STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155614	A. BUILDING 00 B. WING	06/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN HILLS OF NEW ALBANY	326 COUNTRY CLUB DRIVE NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00228029. Complaint IN00228029 - Unsubstantiated due to lack of evidence. Unrelated deficiency is cited. Survey dates: May 30, 31 and June 1, 2017 Facility number: 000321 Provider number: 155614 AIM number: 100286130 Census Bed Type: SNF/NF: 119 SNF: 7 Total: 126 Census Payor Type: Medicare: 4 Medicaid: 89 Other: 33 Total: 126 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on June 6, 2017.	F 0000	Preparation and execution of this response and plan of correction does not constitute an 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. For purpose of any allegation that the facility is not in substantial compliance with federal requirements of participation, the response and plan of correction constitutes Lincoln Hills Health Center's allegation of compliance in accordance with Section 7305 in the State Operations Manual.	
F 0224 SS=E	483.12(a)(1) PROHIBIT			

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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Bldg. 00	MISTREATMENT/NEGLECT/MISAPPROPRIATN a) The facility must- (1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on interview and record review, the facility failed to ensure residents were free from the misappropriation of controlled medications for 5 of 5 residents reviewed for medication administration. (Resident F, G, H, J and K) Findings include: The clinical record for Resident F was reviewed on 5/31/17 at 10:48 a.m. Diagnosis included, but was not limited to, chronic back pain. The physician order, dated 3/21/17, indicated the resident was to have Tramadol (non-narcotic pain medication), 100 milligrams (two 50 milligram tablets) twice a day at 8:00 a.m. and 8:00 p.m. The controlled drug use record indicated on 5/17/17 two 50 mg (milligram) tablets were signed out at 8:00 p.m. by LPN (Licensed Practical Nurse) 11. There was a line across the documentation with the word "error" next to it. The clinical record for Resident G was reviewed on 6/1/17 at 9:38 a.m. Diagnosis included, but was not limited to, Polyosteoarthritis. The physician order, dated 10/17/16, indicated the resident was to have Tramadol (non-narcotic pain medication), 100 milligrams (two 50 milligram tablets) twice a day at 8:00 a.m. and 8:00 p.m. The controlled drug use record indicated on 5/17/17 two 50 mg (milligram) tablets were	F 0224	The facility will continue to prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property. For Residents F, G, H, J, and K narcotic count sheets were verified and corrected. Physician notified. No ill effects noted to any of the residents listed above. Pharmacy notified of the misappropriation of controlled medications for 5 of 5 residents reviewed for medication administration. All residents have the potential to be affected by this alleged deficient practice. Administrator and DON educated LPN 11 on 5/17/17 regarding proper medication administration and medication destruction procedures. All licensed staff and QMA's were reeducated regarding the policies and procedures: PREPARATION AND GENERAL GUIDELINES FOR	06/23/2017

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	signed out at 8:00 p.m. by LPN 11. The clinical record for Resident H was reviewed on 6/1/17 at 10:14 a.m. Diagnoses included, but were not limited to, polyosteoarthritis and right hand contracture. The physician order, dated 4/27/16, indicated to give Tramadol, 100 milligrams, 4 times a day. The controlled drug use record indicated on 5/17/17 two 50 mg (milligram) tablets were signed out at 6:00 p.m. by LPN 11. There was a line across the documentation with the word "error" next to it. The clinical record for Resident J was reviewed on 6/1/17 at 10:35 a.m. Diagnosis included, but was not limited to, low back pain. The physician order, dated 3/29/17, indicated the resident was to have Hydrocodone (pain medication) 10/325 milligrams, twice a day at 8:00 a.m. and 6:00 p.m. The controlled drug use record indicated on 5/17/17 one Hydrocodone 10/325 milligram tablet was signed out at 6:00 p.m. by LPN 11. The clinical record for Resident K was reviewed on 6/1/17 at 10:55 a.m. Diagnosis included, but was not limited to, chronic pain syndrome. The physician order, dated 4/21/17, indicated the resident was to have Hydrocodone 7.5/325 milligrams, twice a day at 8:00 a.m. and 8:00 p.m. The controlled drug use record indicated on 5/17/17 one Hydrocodone 7.5/325 milligram tablet was signed out at 8:00 p.m. by LPN 11.		ADMINISTERING MEDICATIONS, DISPOSAL OF MEDICATIONS AND MEDICATION RELATED SUPPLIES, and ABUSE POLICY & PROCEDURE. Medication cart audits, review of medication administration records, and review of narcotic count records will be conducted by nursing managers on all units. These audits will be conducted weekly times four weeks and then monthly. During these audits nursing managers will observe for any practices which violate facility policy and procedure. If errors are found they will be addressed immediately by nursing management. The results of these rounds will be reported to the DON and Administrator. The DON and Administrator will ensure that additional training and or counseling is provided as necessary. A summary of the audits above will be reported to the QAA committee. The QAA committee will review results and audits will be ongoing until it is found that we are in compliance. DON and Administrator to monitor.	

