

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155362	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/03/2016
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MERRILLVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 8800 VIRGINIA PLACE MERRILLVILLE, IN 46410
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00205349.</p> <p>Complaint IN00205349 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Unrelated deficiencies cited.</p> <p>Survey dates: August 2 & 3, 2016</p> <p>Facility number: 000253 Provider number: 155362 AIM number: 100266660</p> <p>Census bed type: SNF/NF: 143 Total: 143</p> <p>Census Payor type: Medicare: 7 Medicaid: 115 Other: 21 Total: 143</p> <p>Sample: 6</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000		
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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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F 0224 SS=D Bldg. 00	<p>Quality review completed by 32883 on 8/8/16.</p> <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 interview and record review, the facility failed to ensure a resident was free from misappropriation of resident property, related to a resident's 12 syringes of Ativan (anti-anxiety/controlled substance) found missing on 07/13/16, for 1 resident in a sample of 6. (Resident #E)</p> <p>Finding includes:</p> <p>Resident #E's record was reviewed on 08/03/16 at 11:15 a.m.. The resident's diagnoses included, but were not limited to, pulmonary heart disease, chronic obstructive pulmonary disease, and hypertension. The record indicated the resident was receiving Hospice services.</p>	F 0224	<p>F224 -</p> <p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The medication refrigerators where narcotics were stored were checked and the Daily Narcotic Shift Checksheets were reviewed for completion and accuracy on all units on 8/4/2016.</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential of being affected by the deficient practice. A full facility unit audit was completed and any identified or missing signatures were noted</p>	08/31/2016

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	<p>A Physician's Order, dated 04/11/16, indicated Ativan 0.25 ml (milliliters) sublingually (under the tongue) every four hours as needed for restlessness and agitation.</p> <p>A Controlled Substance Accountability Sheet, dated 04/11/16, indicated 12 syringes of Ativan were delivered to the facility from the Hospice Agency and placed in the refrigerator. The sheet indicated the resident had not received the Ativan.</p> <p>The Daily Narcotic Shift Check form (Nurses count narcotics together when going off and coming on shift), dated 07/2016, indicated 07/12/16, 07/13/16, and 07/14/17 signature areas were left blank, which indicated the narcotics had not been counted from oncoming and off going shifts.</p> <p>An Indiana State Department of Health reportable Incident, dated 07/13/16, indicated the Director of Nursing (DON) was notified that 12 vials of injectable Ativan were missing from the narcotic refrigerator and the Ativan was prescribed for Resident #E. The medications had been verified as being in the narcotic refrigerator at the beginning of LPN #1's shift on 07/12/16 at 7 p.m.</p>		<p>and employees notified of the deficiencies.</p> <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; All licensed nursing staff was reeducated on "The Preventing, Investigating, and Reporting of Alleged Sexual Assault and Abuse Violation, and the Medication Storage Policy to prevent there-occurrence of misappropriation of resident property. Reeducation also included that a Controlled substance will be verified by count at the beginning and end of each shift on a Daily Narcotic Shift Check Form</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; The Unit Managers or designee will audit the Daily Narcotic Shift Check Form - 3 X weekly for 4 weeks, then 2 X weekly for 4 weeks, then weekly for 6 months. All results will be reviewed in the monthly QAPI meetings for 6 months for recommendations</p> <p>All results will be reviewed by the DNS or designee to ensure compliance.</p>	

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	<p>A written statement and signed by LPN #2, dated 07/13/16, indicated LPN #2 was going off shift on 07/12/16 at 7 p.m. and had counted the narcotics on C-Hall with LPN #1. The investigation indicated LPN #1 verified there were 12 syringes of Ativan in the Medication Room Narcotic Refrigerator in a plastic zip lock bag.</p> <p>A written statement and signed by LPN #3, dated 07/13/16, indicated LPN #3 had witnessed LPN #1 and LPN #2 counting the narcotics on 07/12/16.</p> <p>A written statement and signed by LPN #1, dated 07/14/16, indicated she had not verified the medication in the refrigerator in the Medication Room and indicated this was the first time the Narcotic Refrigerator had not been checked.</p> <p>During an interview on 08/03/16 at 2:25 p.m., the DON indicated LPN #4 notified her on 07/13/16 when the Ativan could not be found when she counted with LPN #1 who was going off shift.</p> <p>During an interview on 08/03/16 at 2:25 p.m., the Administrator indicated the Local Police were notified of the incident and the facility was waiting for the Police Report.</p>		<p>- 5. By what date the systemic changes will be completed. The changes will be implemented and completed by 8/31/2016</p>	

