STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155687	A. BUILDING 00 B. WING	03/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MUNCIE	2701 LYN-MAR DR MUNCIE, IN 47304

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F 0000 Bldg. 00		F 0000		

This visit was for the Investigation of Complaints IN00221800 and IN00225045.

Complaint IN00221800 - Substantiated. Federal/State deficiencies related to the allegations are cited at F224, F226 and F332.

Complaint IN00225045 - Substantiated. No deficiencies related to the allegations are cited.

Survey dates: March 21, 22 and 23, 2017

Facility number: 000097
Provider number: 155687
AIM number: 100290970

Census bed type:
SNF/NF: 102
Total: 102

Census payor type:
Medicare: 4
Medicaid: 92
Other: 6
Total: 102

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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	These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed on March 28, 2017.			
F 0224 SS=D Bldg. 00	483.12(a)(1) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN a) The facility must- (1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on interveiw and record review, the facility failed to ensure a residents prescribed medication was not used for other residents for 1 of 6 residents reviewed. (Resident B) Findings include: During a review on 3/22/2017 at 8:30 a.m., of recent facility self reported incidents, an investigative report involving missing medication for Resident B was reviewed. The investigative report indicated that on 2/6/2017 LPN #13 was instructed by LPN #11 and LPN #12 to administer Melatonin (hypnotic) and Benadryl (antihistamine), belonging to Resident B, to residents who required assistance with sleeping on the night shift. The facility	F 0224	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Immediately removed the Melatonin from the medication cart and placed in the locked narcotic drawer, count sheet started and must be signed by two nurses. Medical Director was notified and physical assessments were completed. Laboratory tests were ordered and completed. Melatonin was purchased by facility and resident supply was replaced. How other resident's having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All residents who take Melatonin and/or Benadryl were reviewed	03/24/2017

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	investigated the allegation and noted Resident B's Melatonin was brought in to the facility by the family. The medication was kept on the hall two medication cart. The Melatonin was counted and 57 pills were present. After comparing the number of pills in the bottle with the Medication Administration Record, it was noted there should have been 69 pills in the bottle. The nursing staff also identified two residents who may have been given the Melatonin without a physician's order, Resident C and Resident D. The physician was informed and arrived at the facility to assess both residents. No harm was noted. Laboratory test did not indicate medication overdose or adverse affects. The facility replaced the missing doses of Melatonin. During an interview on 3/22/2017 at 3:56 p.m., the Administrator indicated LPN #11 had been terminated prior to the reporting of this incident for unrelated reasons and LPN #12 was immediately suspended pending investigation. The Administrator indicated LPN #13 did not give the medication to residents who did not have a physician's order. During the survey LPN #12 and LPN #13 were unable to be contacted for interview.		and medications were counted, resulting in no missing medication. All licensed nursing staff were educated related to proper medication administration. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Melatonin audit will be completed five times weekly for two months, then three times weekly for two months and then weekly for two months. Medication pass will be completed once weekly on each shift for two months, twice monthly on each shift for two months and then monthly on each shift for two months. Medication cart audits will be completed weekly for two months, two times a month for two months and then monthly for two months. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Audit results will be forward to QAPI each month for six months to track for trends. If any trends are identified in QAPI then audits will be conducted per QAPI recommendations. If no trends are identified then will be reviewed quarterly through audit reports which are forwarded to the QAPI committee for review and recommendation.	

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	During an interview on 3/23/2017 at 12:00 p.m., the Medical Director indicated facility notified him immediately and he assessed both residents identified as possibly receiving the unprescribed medication and found no adverse effects or harm to the residents. During an interview on 3/23/2017 at 10:26 a.m., the Assistant Director or Nursing indicated it was not appropriate practice to give any resident medication belonging to another resident nor is it appropriate to give an unprescribed medication to any resident. Review of a current policy, dated 6/2015, titled "Medication Administration-Preparation and General Guidelines" indicated the following: "... B. Administration ... 2) Medications are administered in accordance with written orders of the perscriber. ... 15) Medications supplied for one resident are never administered to another resident. ...". This federal tag relates to Complaint IN00221800. 3.1-28(a)			

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F 0226 SS=D Bldg. 00	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. Based on record review and interview, the facility failed to ensure an allegation of misappropriation of a residents prescribed medication was reported to administration promptly resulting in a	F 0226	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Medical Director was notified and completed assessments on	03/24/2017