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	During an interview on 5/30/17 at 5:48 p.m., RN 5 indicated on 5/17/17, between 7:00 a.m. and 8:00 a.m., LPN 11 was observed to be nodding off, and again, around 11:15 a.m. and she reported it to the DON (Director of Nursing). During an interview on 5/31/17 at 9:30 a.m., Pharmacist 6 indicated on 5/17/17 he observed LPN 11 sitting at the nurses station with a chart on her lap and she looked like she was sleeping. He reported to the DON who indicated she was taking care of it. "The next day I was told LPN 11 was not on the floor and I did a count sheet audit. There were doses destroyed and an increase in as needed medications given by LPN 11, which was a red flag." During an interview on 5/31/17 at 11:00 a.m., the Dietary Manager (DM) indicated, around 11:30 a.m. on 5/17/17, LPN 11's eyes did not look right and she could barely lift a drink. The DM had informed the DON immediately that something was wrong with the LPN. During an interview on 5/31/17 at 11:25 a.m., RN 8 indicated she observed LPN 11 at the desk with sunken, red eyes and nodding of and immediately reported it to the DON. During an interview on 5/31/17 at 10:40 a.m. with the Administrator and DON, the DON indicated she was notified by the Dietary Manager that something was wrong with LPN 11. "I spoke with RN 8, who indicated LPN 11 seemed under the influence, and at 11:45 a.m. on 5/17/17, she was pulled from the floor and asked to come to the front office." She was then sent to occupational health for a drug screen. A narcotic count of the F hall medication cart was conducted after LPN 11 left for her drug screen, and discrepancies were found. Resident F's narcotic count sheet indicated			

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	2 Tramadol 50 mg (milligram) were signed out by LPN 11 for 8:00 p.m. on 5/17/17 and unaccounted for. Resident G's narcotic count sheet indicated 2 Tramadol 50 mg were signed out by LPN 11 for 8:00 p.m. and unaccounted for. Resident H's narcotic count sheet indicated 2 Tramadol 50 mg were signed out by LPN 11 for 6:00 p.m. on 5/17/17 and unaccounted for. Resident J's narcotic count sheet indicated one Hydrocodone 10/325 mg was signed out by LPN 11 for 6:00 p.m. on 5/17/17 and unaccounted for. Resident K's narcotic count sheet indicated one Hydrocodone 7.5/325 mg was signed out by LPN 11 for 8:00 p.m. on 5/17/17 and unaccounted for. When LPN 11 returned from occupational health and was questioned about the discrepancies, she indicated she had pre-pulled the medications, and when she was called to the office, she destroyed those medications without a witness. The Administrator and DON told LPN 11 it was not facility policy to pre-pull medications or to destroy narcotics without a witness. The drug screen, dated 5/17/17 and verified on 5/23/17 at 11:09 p.m., indicated LPN 11 tested positive for Opiates, Hydrocodone, Benzodiazepines, Alprazolam, and Lorazepam. The employee orientation checklist for LPN 11, dated 6/3/16, indicated she was educated on abuse. The individual inservice record, dated 2/12/17 and signed by LPN 11, indicated she was educated on proper narcotic destruction and that 2 nurses must witness all parts of destruction. On 5/31/17 at 11:08 a.m., RN 4 provided a copy of the document titled "Preparation and General Guidelines", dated 01/17. It included, but was not limited to, the following:			

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	"...Administration...medications are administered at the time they are prepared..." On 5/31/17 at 11:08 a.m., RN 4 provided a copy of the document titled "Disposal of Medications and Medication-Related Supplies", dated 01/17. It included, but was not limited to, the following: "Policy...Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal, and recordkeeping in the facility in accordance with federal and state laws and regulations...Procedures...B. When a dose of a controlled medication is removed from the container for administration but refused by the resident or not given for any reason...It is destroyed in the presence of two licensed facility personnel...and the disposal is documented on the accountability record/book on the line representing that dose..." 3.1-28(a)			