on Residential South. She indicated she transferred Resident A to the nursing side, and her and LPN # 3 counted 16 Tramadol. She indicated her and LPN # 3 both signed the narcotic sign out card. LPN # 3 indicated when Resident A moved back to the apartments, all of the medications and drug sheets were sent except the Tramadol. She indicated she asked LPN # 3 where the Tramadol was, and he looked through the medication carts, thinking it could have been misplaced. LPN # 2</p>				

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	<p>indicated when they could not find the missing medication, they immediately reported it to the DON.</p> <p>On 1/23/14 at 2:45 P.M., the DON provided a written statement from LPN # 2 and LPN # 3. She indicated she had both of the nurses write statements on 1/23/14, as she must have lost their previous statements regarding the missing Tramadol. A notation on a copy of the resident's drug disposition document indicated, "Back to Apts - missing 16 Tramadol. [LPN # 1] counted all other narcs [narcotics] [and] Tramadol accounted for...Call [pharmacy] - bill facility."</p> <p>The Administrator indicated at that time that the missing medication was reported to her sometime that day, but she wasn't sure of the time.</p> <p>On 1/24/14 at 9:30 A.M., Pharmacist # 1 was interviewed. He indicated he was aware of a resident missing Tramadol, but that the pharmacy didn't report this, as it was the resident's property. Pharmacist # 1 indicated the pharmacy did report medication thefts from the facility's general Emergency Drug Kit to the Drug Enforcement Agency and State Board.</p>			

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	<p>O 1/24/14 at 10:00 A.M., the clinical record of Resident A was reviewed.</p> <p>Physician orders, dated 11/22/13, included, "Ultram [Tramadol] 50 mg [one] tablet po [by mouth] q [every] 4 [hours] PRN pain...."</p> <p>A Drug Disposition Record, dated 11/22/13, indicated, "Tramadol 50 mg, Quantity 16," and was signed by LPN # 2 and LPN # 3. The "Method of Disposition" indicated, "Moved to nursing."</p> <p>Documentation indicated the resident did not receive the Tramadol while on the skilled side of the building.</p> <p>A Physician's order, dated 12/11/13, indicated, "May transfer resident to residential [with] current medication orders on 12/12/13."</p> <p>"Post Discharge Instructions," dated 12/12/13, indicated, "Medicaitons/Treatments...Ultram 50 mg [one] tab po q 4[hours] PRN pain...."</p> <p>2. On 1/24/14 at 10:00 A.M., the Administrator provided the current facility policy on "Policy and</p>			

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	<p>Procedure for Reporting of Inappropriate/Improper Behavior/Potential Abuse/Missing Property and Grievances," undated. The policy included: "...The Elder Justice Act under the Patient Protection and Affordable care Act of 2010 shall be utilized for any reports of the reasonable suspicion of a crime against a resident of this facility and the reports must be made to the Indicana State Departament of Health and local law enforcement entity within 2 hours if there is a serious bodily injury. If events causing the suspicion do no [sic] result in the serious bodily injury, it must be reported within 24 hours after forming the suspicion...Definition of Abuse:...Material/Financial abuse (theft) misuse, misappropriation, and/or exploitation of an older adult's material and/or monetary assets...Procedure:...All staff members associated with/near the incident will be interviewed and written statements obtained in a timely manner...A report will be submitted to the appropriate state authority...Incidenta/complaints involving alleged resident abuse will be directed to the Administrator, Director of Nursing, and Social Services Director and investigated</p>			

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F000226 SS=D	<p>immediately."</p> <p>This Federal tag relates to Complaint IN00142668.</p> <p>3.1-28(c) 3.1-28(d) 3.1-28(e)</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 ensure a resident's theft of pain medication was investigated thoroughly and reported to the Indiana State Department of Health and local Police Department, as the facility policy indicated, for 1 of 3 residents reviewed for misappropriation of property, in a sample of 4. Resident A</p> <p>Findings include:</p> <p>1. On 1/23/14 at 10:40 A.M., LPN # 1 indicated Resident A had been a</p>	F000226	F-226 1. What corrective action will be accomplished for resident found to be affected by deficient practice? Resident A has suffered no ill effects. ISDH is aware of misappropriation and facility has reported tramadol misappropriation to local police department and provided case #14-02049 2. How other residents potentially affected will be identified and corrective actions taken? Results of pain medication count audits shall be reviewed by Administrator or designee for investigation completion including completion of grievance/missing property report and adherence to grievance/misappropriation guidelines. Misappropriation shall	02/23/2014
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	<p>resident in the residential section of the facility, and was transferred to the skilled section of the facility for a few weeks. LPN # 1 indicated that when Resident A transferred back to the residential side, it was discovered that the resident's Tramadol [pain medication] medication card and sign out sheet was missing.</p> <p>On 1/23/14 at 12:00 P.M., during interview with the Administrator, she indicated the missing Tramadol was not reported to the ISDH (Indiana State Department of Health) or to the police, because the medication "was not a narcotic."</p> <p>On 1/23/14 at 1:45 P.M., during interview with the Director of Nursing (DON), she indicated Resident A was living in the apartments, or residential, and went to "nursing," or skilled, on 11/22/13. The DON indicated during that transfer, LPN # 2 and LPN # 3 counted 16 Tramadol. The DON indicated when the resident was ready to return to the apartments, on 12/12/13, the staff noticed the medication was missing. The DON indicated both the sign out sheet and the medication card which contained the 16 Tramadol was missing. The DON</p>		<p>be reported to ISDH following unusual occurrence procedures and local police department for compliance with regulatory guidelines. 3. What measures will be put in place or systemic changes made to ensure the deficient practice does not recur? To enhance currently compliant operations all staff shall be in-serviced regarding misappropriation of pain medication as an unusual occurrence and proper procedures for reporting. Procedures shall include immediately informing supervisor and or Administrator, completion of unusual occurrence to ISDH and notification of local police department for misappropriation of pain medication. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur? Results of pain medication count audits shall be reviewed by Quality Assurance committee for investigation completion including completion of grievance/missing property report and adherence to grievance/misappropriation guidelines. Misappropriation shall be reported to ISDH following unusual occurrence procedures and local police department for compliance with regulatory guidelines.</p>				

