

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/24/2024	
NAME OF PROVIDER OR SUPPLIER GREEN OAKS OF GOSHEN		STREET ADDRESS, CITY, STATE, ZIP CODE 282 JOHNSTON STREET, GOSHEN, , 46528					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...			(X5) COMPLETION DATE	
R 0000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00444424, IN00444209, IN00443629, IN00438825 and IN00438536. Complaint IN00444424 - No deficiencies related to the allegations are cited. Complaint IN00444209 - State deficiency related to the allegations is cited at R0064. Complaint IN00443629 - No deficiencies related to the allegations are cited. Complaint IN00438825 - No deficiencies related to the allegations are cited. Complaint IN00438536 - No deficiencies related to the allegations are cited. Unrelated deficiency is cited. Survey dates: October 22, 23 & 24, 2024	R 0000	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.				

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	Facility number: 015205 Residential Census: 110 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality Review completed on 10/30/2024			
R 0064	Residents' Rights- Noncompliance 410 IAC 16.2-5-1.2(hh) (hh) The facility shall exercise reasonable care for the protection of residents ' property from loss and theft. The administrator or his or her designee is responsible for investigating reports of lost or stolen resident property and that the results of the investigation are reported to the resident. Based on interview and record review, the facility failed to protect a resident's narcotic medication from loss or theft for 1 of 6 residents reviewed for medication administration. (Resident B) Finding includes: On 10/23/24 at 1:22 P.M., a review of the clinical record for Resident B was conducted. The record indicated the resident had been transferred to a local hospital, on 10/22/24 and was not available for an interview.	R 0064	The community was alleged to be out of compliance by failing to protect a resident's narcotic medication from loss or theft for 1 of 6 residents reviewed for medication administration. A. The director of nursing was educated by the executive director regarding a policy titled " Medication Management, Administration, & Storage." B. All nursing staff educated by the Executive Director or designee regarding the policy titled " Medication Management, Administration, & Storage,". C. Nursing staff was educated immediately on counting narcotics each shift for missing count signatures. D. Audits of all narcotic books were conducted to identify any other missed counts x 90 days. Nursing staff who failed to count were educated. An audit of the narcotic count sheets will be completed by the Director of Nursing or designee	11/22/2024

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The resident's diagnoses included, but were not limited to: diabetes, hypertension and COPD (Chronic Obstructive Pulmonary Disease).

An active medication list indicated the resident had a physician's order for Norco (an opioid pain reliever (containing hydrocodone and acetaminophen) 10/325 milligrams (mg) three times a day, as needed.

The Narcotic Inventory Sheet, for Resident B indicated on 8/6/24 at 8 P.M., one (1) tablet of Norco had been administered which brought the medication count down from 15 tablets to 14 tablets. The next date, on the Narcotic Inventory Sheet was documented as 8/10/24 at 10:00 P.M., and indicated 8 tablets remained. On the next line it was documented "Med discrepancy" initialed by on-call LPN 21.

A form titled, "Controlled Medication Count Verification," for August of 2024, indicated on 8/20/24, during the evening shift, QMA 17 and QMA 19 had signed their names indicating the narcotic counts were verified as correct during their shift exchange. The night shift count stated "count is off" and was signed by QMA 19 and QMA 22.

An IDOH (Indiana Department

three times a week for 4 weeks, twice a week for 4 weeks, weekly for 4 weeks, and monthly thereafter until found to be in substantial compliance. Results will be reviewed and reported in QAPI.

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of Health) Incident Report #14, dated 8/10/24 at 10:30 P.M., indicated a narcotic count for Resident B's Norco had 6 tablets missing. This concern had been reported to the Director of Nursing (DON) and the area police department. Staff involved were QMA 19, QMA 17, LPN 20 and Agency LPN 18. The incident indicated the Nursing Agency had been contacted to request a statement/interview with LPN 18, however there was no documentation which indicated this had been received.

