

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155200	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/31/2016
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NAME OF PROVIDER OR SUPPLIER  UNIVERSITY NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1564 S UNIVERSITY BLVD UPLAND, IN 46989
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F 0000  Bldg. 00	<p>This visit was for the Investigation of Complaint IN00200569.</p> <p>Complaint IN00200569 - Substantiated. Federal/State deficiencies related to the allegations are cited at F224 and F226.</p> <p>Survey date: 5/31/16</p> <p>Facility number: 000107 Provider number: 155200 AIM number: 100290330</p> <p>Census bed type: SNF/NF: 69 Total: 69</p> <p>Census payor type: Medicare: 6 Medicaid: 46 Other: 17 Total: 69</p> <p>Sample: 3</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>QR completed by 11474 on June 1, 2016.</p>	F 0000	<p>Dear Ms Rhoades, Attached is University Nursing Center's Plan of Correction for the complaint survey completed on 5/31/16. Please accept the plan of correction as written. University Nursing Center is asking for paper compliance for the all the attached deficiencies: F224 and F226.</p> <p>Please also note that in the 2567, RN#3 is mentioned, there was no RN involved in this situation. The staff member should be noted to be a C.N.A. Thank you. Thank you, Stephanie Allen, MHA, HFA University Nursing Center</p>	
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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>483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROP RIATN</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 the mistreatment of residents did not occur in regards to theft of personal property for 1 of 3 residents reviewed for misappropriation. (Residents B, CNA #1)</p> <p>Findings Include:</p> <p>The clinical record of Resident B was reviewed on 5/31/16 at 9:30 a.m. Diagnoses included, but were not limited to, heart failure, hypertension, rheumatoid arthritis, chronic obstructive pulmonary disease and chronic pain. The Quarterly Minimum Data Set assessment (MDS), dated 3/8/16, indicated Resident B was cognitively intact.</p> <p>Review of Resident B's current physician orders from 5/1/-5/31/16, indicated a Fentanyl patch (a narcotic) 50 mcg was to be applied transdermally every 3 days for chronic pain.</p>	F 0224	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident B was informed of the missing medication and the medication was replaced at facility cost. LPN #2 was educated by the DNS to keep keys safeguarded and to immediately report allegations of misappropriation of funds and abuse to the Executive Director. CNA #1 and #2 were terminated.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: All residents who receive narcotics have the potential to be affected. All staff will be inserviced regarding immediately reporting any allegation of misappropriation of funds and abuse. All nurses to be inserviced regarding safeguarding of keys and codes for medication carts, along with proper shift to shift narcotic counting. All CNAs to be inserviced regarding staying out of medication carts and not</p>	06/30/2016			

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	<p>A current care plan, dated 9/2/14, indicated Resident B had a problem with pain related to arthritis, decreased mobility and hemiplegia. Interventions included, but were not limited to, "administer medication as ordered and document effectiveness."</p> <p>During review of the Indiana State Department of Health Incident Report Form, dated 5/17/16, LPN #2 was doing the narcotic count at the end of her shift with another nurse. LPN #2 realized the box of Fentanyl for Resident B had 4 patches at the start of her shift and now contained only 3 patches. LPN # 2 immediately attempted to contact the Director of Nursing (DON). She was unable to reach her initially, but the DON arrived a little later. A written statement from LPN #2, provided by the Administrator on 5/31/16 at 2:13 p.m., indicated LPN #2 had worked with RN #3 and CNA #1 the night prior. LPN #2 indicated she locked her medication keys in the medication cart.</p> <p>On 5/31/16 at 11:24 a.m., the Administrator indicated she brought RN #3 into her office for a statement on 5/17/16. RN #3 denied any knowledge of the incident. After watching the facility video with the Administrator, RN #3 indicated she thought CNA #1 was just</p>		<p>having any authority to be in medication carts as not part of their job description. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? All staff will be inserviced by the ED or designee regarding immediately reporting any allegation of misappropriation of funds and abuse to the Executive Director by 6/30/16. All nurses will be inserviced by the DNS or designee regarding safeguarding of keys and codes for medication carts and proper shift to shift narcotic counts by 6/30/16. All CNAs to be inserviced by the DNS or designee regarding staying out of medication carts, no authority to be in medication carts as not part of their job description by 6/30/16. How the corrective action will be monitored to ensure the deficient practice will not recur? All residents with a narcotic medication will have their narcotic sheets audited daily for one month, then weekly for 2 months, followed by monthly for 3 months by the Medical Records Coordinator or designee to ensure no missing narcotic mediations. DNS or designee to validate shift to shift narcotic counts randomly across all shifts weekly for one month, then monthly for five months to ensure compliance. SSD or designee to conduct resident interviews</p>		

