STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	15E064		07/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE HAVEN HEALTH CARE CENTER	505 N GAVIN ST MUNCIE, IN 47303

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00205084 and IN00204622. Complaint IN00205084 - Unsubstantiated due to lack of evidence. Complaint IN00204622 - Substantiated. Federal/State deficiencies related to the allegations are cited at F224 and F226. Survey date: July 18, 2016 Facility number: 000311 Provider number: 15E064 AIM number: 100285520 Census bed type: NF: 39 Total: 39 Census payor type: Medicaid: 38 Other: 1 Total: 39 Sample: 4 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	F-0000 This Plan of Correction is prepared and executed because itis required by the provisions of the State and Federal regulations, and notbecause Brookside Haven Care Center agrees with the allegations and citationslisted on this statement of deficiencies. This Plan of Correction shall operateas Brookside Haven's written credible allegations of compliance. Brookside Haven respectfully request papercompliance on the attached Plan of Correction.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	QR completed by 11474 on July 19, 2016.			
F 0224 SS=D Bldg. 00	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN 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 the mistreatment of residents did not occur in regards to theft of personal property for 1 of 4 residents reviewed for mistreatment. (Residents B) Findings Include: The clinical record of Resident B was reviewed on 7/18/16 at 2:50 p.m. Diagnoses included, but were not limited to, dysphagia, Parkinson's disease, paranoid schizophrenia, dementia and chronic pain. The Quarterly Minimum Data Set (MDS) assessment, dated 6/14/16, indicated Resident B was severely cognitively impaired. Review of Resident B's current physician	F 0224	F-224 1.) It is the intent of this facility to ensure themistreatment of resident's does not occur to theft of personal property. It isalso the intent of this facility to implement their policy related to themisappropriation of resident property. Director of Nursing and day charge nursecompleted an audit of both medication carts including narcotic drawer to ensurethe card of 30 hydrocodone had not been misplaced in another area. At this timethe count on the Narcotics are correct. LPN #2 whom refused drug screen was an agency nurse. The agency companywhich LPN #2 was employed with was informed that LPN#2 was no longer permittedto work in our facility since refusing drug screen. 2.) Any resident has the potential	08/08/2016

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	orders, from 7/1-7/31/16, indicated hydrocodone bitartrate and acetaminophen (opioid pain medication) 10/325 mg, 1 tablet four times daily for chronic pain and cellulitis. A current care plan, dated 3/3/16 and revised 6/24/16, indicated Resident B had a problem with discomfort related to osteoporosis, cervical dystonia and severe neck flexion. Interventions included, but were not limited to, "administer medication as observe for signs and symptoms of discomfort." During review of the Indiana State Department of Health Incident Report Form, dated 7/6/16, the Administrator was notified by staff that one card of #30 hydrocodone bitartrate and acetaminophen for Resident B was missing from the west medication cart. The Administrator notified the local police, as well as, started an internal investigation. All nurses and the qualified medication aide (QMA) were sent for drug screens and provided statements. During an interview on 7/18/16 at 9:50 a.m., the Administrator indicated all the urine drug screen tests returned negative. She indicated the facility had used a staffing agency during that time. She		to be affected,however resident "B" was not affected due to Hydrocodone being retrieved fromEDK until replacement supply arrived at facility cost. 3.) The HFA and DON immediately notified Pharmacy,Medical Director and Muncie Police Department. Pharmacy was notified to replacethe hydrocodone at facility cost and obtained the hydrocodone from the EDK forresident "B" until supply arrived from pharmacy. Facility did not violate facility policyhowever it is believed agency nurse, LPN #2 violated nursing standard ofpractice. 4.) Re-educated/in-serviced nurses and QMA's onpolicy and procedure on sign in/out sheets for Narcotic count record. Directorof Nursing will monitor daily by doing an independent audit of carts, andnarcotic records. DON, Designee willmonitor daily x30, then weekly X90 days then monthly X2 months. Director ofNursing will report to the QAA Committee during regular scheduled meetings andwill follow any recommendations as deemed necessary. 5.) Date Completed: 8/8/16	