A time line of events, for the medication discrepancy, dated 8/13/24, was provided by the Administrator, who indicated he was not the Administrator during the incident. The time line indicated, on 8/10/24, an on-call LPN 21 had been contacted due to a medication discrepancy had been discovered, during the exchange of the evening shift (QMA 19) and night shift (QMA 21). It was reported to the on-call LPN 21 six (6) Norco tablets were missing on the Norco medication card for Resident B. The timeline indicated the count at 2:00 P.M., "may have been inaccurate".

A hand written statement by QMA 19, dated 8/10/24 at 10:55 P.M., indicated QMA 19 she had been counting medication with QMA 20 around 9:45 P.M. "

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...When they got to [Resident's name] bubble pack, and the pack had 8 hydrocodone/Norco pills. The book says it should have 14 pills" The statement indicated QMA 19 had counted with QMA 17 at 2:00 P.M., and stated " ...After about halfway through, she was counting too fast for me to keep up. I said, forget it I stopped counting the rest" The statement indicated an agency LPN 18 had been working until 7:00 P.M., and had handed the keys, to the medication room, to QMA 19, but did not count with QMA 19 before leaving the facility.

A copy of an email statement, dated 10/14/24 at 7:49 P.M., indicated RN 23 had counted narcotics at the end of her shift, on 8/10/24, with the day shift QMA 17 and the narcotic counts were correct.

A typed statement, not dated or timed, indicated QMA 17 had counted with the night nurse, RN 23, at the start of her day shift and the count was correct. At the end of her shift (2:00 P.M.) she started to count the narcotics with QMA 19 "...going the same speed I always go and after halfway through [name of QMA 19] stopped counting and said were good signed her name" QMA 17 indicated the count was accurate, to her knowledge.

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A hand written statement by QMA 20, not dated or timed, indicated after report from the day QMA 17, it was decided QMA 19 and QMA 17 would count the narcotics and QMA 19 signed off after the count. An agency LPN 18, QMA 17 and herself had worked the evening shift. QMA 19 & LPN 18 had the set of keys to the narcotics. The statement indicated the agency LPN 18 and left the facility, around 7:00 P.M., and left her keys with QMA 19, which QMA 19 handed them off to QMA 20. At the end of the shift, QMA 19 and QMA 20 went into the medication room to count the narcotics and it was noted Resident B's card had 8 tablets left on the card, leaving 6 missing. QMA 19 notified the on call LPN 21, to report the concern.

A typed statement by the Interim Administrator, dated 8/18/24, indicated " ...Video 2nd floor nursing area reviewed for any suspicious activity in and out of the nurses station area from 8/8/24 to 8/11/24. Nothing concerning noted"

During an interview, on 10/23/24 at 2:37 P.M., the Administrator indicated he would try to review the video again, since the statement regarding the video did not contain information regarding who was seen in the hallway near the medication

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room.

During an interview, on 10/23/24 at 3:25 P.M., QMA 19 indicated she was coming onto second shift, on 8/10/24, and had counted narcotics with QMA 17. QMA 19 indicated she was a new QMA and during the count QMA 17 had just stated the number of tablets on each card, without saying the resident's name on the card. QMA 19 indicated she "messed up" and should have finished the count correctly with QMA 17. Both QMAs signed the count verification sheet which indicated the count had been correct even though they had not finished the count. She indicated there was an agency LPN 18 working with her, on 8/10/24, and LPN 18 also had keys to the narcotic room and left the facility around 7:00 P.M. QMA 19 indicated LPN 18 had handed over the keys, to the medication room and there had been no narcotic count completed between them. QMA 19 indicated she had handed those keys over to QMA 20, who was also working the second shift. At around 9:30 P.M., QMA 19 indicated she and QMA 20 had counted the narcotics and discovered some of Resident B's Norco were missing. QMA 19 called the on-call LPN 21 to inform her. So when the count was handed over to the night shift QMA 22,

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the Narcotic Inventory Sheet was documented to have 8 tablets on the Norco drug card instead of 14.

During an interview, on 10/24/24 at 10:45 A.M., QMA 17 indicated on 8/10/24, she had not completed a "full count" of the narcotics during an shift change, from day shift to evening shift, with QMA 19. She indicated she had worked the day shift and had checked the count on her own around 1:00 P.M., and it had been correct with 14 tablets. She indicated QMA 19 had gotten frustrated during the count and stopped the process. QMA 17 indicated she had offered to start again, but QMA 17 would not complete the narcotic count with her. QMA 17 admitted she had signed the Controlled Medication Count Verification form for the evening count exchange as being correct, even though the count had not been completed.