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	<p>messing with the sharps container, but was actually stealing the medication. RN #3 failed to report the incident to the DON or Administrator. Both CNA #1 and RN #3 were suspended pending an investigation. The Administrator indicated both employees had since been terminated. She was unable to obtain a statement from CNA #1. The Administrator indicated the facility had replaced the medication at no cost to the resident.</p> <p>Review of the "General Orientation Acknowledgement Form", CNA #1 signed the content for resident neglect, abuse and misappropriation of property policy. The form was signed 6/10/15.</p> <p>Review of a current facility policy, dated February 2010 and revised July 2015, provided by the Administrator on 5/31/16 at 9:20 a.m., titled "Abuse Prohibition, Reporting, and Investigation" indicated the following:</p> <p>"It is the policy of American Senior Communities to protect residents from abuse including physical abuse, sexual abuse, verbal abuse, mental abuse, involuntary seclusion, and misappropriation of resident property and/or funds.</p>		<p>weekly for one month, then monthly for 5 months regarding misappropriation of funds and abuse. Executive Director or designee will monitor Medical Records Coordinator or designee, SSD or designee and DNS or designee's compliance weekly to ensure compliance. IDT will review the results of the auditing at the monthly CQI meeting to ensure compliance. If a 95% threshold is not met on any of the above indicators, an internal plan of correction will be formed to ensure compliance. By what date the systemic changes will be completed? 6/30/16</p>				

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F 0226 SS=D Bldg. 00	<p>...Misappropriation of Resident Funds or Property-the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings or money without the resident's consent. Note: Includes any medication dispensed in the name of the resident...."</p> <p>This Federal tag relates to Complaint IN00200569.</p> <p>3.1-28(a)</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 implement their policy related to the misappropriation of resident property for 1 of 3 residents review for misappropriation of property. (Residents B, CNA #1)</p> <p>Findings Include:</p> <p>The clinical record of Resident B was reviewed on 5/31/16 at 9:30 a.m.</p>	F 0226	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident B was informed of the missing medication and the medication was replaced at facility cost. LPN #2 was educated by the DNS to keep keys safeguarded and to immediately report allegations of misappropriation of funds and abuse to the Executive Director. CNA #1 and #2 were terminated. A pain assessment</p>	06/30/2016

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	<p>Diagnoses included, but were not limited to, heart failure, hypertension, rheumatoid arthritis, chronic obstructive pulmonary disease and chronic pain. The Quarterly Minimum Data Set (MDS) dated 3/8/16, indicated Resident B was cognitively intact.</p> <p>Review of Resident B's current physician orders, from 5/1/-5/31/16, for a Fentanyl patch (a narcotic) 50 mcg was to be applied transdermally every 3 days for chronic pain.</p> <p>A current care plan, dated 9/2/14, indicated Resident B had a problem with pain related to arthritis, decreased mobility and hemiplegia. Interventions included, but were not limited to, "administer medication as ordered and document effectiveness."</p> <p>During review of the Indiana State Department of Health Incident Report Form dated 5/17/16, LPN #2 was doing the narcotic count at the end of her night shift with another nurse. LPN #2 realized the box of Fentanyl for Resident B had 4 patches at the start of her shift and now contained only 3 patches. LPN # 2 immediately attempted to contact the Director of Nursing (DON). She was unable to reach her initially, but the DON arrived a little later. A written statement</p>		<p>was completed on resident B, and no concerns were noted as resident never went without medication. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: All residents who receive narcotics have the potential to be affected. All staff will be inserviced regarding immediately reporting any allegation of misappropriation of funds and abuse. All nurses to be inserviced regarding safeguarding of keys and codes for medication carts, along with proper shift to shift narcotic counting. All CNAs to be inserviced regarding staying out of medication carts and no authority to be in medication carts as not part of their job description. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? All staff will be inserviced by the ED or designee regarding immediately reporting any allegation of misappropriation of funds and abuse to the Executive Director by 6/30/16. All nurses will be inserviced by the DNS or designee regarding safeguarding of keys and codes for medication carts and proper shift to shift narcotic counts by 6/30/16. All CNAs to be inserviced by the DNS or designee regarding staying out of medication carts and no authority to be in</p>		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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