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	indicated LPN #2 refused to submit a urine test for both the facility and also the company he worked for. She indicated she notified the agency and told them LPN #2 was no longer able to work in their facility because he had refused the test. She indicated it was very "slick" for someone to remove both the sheet and entire card from the end. During an interview on 7/18/16 at 11:08 a.m. with the Director of Nursing (DON) and LPN #1, LPN #1 indicated she attempted to re-order the medication, but the pharmacy informed her the medication was "too early" to order. The pharmacy indicated 4 cards had previously been sent. LPN #1 indicated only three cards showed in the narcotic book. The DON indicated the count would not show as "off" because the card count matched the sheet count. During an interview on 7/18/16 at 2:30 p.m., the Administrator indicated the narcotic sheet was marked 4 of 4, but both the sheet and card were missing. The next two doses of pain medication were removed from the Emergency Drug Kit (EDK) and the medication was replaced at the expense of the facility. Review of the police report, indicated the medication was in blister packs labeled 1			

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	of 4, 2 of 4, 3 of 4 and 4 of 4. The blister pack labeled 4 of 4 could not be found. Review of a delivery receipt from the pharmacy, dated 6/13/16, indicated 4 cards with a quantity of #30 tablets of hydrocodone bitartrate and acetaminophen were delivered. Review of the "Add and Remove Card Count Sheet", dated 6/2016, indicated on 6/14/16, 4 cards of hydrocodone bitartrate and acetaminophen were added for Resident B. During an observation on 7/18/16 at 3:28 p.m., LPN #1 and QMA #3 counted both west and east hall medication carts. The count of the sheets matched the count of the cards. Review of a undated current facility policy, provided by the Administrator on 7/18/16 at 2:30 p.m., titled "ABUSE AND PREVENTION POLICY" indicated the following: "POLICY: This facility shall observe the resident's right to remain free from verbal, sexual, physical, and mental abuse, mistreatment, neglect, corporal punishment and involuntary seclusion.			

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	RESIDENT ABUSE: Resident abuse is defined as any action which may cause a resident to suffer from discomfort, fear, or embarrassment. Examples of abuse as as follows, but are not inclusive: ...MISAPPROPRIATION OF PROPERTY is defined as the patterned or deliberate misplacement exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's concent [sic]." This Federal tag relates to Complaint IN00204622. 3.1-28(a)			
F 0226 SS=D Bldg. 00	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 policy related to the misappropriation of resident property for 1 of 4 residents reviewed for property theft. (Residents B)	F 0226	F-226 1.) It is the intent of this facility to ensure themistreatment of resident's does not occur to theft of personal property. It isalso the intent of this facility to implement their policy related to	08/08/2016

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	Findings Include: The clinical record of Resident B was reviewed on 7/18/16 at 2:50 p.m. Diagnoses included, but were not limited to, dysphagia, Parkinson's disease, paranoid schizophrenia, dementia and chronic pain. The Quarterly Minimum Data Set (MDS) dated 6/14/16, indicated Resident B was severely cognitively impaired. Review of Resident B's current physician orders, from 7/1-7/31/16, indicated hydrocodone bitartrate and acetaminophen (opioid pain medication) 10/325 mg, 1 tablet four times daily for chronic pain and cellulitis. A current care plan, dated 3/3/16 and revised 6/24/16, indicated Resident B had a problem with discomfort related to osteoporosis, cervical dystonia and severe neck flexion. Interventions included, but were not limited to, administer medication as observe for signs and symptoms of discomfort. During review of the Indiana State Department of Health Incident Report Form dated 7/6/16, the Administrator was notified by staff that one card of #30 hydrocodone bitartrate and		themisappropriation of resident property. Director of Nursing and day charge nursecompleted an audit of both medication carts including narcotic drawer to ensurethe card of 30 hydrocodone had not been misplaced in another area. At this timethe count on the Narcotics are correct. LPN #2 whom refused drug screen was an agency nurse. The agency companywhich LPN #2 was employed with was informed that LPN#2 was no longer permittedto work in our facility since refusing drug screen. 2.) Any resident has the potential to be affected,however resident “B” was not affected due to Hydrocodone being retrieved fromEDK until replacement supply arrived at facility cost. 3.) The HFA and DON immediately notified Pharmacy,Medical Director and Muncie Police Department. Pharmacy was notified to replacethe hydrocodone at facility cost and obtained the hydrocodone from the EDK forresident “B” until supply arrived from pharmacy. Facility did not violate facility policyhowever it is believed agency nurse, LPN #2 violated nursing standard ofpractice. 4.) Re-educated/in-serviced nurses and QMA’s onpolicy and procedure on sign in/out sheets for Narcotic	