A Video for 8/10/24 was reviewed by the current Administration, on 10/23/24 and reported at 3:51 P.M., the video did not have a view of the medication room door, due to the angle of the camera. However, the video did record from 2:02 P.M. through 9:19 P.M., QMA 19 and agency LPN 20., who had keys to the medication room, were

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observed on the video, in the hallway, near the medication room.

During an interview, on 10/24/24 at 1:00 P.M., the Administrator indicated he could not locate a police report even though it had been documented the police department had been contacted about the medication diversion.

On 10/23/24 at 4:06 P.M., the Regional Nurse provided a policy titled, " Medication Management, Administration, & Storage" dated 3/2022 and revised on 1/2024, and indicated the policy was the one currently used by the facility. The policy indicated "...F. Controlled Substances - Hand Off Procedure...a. At shift change, the oncoming licensed nurse or QMA responsible for medication administration will verify the resident, medication, dosage and count of all controlled substances in the narcotic lock box by physically counting each medication in the direct presence of an off going licensed nurse or QMA...2. Upon completion of the controlled substance count, each party, both oncoming and outgoing, should provide their signature, date and time on the Controlled Medication Shift to Shift Change Log. a. In the event of a controlled substance discrepancy is discovered during the controlled substance

count, the Director of Nursing, or designee, should be notified immediately. If unable to contact the Director of Nursing, the Executive Director will be notified immediately. All staff must remain on duty until the discrepancy is resolved or further direction is given...."

This State Residential finding relates to Complaint IN00444209.

Based on interview and record review, the facility failed to protect a resident's narcotic medication from loss or theft for 1 of 6 residents reviewed for medication administration.

(Resident B)

Finding includes:

On 10/23/24 at 1:22 P.M., a review of the clinical record for Resident B was conducted. The record indicated the resident had been transferred to a local hospital, on 10/22/24 and was not available for an interview. The resident's diagnoses included, but were not limited to: diabetes, hypertension and COPD (Chronic Obstructive Pulmonary Disease).

An active medication list indicated the resident had a physician's order for Norco (an opioid pain reliever (containing hydrocodone and acetaminophen) 10/325

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milligrams (mg) three times a day, as needed.

The Narcotic Inventory Sheet, for Resident B indicated on 8/6/24 at 8 P.M., one (1) tablet of Norco had been administered which brought the medication count down from 15 tablets to 14 tablets. The next date, on the Narcotic Inventory Sheet was documented as 8/10/24 at 10:00 P.M., and indicated 8 tablets remained. On the next line it was documented "Med discrepancy" initialed by on-call LPN 21.

A form titled, "Controlled Medication Count Verification," for August of 2024, indicated on 8/20/24, during the evening shift, QMA 17 and QMA 19 had signed their names indicating the narcotic counts were verified as correct during their shift exchange. The night shift count stated "count is off" and was signed by QMA 19 and QMA 22.

An IDOH (Indiana Department of Health) Incident Report #14, dated 8/10/24 at 10:30 P.M., indicated a narcotic count for Resident B's Norco had 6 tablets missing. This concern had been reported to the Director of Nursing (DON) and the area police department. Staff involved were QMA 19, QMA 17, LPN 20 and Agency LPN 18. The incident indicated the Nursing Agency had been

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contacted to request a statement/interview with LPN 18, however there was no documentation which indicated this had been received.

A time line of events, for the medication discrepancy, dated 8/13/24, was provided by the Administrator, who indicated he was not the Administrator during the incident. The time line indicated, on 8/10/24, an on-call LPN 21 had been contacted due to a medication discrepancy had been discovered, during the exchange of the evening shift (QMA 19) and night shift (QMA 21). It was reported to the on-call LPN 21 six (6) Norco tablets were missing on the Norco medication card for Resident B. The timeline indicated the count at 2:00 P.M., "may have been inaccurate".

