

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155242	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/01/2016
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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF MUNCIE	STREET ADDRESS, CITY, STATE, ZIP CODE 4301 N WALNUT ST MUNCIE, IN 47303
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00200978.</p> <p>Complaint IN00200978 - Substantiated. Federal/State deficiencies related to the allegations are cited at F224.</p> <p>Survey dates: May 31 and June 1, 2016</p> <p>Facility number: 000146 Provider number: 155242 AIM number: 100291200</p> <p>Census bed type: SNF/NF: 121 Total: 121</p> <p>Census payor type: Medicare: 21 Medicaid: 86 Other: 14 Total: 121</p> <p>Sample: 3</p> <p>This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>QR completed by 11474 on June 2, 2016.</p>	F 0000		

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 0224 SS=D Bldg. 00	<p>483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATION</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on interview and record review, the facility failed to ensure residents were free from misappropriation for 1 of 3 residents reviewed for misappropriation of property in a sample of 3. (Resident B)</p> <p>Findings include:</p> <p>The clinical record for Resident B was reviewed on 5/31/16 at 4:35 p.m. Diagnoses for Resident B included, but were not limited to, anemia, hypothyroidism, chronic pain, and hypertension.</p> <p>During a review on 5/31/15 at 3:00 p.m., of recent facility self reportable incidents, an investigative report involving missing medication for Resident B was reviewed. The investigative report indicated that on 5/4/16, LPN #2 and LPN #5 signed a pharmacy manifest for the receipt of 120 doses of oxycodone 5-325 mg (narcotic pain medication) for Resident B. The reportable indicated on 5/20/16, 60 doses of the medication intended for Resident B</p>	F 0224	<p>This Plan of Correction is the facility's credible allegation of compliance. The facility respectfully requests a desk review and has provided evidence of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. F224</p> <p>1. Corrective action accomplished for those residents found to have been affected by the deficient practice: Resident's medication was immediately replaced at the facility expense. The resident never missed any medication and the facility procedures prevented any possibility of the resident missing any prescribed medication.</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: All narcotics in the facility have been</p>	06/02/2016

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	<p>were reported missing along with the narcotic count sheet.</p> <p>During an interview on 5/31/16 at 3:00 p.m., the Administrator and the Director of Nursing indicated an investigation was initiated to determine the root cause of the missing medication. No root cause was determined.</p> <p>During an interview on 5/31/16 at 4:25 p.m., LPN #1 indicated on 5/19/16 the medications were noted needing reorder from the pharmacy. LPN # 1 sent the physician a request to send in the reorder to the pharmacy. This information was passed onto the night shift nurse stating the pharmacy would deliver the medication that night.</p> <p>During an interview on 5/31/16 at 4:40 p.m., LPN #3 indicated LPN #1 had indicated, in verbal report, the pharmacy would deliver the medications for Resident B during the night shift. LPN #3 indicated the medications were not included in the medication delivery that night. LPN #3 indicated pharmacy was called to determine the reason the medications were not included in the night medication delivery and the facility was informed by the pharmacy the medications were not due to be refilled at that time. The Administrator was</p>		<p>audited and accounted for (attachment 1). No other residents were found to be affected.</p> <p>3.What measures will be put in place or what systematic changes will be made to ensure that the deficient practice does not recur: Nursing staff has been educated on medication and narcotic storage and accounting, misappropriation / resident abuse, drugdiversion and drug free workplace policies. (Attachment 2) Additional tracking of controlled substances, the number of medication cards and controlled substance count sheets has been implemented. (Attachment 3)</p> <p>4.How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place: All narcotic narcotics and count sheets will be audited by unit managers weekly for 4 weeks, then monthly for 4 months,then quarterly for 3 quarters and will then be reevaluated by the QAAcommittee. The results of these audits will be presented to the QAA committeemonthly for 4 months and then quarterly for three quarters.</p> <p>5.Systematic changes will be completed by June 2nd 2016</p>				

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	<p>notified of the missing medications. LPN #3 was able to provide Resident B with the pain medication for the Emergency Drug Kit so Resident B would not miss any scheduled doses.</p> <p>During an interview on 6/1/16 at 9:41 a.m., LPN #4 indicated two narcotic count sheets as well as two oxycodone cards (total of 120 pills) were present on 5/13/16. "I know I remember seeing two cards about one week before they were missing. They were rubber banded together and I had to remove the rubber band to pop the pill out." LPN #4 indicated the rubber band was not replaced and both cards were returned to the narcotic box and there had been two narcotic count sheets.</p> <p>No further information was provided.</p> <p>This federal tag relates to Complaint IN00200978.</p> <p>3.1-28(a)</p>			