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	acetaminophen for Resident B was missing from the west medication cart. The Administrator notified the local police, as well as, started an internal investigation. All nurses and qualified medication aide (QMA) were sent for drug screens and provided statements. During an interview on 7/18/16 at 9:50 a.m., the Administrator indicated all the urine drug screen tests returned negative. She indicated the facility had used a staffing agency during that time. She indicated LPN #2 refused to submit a urine test for both the facility and also the company he worked for. She indicated she notified the agency and told them LPN #2 was no longer able to work in their facility because he had refused the test. She indicated it was very "slick" for someone to remove both the sheet and entire card from the end. During an interview on 7/18/16 at 11:08 a.m. with the Director of Nursing (DON) and LPN #1, LPN #1 indicated she attempted to re-order the medication, but the pharmacy informed her the medication was "too early" to order. The pharmacy indicated 4 cards had previously been sent. LPN #1 indicated only three cards showed in the narcotic book. The DON indicated the count would not show as "off" because the card		count record. Directorof Nursing will monitor daily by doing an independent audit of carts, andnarcotic records. DON, Designee willmonitor daily x30, then weekly X90 days then monthly X2 months. Director ofNursing will report to the QAA Committee during regular scheduled meetings andwill follow any recommendations as deemed necessary. 5.) Date Completed: 8/8/16	

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	count matched the sheet count. During an interview on 7/18/16 at 2:30 p.m., the Administrator indicated the narcotic sheet was marked 4 of 4, but both the sheet and card were missing. The next two doses of pain medication was removed from the Emergency Drug Kit (EDK) and the medication was replaced at the expense of the facility. Review of the police report, indicated the medication was in blister packs labeled 1 of 4, 2 of 4, 3 of 4 and 4 of 4. The blister pack labeled 4 of 4 could not be found. Review of a delivery receipt from the pharmacy, dated 6/13/16, indicated 4 cards with a quantity of #30 tablets of hydrocodone bitartrate and acetaminophen were delivered. Review of the "Add and Remove Card Count Sheet", dated 6/2016, indicated on 6/14/16, 4 cards of hydrocodone bitartrate and acetaminophen were added for Resident B. During an observation on 7/18/16 at 3:28 p.m., LPN #1 and QMA #3 counted both west and east hall medication carts. The count of the sheets matched the count of the cards.			

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	Review of a undated current facility policy, provided by the Administrator on 7/18/16 at 2:42 p.m., titled "CONTROLLED MEDICATION-ADMINISTRATION" indicated the following: "POLICY: Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal, and record keeping in the facility in accordance with federal and state laws and regulations. PROCEDURE: ...8. At each shift change, a physical inventory of all Schedule II medications and any other Schedule III, IV, or V's designated by the facility policy is conducted by two licensed nurse and is documented on an audit record. Alternatively, the shift change audit may be recorded on the medication count sheet if there is a designated column for the audit. This Federal tag relates to Complaint IN00204622. 3.1-28(a)			

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