STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	155070		05/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN VALLEY CARE CENTER	3118 GREEN VALLEY RD NEW ALBANY, IN 47150

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00198398. Complaint IN00198398 - Substantiated. Federal/State deficiencies related to the allegation are cited at F-224. Survey date: May 11, 2016. Facility number: 000028 Provider number: 155070 AIM number: 100275370 Census bed type: SNF/NF: 110 Total: 110 Census payor type: Medicare: 14 Medicaid: 87 Other: 09 Total: 110 Sample: 3 This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed by 34233 on May 16, 2015.	F 0000	Allegation of CompliancePlease accept the following plan of correction for the abbreviated survey on May 11, 2016.Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provision of the Federal and State Laws. This facility appreciated the time and dedication of the Survey Team; the facility will accept the survey as a tool for our facility to use in continuing to better the quality of care provided to the residents in our community.We respectfully request consideration for a desk review and paper compliance.	

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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F 0224 SS=D Bldg. 00	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN 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 record review and interview, the facility failed to ensure effective monitoring and interventions to prevent the theft of pain medication for 1 of 3 residents reviewed for pain medication storage (Resident # B). Findings include: On 05/11/16 at 9:10 a.m., review of the MDS (Minimum Data Set)14 day scheduled assessment, dated 04/25/16, indicated a BIMS (Brief Interview of Mental Status) score of 06 indicating sever cognitive imparment. The Active Diagnosis indicated dementia and psychotic disorder. The review of the Admission Diagnosis, on 05/11/16 at 9:16 a.m., indicated but were not limited to, dementia, anxiety and chronic pain. On 05/11/16 at 9:25 a.m., the Administrator provided a reportable	F 0224	1.Upon review of the self-reported event that occurred on 4/18/16, no harm was incurred by resident B related to the alleged deficient practice. On 4/14/16, MD placed Fentanyl on hold with instructions to give PRN meds as needed and monitor pain management, pain was controlled without the Fentanyl patch and MD wrote order on 4/18/16 to discontinue. 2.Residents that have orders for narcotic medication have the ability to be affected by the alleged deficient practice. An audit of resident's narcotics was completed on 4/18/2016 and 5/16/2016 by Nursing Administration to ensure that all medications were accounted for and the integrity of packaging was inspected for tampering. 3.On 4/20/2016 and 5/20/2016, Licensed Nursing Staff were inserviced by the Staff Development Coordinator and/or designee on the narcotic count procedure to include inspection of narcotic cards, bottles, and patches for tampering.	05/23/2016

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	event for Resident B which occurred on 04/18/16. Details of the incident included, but were not limited to, " two nurses on the 400 hall reported that when they were in the process of destroying four fentanyl patches, two patches had been tampered with and scotch tape had been applied to the edge of the packets" On 04/22/16 the follow up was conducted by staff interviewing the nurses who had access to the medication carts during the time frame of the discovery of the fentanyl package tampering, with no findings. No discrepancies in the narcotic counts were discovered. The facility created new narcotic count sheets which indicated an inspection of medications for tampering. On 04/27/16 a follow up note was added to indicate the facility had previously terminated the nurse who had been suspected for diversion of the fentanyl patches, was found to be positive for fentanyl. On 05/11/16 at 10:00 a.m., the DON (Director of Nursing) provided a copy of the "INCIDENT FOLLOW-UP & RECOMMENDATION FORM", dated 04/18/16, which indicated a check mark for "No abuse, neglect, misappropriation." A Summary of Investigative Facts indicated "During my		4.The Director of Nursing and/or designee will audit narcotic count procedure at least two (2) times a week for four (4) weeks and continue weekly for no less than two (2) additional months to ensure that narcotic medications are accounted for and licensed nurses are inspecting the integrity of the packaging of medications as indicated. The results of these audits will be presented to the monthly Quality Assurance/Performance Improvement Committee. The facility will achieve 95% compliance threshold prior to adjusting the frequency of audits. Plan to be updated as indicated.	