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	delay in the investigation process for 1 of 5 residents reviewed for abuse. (LPN 11, LPN 12, LPN 13 and Resident B) Findings include: During a review on 3/22/2017 at 8:30 a.m., of recent facility self reported incidents, an investigative report involving missing medication for Resident B was reviewed. The investigative report indicated that on 2/6/2017 LPN #13 was instructed by LPN #11 and LPN #12 to administer Melatonin and Benadryl, belonging to Resident B, to residents who required assistance with sleeping on the night shift. The facility investigated the allegation and noted Resident B's Melatonin was brought into the facility by the family. The medication was kept on the hall 2 medication cart. The Melatonin was counted and 57 pills were present. After comparing the number of pills in the bottle with the Medication Administration Record, it was noted there should have been 69 pills in the bottle. The nursing staff also identified two residents who may have been given the Melatonin without a physician's order, Resident C and Resident D. The physician was informed and arrived at the facility to assess both residents. No harm was noted. Laboratory test did not		residents. Laboratory tests were ordered and performed and did not indicate overdose or adverse effects. Melatonin was purchased and replaced for resident. Abuse in service for all staff was started. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents had the potential to be affected. All residents on Melatonin and/or Benadryl were reviewed and medications were counted with none found to be missing. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? An all staff in service on proper reporting of abuse. All licensed nursing staff were in serviced on proper medication administration. Abuse audit will be completed by randomly asking staff questions related to abuse and abuse reporting. This will be completed three times weekly for two months, twice weekly for two months and then once weekly for two months. How will the corrective actions be monitored to ensure the deficient practice will not recur? Audit results will be forward to QAPI each month for six months	

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	indicate medication overdose or adverse affects. The facility replaced the missing doses of Melatonin. Review of the facility investigation report indicated on 2/6/2017 RN #10 reported an allegation of suspected misappropriation of resident property. The incident occurred during LPN #13's orientation. LPN #13 was hired on 11/21/2016. During an interview on 3/22/2017 at 11:50 a.m., RN #10 indicated she was on her way to work and received a telephone call from another employee who voiced concern related to a rumor in regard to using a residents prescribed melatonin and benedryl on other residents who were having trouble sleeping. "I heard it from [staff member] who was afraid and she came to me and I reported it right away." RN #10 refused to identify the staff member. During an interview on 3/22/2017 at 3:56 p.m., The Administrator indicated LPN #11 was terminated prior to the reporting of the incident and LPN #12 had been immediately suspended pending investigation. The Administrator indicated LPN #13 did not report this incident right away because she didn't know if the other two LPN's were joking.		to track for trends. If any trends are identified in QAPI then audits will be conducted per QAPI recommendations. If no trends are identified then will be reviewed quarterly through audit reports which are forwarded to the QAPI committee for review and recommendation.	

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	She indicated LPN #13 knew about the allegation for a few days prior to notification however did not know the exact time frame. Neither LPN #12 or LPN #13 could be reached for interview during this survey. Review of a current policy dated 1/13/2016, titled Prevention Investigation, and Reporting Alleged Sexual Assault and Abuse Violation indicated the following: "Policy Statement: It is the responsibility of all employees to immediately report any reasonable suspicion of a crime, alleged violation of abuse, neglect injuries of unknown source and misappropriation of resident property. It is the policy of this center to take appropriate steps to prevent the occurrence of: Abuse Neglect Misappropriation of resident Property It is also the policy of this center to take appropriate steps to ensure that all alleged violation of federal or stat laws which involve mistreatment, neglect, abuse injuries of unknown source and misappropriation of resident property ("alleged violation") are reporting immediately to the Executive Director or			

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	Director of Nursing of the Living Center.... ...Reporting: ... ...If the reportable event does not result in a serious bodily injury, the staff member shall report the suspicion not later than 24 hours after forming the suspicion. Failure to report in the required time frames may result in disciplinary action, including up to termination. Staff must report the suspicion of an incident to the Executive director, Director of Nursing, or supervisor." This federal tag relates to Complaint IN00221800. 3.1-28(a)			
F 0281 SS=D Bldg. 00	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. Based on record review and interview, the facility failed to ensure staff provided care in accordance with professional standards related to instructing a nurse to medicate residents with another resident's	F 0281	What corrective actions will be accomplished for those resident found to have been affected by the deficient practice? Melatonin was pulled from the medication cart and placed in the	03/24/2017