A hand written statement by QMA 19, dated 8/10/24 at 10:55 P.M., indicated QMA 19 she had been counting medication with QMA 20 around 9:45 P.M. " ...When they got to [Resident's name] bubble pack, and the pack had 8 hydrocodone/Norco pills. The book says it should have 14 pills" The statement indicated QMA 19 had counted with QMA 17 at 2:00 P.M., and stated " ...After about halfway through, she was counting too fast for me to keep up. I said, forget it I stopped counting the rest" The statement indicated

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an agency LPN 18 had been working until 7:00 P.M., and had handed the keys, to the medication room, to QMA 19, but did not count with QMA 19 before leaving the facility.

A copy of an email statement, dated 10/14/24 at 7:49 P.M., indicated RN 23 had counted narcotics at the end of her shift, on 8/10/24, with the day shift QMA 17 and the narcotic counts were correct.

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A hand written statement by QMA 20, not dated or timed, indicated after report from the day QMA 17, it was decided QMA 19 and QMA 17 would count the narcotics and QMA 19 signed off after the count. An agency LPN 18, QMA 17 and herself had worked the evening shift. QMA 19 & LPN 18 had the set of keys to the narcotics. The statement indicated the agency

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LPN 18 and left the facility, around 7:00 P.M., and left her keys with QMA 19, which QMA 19 handed them off to QMA 20. At the end of the shift, QMA 19 and QMA 20 went into the medication room to count the narcotics and it was noted Resident B's card had 8 tablets left on the card, leaving 6 missing. QMA 19 notified the on call LPN 21, to report the concern.

A typed statement by the Interim Administrator, dated 8/18/24, indicated " ...Video 2nd floor nursing area reviewed for any suspicious activity in and out of the nurses station area from 8/8/24 to 8/11/24. Nothing concerning noted"

During an interview, on 10/23/24 at 2:37 P.M., the Administrator indicated he would try to review the video again, since the statement regarding the video did not contain information regarding who was seen in the hallway near the medication room.

During an interview, on 10/23/24 at 3:25 P.M., QMA 19 indicated she was coming onto second shift, on 8/10/24, and had counted narcotics with QMA 17. QMA 19 indicated she was a new QMA and during the count QMA 17 had just stated the number of tablets on each card, without saying the resident's

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name on the card. QMA 19 indicated she "messed up" and should have finished the count correctly with QMA 17. Both QMA's signed the count verification sheet which indicated the count had been correct even though they had not finished the count. She indicated there was an agency LPN 18 working with her, on 8/10/24, and LPN 18 also had keys to the narcotic room and left the facility around 7:00 P.M. QMA 19 indicated LPN 18 had handed over the keys, to the medication room and there had been no narcotic count completed between them. QMA 19 indicated she had handed those keys over to QMA 20, who was also working the second shift. At around 9:30 P.M., QMA 19 indicated she and QMA 20 had counted the narcotics and discovered some of Resident B's Norco were missing. QMA 19 called the on-call LPN 21 to inform her. So when the count was handed over to the night shift QMA 22, the Narcotic Inventory Sheet was documented to have 8 tablets on the Norco drug card instead of 14.

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indicated she had worked the day shift and had checked the count on her own around 1:00 P.M., and it had been correct with 14 tablets. She indicated QMA 19 had gotten frustrated during the count and stopped the process. QMA 17 indicated she had offered to start again, but QMA 17 would not complete the narcotic count with her. QMA 17 admitted she had signed the Controlled Medication Count Verification form for the evening count exchange as being correct, even though the count had not been completed.

A Video for 8/10/24 was reviewed by the current Administration, on 10/23/24 and reported at 3:51 P.M., the video did not have a view of the medication room door, due to the angle of the camera. However, the video did record from 2:02 P.M. through 9:19 P.M., QMA 19 and agency LPN 20., who had keys to the medication room, were observed on the video, in the hallway, near the medication room.

During an interview, on 10/24/24 at 1:00 P.M., the Administrator indicated he could not locate a police report even though it had been documented the police department had been contacted about the medication diversion.