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	destruction of Duragesic patches 12 mcg [micrograms] 2/4 packets had been tampered with and were gone." On 05/11/16 at 10:00 a.m., the DON provided a copy of the "WITNESS INTERVIEW FORM", which indicated eight nurses to be interviewed. All eight nurses indicated either the patches were intact, did not remove the patches to count or did not work the cart, during the count at shift change, for the time of their work schedule. This included RN # 1, who indicated, by telephone, she had worked on 04/13/16, 04/16/16, and 04/17/16. She also indicated she had "Flipped thru them when counting, did not see anything tampered with or would have reported it." During the review of the witness statement, provided by the DON on 05/11/16 at 10:00 a.m., LPN # 1 indicated on 04/18/16, "While destroying Fentanyl patches that were Dc'd [discontinued] with .... [LPN # 2], noted that 2 packets did not contain the patches. Both packets had been taped together with clear tape. Two patches were intact in there [sp] sleeves. During AM count noted that all 4 patches were there but, did not examine them closely." The review of the timeline of events by			

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	LPN # 2, provided by the DON on 05/11/16 at 10:05 a.m., indicated on "Wed. 4-13-16 12 mcg fentanyl placed by ....[RN # 1] on resident ....[#B]-mid back covered with Tegaderm, I saw it in place this day. Thurs. 4-14-16 830 am I came in and went to check fentanyl placement unable to find, had 2nd nurse, ...[LPN # 3] verify, we searched trash, linens, under bed, etc could not locate patch. Called Dr.... to ask if we could replace patch, he stated to hold until next day due & give PRNs [as needed] & document pain mgmt [management]. (order written). Fri 4-15-16 I spoke with Dr.... and reported res. pain appeared controlled without patch he said hold patch 4-16 & call 4-18 with updates in pain mgmt. order written. Mon 4-18-16 Updated Dr.... on .... [Resident # B] pain - was controlled with PRNs. New order noted to d/c [discontinue] fentanyl patch at this time. Left message with spouse. I obtained an order to discontinue fentanyl patches on resident....[Resident # B] I wrote the order and asked a 2nd nurse to dispose of remaining patches. We took the 4 packets and medication sheet to med room, I opened first one cut patch up (wearing gloves) and placed into destroyer bottle, 2nd nurse opened 2nd packet and cut up patch and placed into destroyer bottle. I opened 3rd patch and there was NO patch in packet, upon inspection noted packet			

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	had been cut & scotch taped at one end, showed 2nd nurse to verify no patch, 2nd nurse opened 4th packet & there was film but no patch on film, upon inspection it had also been cut and scotch taped back. We (myself & 2nd nurse) told unit coordinator and reported it to SDC [Staff Development Coordinator] & ED [Executive Director], we took all packets, count sheet and destroyer bottle to SDC & ED & reported our findings." The review of the staff schedule for 04/13/16 to 04/18/16, provided by the DON on 05/11/16 at 10:05 a.m., indicated RN # 1 had worked the 6 a.m. to 6 p.m. shift on 04/17/16. On 05/11/16 at 10:05 a.m., the DON provided a copy of the Physician Orders for April 2016, which indicated on 04/12/16 an order for "fentanyl 12 mcg/hr [hour] transdermal patch Topical every 72 hours History of removing patch, Place out of reach on back and cover with Tegaderm." There was also an order to "Monitor for fentanyl Patch placement Every shift." On 05/11/16 at 10:05 a.m., the DON provided a copy of the e-mail sent to the facility by a Case Manager, with the results of the drug test for RN # 1, indicating the RN tested positive for			

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	fentanyl. During an interview, on 05/11/16 at 9:20 a.m., the DON indicated when the nurses noticed the discontinued patches had been opened an investigation was started. She also indicated RN # 1 was in her probationary period and was observed to have unusual behaviors. When RN #1 was drug tested, the results were positive for fentanyl and she was terminated. The review of the facility policy on 05/11/16 at 12:46 p.m., provided by the DON, indicated, but was not limited to the following: Medication Destruction Policy Discontinued medications and medications left in the facility after resident's discharge, if not qualifying for return to the pharmacy for credit, are destroyed. 3.1-27(a)(3)			