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	medication to put them to sleep. This deficient practice had the potential to affect 51 of 102 residents living in the facility. (LPN 11, LPN 12, LPN 13) Findings include: During a review on 3/22/2017 at 8:30 a.m., of recent facility self reported incidents, an investigative report involving missing medication for Resident B was reviewed. The investigative report indicated that on 2/6/2017 LPN #13 was instructed by LPN #11 and LPN #12 to administer Melatonin (hypnotic) and Benadryl (antihistamine), belonging to Resident B, to residents who required assistance with sleeping on the night shift. The facility investigated the allegation and noted Resident B's Melatonin was brought in to the facility by the family. The medication was kept on the hall two medication cart. The Melatonin was counted and 57 pills were present. After comparing the number of pills in the bottle with the Medication Administration Record, it was noted there should have been 69 pills in the bottle. The nursing staff also identified two residents who may have been given the Melatonin without a physician's order, Resident C and Resident D. The physician was informed and arrived at the		locked narcotic drawer. All licensed nursing staff in serviced related to medication administration. Medical Director notified and physical assessments were completed. Melatonin was purchased by facility and replaced for resident. LPN #13 had previously been terminated. LPN #12 was immediately suspended and eventually terminated. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken? All residents had the potential to be affected. All licensed nursing staff were in serviced on proper medication administration. All staff in serviced related to abuse policy. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Melatonin audit will be done five times weekly for two months, then three times weekly for two months and then weekly for two months. Medication pass audit will be done once weekly on each shift for two months, twice monthly on each shift for two months and then monthly on each shift for two months. How will the corrective actions be	

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	facility to assess both residents. No harm was noted. Laboratory test did not indicate medication overdose or adverse affects. The facility replaced the missing doses of Melatonin. Review of the facility investigation report indicated on 2/6/2017 RN 10 reported an allegation of suspected misappropriation of resident property. The incident occurred during LPN 13's orientation. LPN 13 was hired on 11/21/2016. During an interview on 3/22/2017 at 11:50 a.m., RN 10 indicated she was on her way to work and received a telephone call from another employee who voiced concern related to a rumor in regard to using a residents prescribed melatonin and benedryl on other residents who were having trouble sleeping. "I heard it from [staff member] who was afraid and she came to me and I reported it right away." RN 10 refused to identify the staff member. During an interview on 3/22/2017 at 3:56 p.m., The Administrator indicated LPN 11 was terminated prior to the reporting of the incident and LPN 12 had been immediately suspended pending investigation. The Administrator indicated LPN 13 did not report this incident right away because she didn't		monitored to ensure the deficient practice will no recur, i.e., what quality assurance program will be put into place? Audit results will be forward to QAPI each month for six months to track for trends. If any trends are identified in QAPI then audits will be conducted per QAPI recommendations. If no trends are identified then will be reviewed quarterly through audit reports which are forwarded to the QAPI committee for review and recommendation.	

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	know if the other two LPN's were joking. She indicated LPN 13 knew about the allegation for a few days prior to notification however did not know the exact time frame. During an interview on 3/23/2017 at 10:26 a.m., the Assistant Director or Nursing indicated it was not appropriate practice to give any resident medication belonging to another resident nor is it appropriate to give an unprescribed medication to any resident. Review of a current policy, dated 6/2015, titled "Medication Administration-Preparation and General Guidelines" indicated the following: "... B. Administration ... 2) Medications are administered in accordance with written orders of the perscriber. ... 15) Medications supplied for one resident are never administered to another resident. ...". Review of the current "Standards for the Competent Practice of Registered and Licensed Practical Nursing" indicated the following: "... Unprofessional Conduct ... (11) Diverting prescription drugs for own or another's use. (12) Misappropriating money or property			

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	from a patient/client or employee. ..." This Federal tag relates to complaint IN00221800. 3.1-35(g)(1)			
F 0332 SS=D Bldg. 00	483.45(f)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE (f) Medication Errors. The facility must ensure that its- (1) Medication error rates are not 5 percent or greater; Based on observation, record review and interview the facility failed to ensure medications were administered timely and appropriately resulting in a medication error rate of 26%. This deficient practice affected 2 of 4 residents reviewed for medication administration. (Resident F and Resident G) Findings include: 1. The clinical record of Resident F was reviewed on 3/22/2017 at 10:22 a.m. . Diagnoses included, but were not limited to, end stage renal disease, bradycardia, peripheral vascular disease, bilateral below the knee amputations and acute bilateral glaucoma. During a medication administration	F 0332	What corrective actions will be accomplished for those residents found to have been affected by the deficient practices? Medication error reports were completed for the medications given out of time frame. Medication error reports were completed for the eye drops given improperly. LPN #1 was in serviced related to proper medication administration. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents who had medications ordered in the time frame had the potential to be affected. All licensed nursing staff in serviced related to proper medication administration. All licensed nursing staff in	03/24/2017