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	<p>indicated she found out about it on a Monday morning. The DON indicated she did not report the missing medication, because it was a PRN (as needed) medication, and it was not a narcotic. The DON indicated she called the pharmacy and had it replaced. She indicated she spoke to both LPN # 2 and LPN # 3 about the incident. She did not indicate she spoke to any other staff about the incident. The DON acknowledged a medication theft occurred from the facility Emergency Drug Kit around the same time, on 12/2/13.</p> <p>On 1/23/14 at 2:25 P.M., LPN # 3 was interviewed. He indicated he was working on 11/22/13 when Resident A was moved to his unit. He indicated he and LPN # 2 counted the resident's medications, including the Tramadol. He indicated approximately 3-4 weeks later, the resident was transferred back to the apartments. He indicated there was not a narcotic sheet, nor the medication. He indicated the Tramadol was a prn drug, and he had never given it to the resident, and so didn't realize it was missing during the few weeks the resident was on the nursing side. LPN # 3 indicated he immediately reported it</p>			
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	<p>to the DON or to the Unit Manager.</p> <p>On 1/23/14 at 2:25 P.M., LPN # 2 was interviewed. She indicated she was the Unit Manager on Residential South. She indicated she transferred Resident A to the nursing side, and her and LPN # 3 counted 16 Tramadol. She indicated her and LPN # 3 both signed the narcotic sign out card. LPN # 3 indicated when Resident A moved back to the apartments, all of the medications and drug sheets were sent except the Tramadol. She indicated she asked LPN # 3 where the Tramadol was, and he looked through the medication carts, thinking it could have been misplaced. LPN # 2 indicated when they could not find the missing medication, they immediately reported it to the DON.</p> <p>On 1/23/14 at 2:45 P.M., the DON provided a written statement from LPN # 2 and LPN # 3. She indicated she had both of the nurses write statements on 1/23/14, as she must have lost their previous statements regarding the missing Tramadol. A notation on a copy of the resident's drug disposition document indicated, "Back to Apts - missing 16 Tramadol. [LPN # 1] counted all other narcs [narcotics] [and]</p>			
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	<p>Tramadol accounted for...Call [pharmacy] - bill facility."</p> <p>On 1/24/14 at 9:30 A.M., Pharmacist # 1 was interviewed. He indicated he was aware of a resident missing Tramadol, but that the pharmacy didn't report this, as it was the resident's property. Pharmacist # 1 indicated the pharmacy did report medication thefts from the facility's general Emergency Drug Kit to the Drug Enforcement Agency and State Board.</p> <p>O 1/24/14 at 10:00 A.M., the clinical record of Resident A was reviewed.</p> <p>Physician orders, dated 11/22/13, included, "Ultram [Tramadol] 50 mg [one] tablet po [by mouth] q [every] 4 [hours] PRN pain...."</p> <p>A Drug Disposition Record, dated 11/22/13, indicated, "Tramadol 50 mg, Quantity 16," and was signed by LPN # 2 and LPN # 3. The "Method of Disposition" indicated, "Moved to nursing."</p> <p>Documentation indicated the resident did not receive the Tramadol while on the skilled side of the building.</p>				

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	<p>A Physician's order, dated 12/11/13, indicated, "May transfer resident to residential [with] current medication orders on 12/12/13."</p> <p>"Post Discharge Instructions," dated 12/12/13, indicated, "Medicaitons/Treatments...Ultram 50 mg [one] tab po q 4[hours] PRN pain...."</p> <p>2. On 1/24/14 at 10:00 A.M., the Administrator provided the current facility policy on "Policy and Procedure for Reporting of Inappropriate/Improper Behavior/Potential Abuse/Missing Property and Grievances," undated. The policy included: "...The Elder Justice Act under the Patient Protection and Affordable care Act of 2010 shall be utilized for any reports of the reasonable suspicion of a crime against a resident of this facility and the reports must be made to the Indicana State Departament of Health and local law enforcement entity within 2 hours if there is a serious bodily injury. If events causing the suspicion do no [sic] result in the serious bodily injury, it must be reported within 24 hours after forming the suspicion...Definition of Abuse:...Material/Financial abuse</p>			

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	<p>(theft) misuse, misappropriation, and/or exploitation of an older adult's material and/or monetary assets...Procedure:...All staff members associated with/near the incident will be interviewed and written statements obtained in a timely manner...A report will be submitted to the appropriate state authority...Incidenta/complaints involving alleged resident abuse will be directed to the Administrator, Director of Nursing, and Social Services Director and investigated immediately."</p> <p>This Federal tag relates to Complaint IN00142668.</p> <p>3.1-28(a)</p>			