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F 0431 SS=D Bldg. 00	<p>A facility policy, dated 02/12/2016, received from the DON as current, and titled, "Preventing, Investigating, and Reporting Alleged Sexual Assault and Abuse Violation", indicated, "...It is the responsibility of all employees to immediately report any reasonable suspicion of a crime...and misappropriation of resident property...It is the policy of this center to take appropriate steps to prevent the occurrence of...Misappropriation of resident property..."</p> <p>3.1-28(a)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p>			

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	<p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, record review, and interview, the facility failed to, ensure Ativan (antianxiety/scheduled II drug controlled medication) were accurately reconciled, related to missing bottles of Ativan syringes and failed to ensure Ativan and morphine syringes (narcotic pain medication) were stored securely for 1 resident in a sample of 6 . (Resident #E)</p> <p>Finding includes:</p> <p>Resident #E's record was reviewed on 08/03/16 at 11:15 a.m.. The resident's</p>	F 0431	<p>F431</p> <p><u>Plan of Correction</u></p> <p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The medication that was unlabeled had labels place immediately and temperature logs were noted as current on all of the refrigerators on all units and they were locked per guidelines. Monthly meetings with the assigned pharmacist will occur during the QAPI meetings to review reconciliation reports</p>	09/02/2016
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	<p>diagnoses included, but were not limited to, pulmonary heart disease, chronic obstructive pulmonary disease, and hypertension. The record indicated the resident was receiving Hospice services.</p> <p>A Physician's Order, dated 04/11/16, indicated Ativan 0.25 ml (milliliters) sublingually (under the tongue) every four hours as needed for restlessness and agitation.</p> <p>A Controlled Substance Accountability Sheet, dated 04/11/16, indicated 12 syringes of Ativan were delivered to the facility from the Hospice Agency and placed in the refrigerator. The sheet indicated the resident had not received the Ativan.</p> <p>An observation of the Medication Room on the C-Unit with LPN #5, indicated there were there were 15 syringes of morphine 5 mg (milligrams) per 0.25 ml (milliliters) and a bottle with 8 ml of Ativan stored in an unlocked refrigerator in the locked medication room, which belonged to Resident #E.</p> <p>An interview at the time of the observation, LPN #5 indicated the Nurses' count narcotics at the beginning and end of each shift, which includes the narcotics kept in the refrigerator. She</p>		<p>and pharmacy audits to ensure properlabeling.</p> <p>1.Howother residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken; All residents have the potential of beingaffected by the deficient practice. All medication reconciliations are to bereviewed with the assigned facility pharmacist.</p> <p>2.Whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur; All licensed nursing staff wasreeducated on policy "Phar500 – Storage of Medications"</p> <p>3.Howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place; The Unit Managers or designee will use the Medication Storage Audit sheet - 3 X weekly for 4 weeks, then 2 X weekly for 4 weeks, then weekly for 6 months. The DNS or designee will meetwith the assigned pharmacist and round monthly for compliance.</p> <p>The results will be reviewed bythe DNS or designee to ensure</p>	

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	<p>indicated the refrigerator with the lock had no narcotics stored inside so the lock was not on. She indicated the morphine and Ativan should have been in the locked refrigerator.</p> <p>During an interview on 08/03/16 at 2:15 p.m., LPN #3 indicated she had counted the Ativan and morphine upon starting the shift in the morning and the medications were not in the locked refrigerator and were stored in the unlocked refrigerator. She indicated the door to medication room is always kept locked and only the nurses' had access to the medications.</p> <p>A facility policy, dated 01/06/15, received from the DON as current, titled, "Storage of Medications", indicated, "...Controlled medications must be stored separately from non-controlled medications. The access system...used to lock Schedule II medications and other medications subject to abuse, cannot be the same access system used to obtain the nonscheduled medications..."</p> <p>A facility policy, dated 11/2010, received from the DON as current, titled, "Medication Storage", indicated, "...Schedule II controlled medications...were maintained within a separately locked permanently affixed</p>		<p>compliance.</p> <p>All results will be reviewed in the monthly QAPI meetings for 6 months for recommendations.</p> <p>-</p> <p>4. By what date the systemic changes will be completed. The changes will be implemented and completed by 9/2/2016.</p>				

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	<p>compartment. Sufficiently detailed records of receipt and disposition of controlled medications were maintained to enable an accurate reconciliation. All medication records were in order and an account of all controlled medications was maintained and periodically reconciled..."</p> <p>3.1-25(n)</p>			