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	observation with LPN 1 on 3/21/2017 at 7:00 p.m., the following concerns were noted: At 7:21 p.m., heparin (anticoagulant) 5,000 units/1 mL (milliliter) subcutaneous injection. Review of the physician order indicated the medication was scheduled to be given at 4:00 p.m. Diagnosis: renal disease. At 7:22 p.m., Brimonidine Solution (antiglaucoma medication) 0.2%, 1 drop to each eye. Review of the physician order indicated the medication was scheduled to be given at 4:00 p.m. Diagnosis: acute bilateral glaucoma. At 7:23 p.m., Timolol Mal Solution (antiglaucoma medication) 0.5%, 1 drop to each eye. Review of the physician order indicated the medication was scheduled to be given at 4:00 p.m. Diagnosis: acute bilateral glaucoma. At 7:25 p.m., Percocet (analgesic) 10-325 mg 1 tablet. Review of the physician order indicated this medication was scheduled to be given at 5:00 p.m. Diagnosis: pain. At 7:28 p.m., Latanoprost Solution (antiglaucomas) .005%, 1 drop to each eye. Review of the physician order		serviced related to proper administration of eye drops. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? Medication pass will be audited once weekly on each shift for two months, twice monthly on each shift for two months and then monthly on each shift for two months. How will the corrective actions be monitored to ensure the deficient practice will not recur? Audit results will be forward to QAPI each month for six months to track for trends. If any trends are identified in QAPI then audits will be conducted per QAPI recommendations. If no trends are identified then will be reviewed quarterly through audit reports which are forwarded to the QAPI committee for review and recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155687	A. BUILDING 00 B. WING	03/23/2017

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	indicated the medication was scheduled to be given at 8:00 p.m. Diagnosis: acute bilateral glaucoma. During an interview on 3/22/2017 at 9:30 a.m., the DON (Director of Nursing) indicated LPN 1 had not administered the eye drop medications appropriately. A policy for administration of eye drops was requested at this time. The DON also indicated all medications must be administered no more than one hour prior or one hour after to the ordered administration time. The DON also indicated late administrations should be documented on the MAR (Medication Administration Record). Review of a current policy dated 6/2015, titled "Specific Medication Administration Procedures Eye Drop Administration" indicted the following: "...Purpose To administer ophthalmic solution/suspension into the eye in a safe, accurate, and effective manner. ... Procedures ... J. If another drop of the same or different medication is prescribed for administration in the same eye at the same time, wait 10 minutes, then repeat procedure above. ..." 2. The clinical record of Resident G was			

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	reviewed on 3/22/2017 at 10:38 a.m. . Diagnoses included, but were not limited to, dementia, major depressive disorder and hypertension. During a medication administration observation with LPN 1 on 3/21/2017 at 7:00 p.m., the following concerns were noted: At 6:40 p.m., Calcium-Vitamin D (supplement) 600-400 tablet. Review of the physician order indicated the medication was scheduled to be given at 4:00 p.m. Diagnosis: vitamin deficiency. At 6:48 p.m., Tylenol (analgesic) 650 mg. Review of the physician order indicated the medication was scheduled to be given at 4:00 p.m. Diagnosis: discomfort. Review of a current policy dated 6/2015, titled Medication Administration-Preparation and General Guidelines" indicated the following: "Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications dose only after they have been properly oriented to the facility's			

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	medication distribution system (procurement, storage, handling and administration). The facility has sufficient staff and a medication distribution system to ensure safe administration of medications without unnecessary interruptions. Procedures... ...12. Medications are administered within [60 minutes] of scheduled time, except before , with or after meals orders, which are administered [based on mealtimes]. Unless otherwise specified by the perscriber, routine medications area administered according to the established medication administration schedule for the facility.... ...D. Documentation (including electronic)... ...7) If an electronic MAR system is used, specific procedures required for resident identification, identifying medications due at specific times, and documentation of administration refusal, holding of doses, and dosing parameters such as vital signs and lab values are described in system's user manual. These procedures should be followed, and may differ slightly from the procedures for using paper MARs. Electronic systems			

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	also describe procedures for secure access, maintaining privacy of resident information, and for the electronic signatures. Maintenance and support procedures for these systems are described in the system use manuals. Procedures will vary between the various electronic systems available...." This federal tag relates to Complaint IN00221800. 3.1-25(b)(9) 3.1-48(c)(1)			