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On 10/23/24 at 4:06 P.M., the Regional Nurse provided a policy titled, " Medication Management, Administration, & Storage" dated 3/2022 and revised on 1/2024, and indicated the policy was the one currently used by the facility. The policy indicated "...F. Controlled Substances - Hand Off Procedure...a. At shift change, the oncoming licensed nurse or QMA responsible for medication administration will verify the resident, medication, dosage and count of all controlled substances in the narcotic lock box by physically counting each medication in the direct presence of an off going licensed nurse or QMA...2. Upon completion of the controlled substance count, each party, both oncoming and outgoing, should provide their signature, date and time on the Controlled Medication Shift to Shift Change Log. a. In the event of a controlled substance discrepancy is discovered during the controlled substance count, the Director of Nursing, or designee, should be notified immediately. If unable to contact the Director of Nursing, the Executive Director will be notified immediately. All staff must remain on duty until the discrepancy is resolved or further direction is given...."

This State Residential finding relates to Complaint

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	IN00444209.			
R 0117	Personnel - Deficiency 410 IAC 16.2-5-1.4(b) (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interview, the facility failed to ensure at least one staff member had CPR (Cardiopulmonary	R 0117	The community was alleged to be out of compliance by failing to ensure that staff met requirements regarding First Aid training certification of 1 certified staff per shift for 4 of 21 shifts reviewed. A The director of Nursing, Nursing Scheduler, and Business Office Manager were educated by the Executive Director regarding the policy titled "CPR and First Aid Certifications,". B Clinical staff will received first aid certification. C An audit was completed to ensure all staff obtained necessary first aid certifications. An audit will be completed by the Executive Director/ designee weekly for 4 weeks and monthly thereafter for 6 months. Variances will be corrected and reported to the community QAPI.	11/22/2024

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Resuscitation) and First Aid certification/training on each shift. This had the potential to effect all 110 residents who resided at the facility.

Finding includes:

A review of the employee work schedule, dated 10/19/24 through 10/26/24, indicated staff had worked 8-hour shifts. The following dates staff members had worked and did not have the required CPR and/or First Aide certification, during their shift:

- CNA 2, QMA 3 and LPN 4 had worked the evening shift, on 10/19/24.

- LPN 5, LPN 13, QMA 6 and CNA 7 had worked the day shift, on 10/21/24.

- QMA 8 and CNA 9 had worked the night shift, on 10/21/24.

- QMA 10, CNA 11 and CNA 12 had worked the evening shift, on 10/22/24.

During an interview on 10/23/24 at 1:30 P.M., the Administrator indicated there had been days when staff members were scheduled, who were not CPR or First Aid certified.

On 10/23/2024 at 1:40 P.M., the Administrator provided the policy titled, "CPR and First Aid Certifications," dated 4/24/24,

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and indicated it was the one currently being used by the facility. The policy indicated, "...D. It is the responsibility of the Director of Nursing or designee to ensure at least one on-duty employee has current CPR & First Aid Certifications at all times...."

Based on record review and interview, the facility failed to ensure at least one staff member had CPR (Cardiopulmonary Resuscitation) and First Aid certification/training on each shift. This had the potential to effect all 110 residents who resided at the facility.

Finding includes:

A review of the employee work schedule, dated 10/19/24 through 10/26/24, indicated staff had worked 8-hour shifts. The following dates staff members had worked and did not have the required CPR and/or First Aide certification, during their shift:

- CNA 2, QMA 3 and LPN 4 had worked the evening shift, on 10/19/24.

- LPN 5, LPN 13, QMA 6 and CNA 7 had worked the day shift, on 10/21/24.

- QMA 8 and CNA 9 had worked the night shift, on 10/21/24.

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- QMA 10, CNA 11 and CNA 12 had worked the evening shift, on 10/22/24.

During an interview on 10/23/24 at 1:30 P.M., the Administrator indicated there had been days when staff members were scheduled, who were not CPR or First Aid certified.

On 10/23/2024 at 1:40 P.M., the Administrator provided the policy titled, "CPR and First Aid Certifications," dated 4/24/24, and indicated it was the one currently being used by the facility. The policy indicated, "...D. It is the responsibility of the Director of Nursing or designee to ensure at least one on-duty employee has current CPR & First Aid Certifications at all times...."

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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