STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155070	A. BUILDING 00 B. WING	04/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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 Complaints IN00431126 and IN00433036. Complaint IN00431126 - No deficiencies related to the allegation is cited. Complaint IN00433036 - No deficiencies related to the allegation is cited. An unrelated deficiency is cited. Survey dates: April 27, 29 and 30, 2024 Facility number: 000028 Provider number: 155070 AIM number: 100275370 Census Bed Type: SNF/NF: 121 Total: 121 Census Payor Type: Medicare: 10 Medicaid: 83 Other: 28 Total: 121 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on May 3, 2024.	F 0000		
F 0602 SS=D Bldg. 00	483.12 Free from Misappropriation/Exploitation Based on interview and record review, the facility failed to ensure misappropriation of resident	F 0602	602– Free from Misappropriation/Exploitation	05/02/2024

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

Greg Dattilo | Executive Director | 05/20/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	property did not occur for 1 of 3 residents reviewed for misappropriation. (Resident D) Findings include: The clinical record for Resident D was reviewed on 4/29/24 at 12:21 p.m. The resident's diagnoses included, but were not limited to, depression, anxiety and pain. The physician's order, dated 4/17/24, indicated Resident D was to receive Oxycodone (narcotic pain medication) 5 mg (milligrams), one half of a tablet (2.5 mg) twice a day and every 4 hours as needed for pain. The internal facility incident report, dated 4/23/24 at 4:05 p.m., indicated Resident D was missing one card with 22.5 tablets of Oxycodone and one narcotic count sheet. The Oxycodone was sent to the facility, from the pharmacy on 4/19/24. All statements had been obtained from staff that worked the medication cart except for QMA (Qualified Medication Aide) 9. The State incident report, dated 4/26/24, indicated a narcotic discrepancy had been identified on the Memory Care Unit for Resident D. The pharmacy delivery receipt, dated 4/18/24 at 10:16 p.m., indicated for Resident D there were four cards of Oxycodone 5 mg tablets, with 15 tablets in each card. The medication card were sent out for delivery to the facility and were received by the facility on 4/19/24. On 4/21/24 at 6:00 p.m., the Shift Change Controlled Substance Inventory Sheet indicated at the start of shift, there were 23 cards and 26 narcotic count sheets. One card and one narcotic		**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident assessed for any changes in mental status, psycho social well-being. Replaced missing medication at facility expense. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** Residents with narcotic orders have the potential to be effected One time narcotic reconciliation for current resident population. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Re-Educate QMAs, LPNs, RNs controlled medication guidance policy, drug destruction process	

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	count sheet were removed with an end of shift total of 22 cards and 25 narcotic count sheets. Resident D had 4 cards and 4 sheets related to her medication, Oxycodone. The resident's count were included in the facility Shift Change Controlled Substance Inventory Sheets total on 4/22/24 at 6:00 p.m. The night shift nurse was LPN 7 and the on-coming day shift nurse on 4/22/24 at 6:00 a.m. was QMA 9. During an interview on 4/30/24 at 2:50 p.m., LPN 7 indicated when she counted the narcotic cards and sheets with QMA 9, on 4/22/24 at 6:00 a.m., there were a total of 22 cards and 25 narcotic count sheets. On 4/30/24 at 11:45 a.m., the facility Shift Change Controlled Inventory Sheets were reviewed. The Shift Change controlled Substance Inventory Sheet, dated 4/22/24 at 6:00 a.m., had 22 cards and 25 narcotic count sheets documented at the start of the shift. One card and one narcotic count sheet were added and subtracted with an end of shift total of 22 cards and 25 narcotic count sheets. There was a single line drawn through the end of shift numbers from 22 cards and 25 narcotic count sheets. A handwritten total was changed to 21 cards and 24 narcotic count sheets written underneath the previous number. The day shift nurse was QMA 9 and the oncoming night shift nurse was LPN 6. During an interview on 4/30/24 at 2:31 p.m., LPN 6 indicated she worked on 4/22/24 from 10:00 p.m. until 6:00 a.m. on 4/23/24. She only counted the narcotics with QMA 9, not the cards or narcotic count sheets. When she came on shift at 10:00 p.m. there were no alteration or handwritten changes on the Shift Change Controlled Inventory Sheets. The LPN indicated she had not		Notification of DON if another staff member does not or refuses to count controlled medications at shift change. Visualization of medication destruction/correction prior to cosigning shift count **How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** DON/designee will audit narcotics and count sheets 5 x week for 2 weeks, weekly x 2weeks, monthly x 2 months. Any issues identified will be immediately corrected with 1:1 re-education, progressive disciplinary action as determined by ED/DON, up to including termination. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter for a total of 6 months. Frequency and duration of reviews will be increased as needed if any areas of noncompliance are identified during the auditing process.	

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	administered any Controlled medication to Resident D. There had not been any corrections, changes, or alterations to the Shift Change Controlled Substance Inventory Sheets upon her arrival or at the end of her shift. The Shift Change Controlled Substance Inventory Sheet, dated 4/22/24 at 10:00 p.m., indicated at the start of the shift, there were 22 cards and 25 narcotic count sheets. Those numbers were changed from 22 cards and 25 narcotic count sheets to 21 cards and 24 narcotic count sheets. There was a single line drawn through the end of shift numbers from 22 cards and 25 narcotic count sheets. A handwritten total was changed to 21 cards and 24 narcotic count sheets written underneath the previous number. The night shift nurse was LPN 6 and the oncoming day shift nurse was QMA 9. The Shift Change Controlled Substance Inventory Sheets, dated 4/23/24 at 6:00 a.m., indicated at the start of the shift, there were 21 cards and 24 narcotic count sheets. The night shift nurse was LPN 6 and the oncoming day shift nurse was QMA 9. Review of the April 2024 medication administration record (MAR) indicated the last dose of the Oxycodone that was administered from the missing narcotic count sheet was on 4/22/24 at 8:00 p.m. by QMA 9. On 4/29/24 at 9:25 a.m., the Director of Nursing (DON) indicated, on 4/23/24, once they realized there was a discrepancy she reached out to QMA 9 by telephone and both of the QMA's phone numbers were disconnected. The DON reached out by social media messenger and requested for QMA 9 to return her call. As of 4/29/24, the QMA		Date of Compliance – 5/02/2024	

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	9 had not returned her call or reached out to her in any way. The DON spoke with Officer 20, who was over the case, on Saturday evening, 4/27/24. Officer 20 reported to her that he had gotten in touch with QMA 9. He reported QMA 9 told him she would not speak to him without legal counsel. During an interview on 4/30/24 at 2:24 p.m., Unit Manager indicated, on 4/23/24, LPN 8 was going through all the new pharmacy orders to double check and make sure they were correct. LPN 8 noticed the staff were using page two of the narcotic count sheets and should have been using page one for Resident D's Oxycodone. The Unit Manager and LPN 8 could not locate page 1 of the controlled substance record for Resident D's Oxycodone or the medication card that correlated with page one of the controlled substance records. There should have been a card of 22.5 Oxycodone tablets and a sheet that correlated. The resident's medication appeared to be missing. QMA 9 was the last to sign off of the page 1 controlled substance record based on the MAR and she was the first to sign off on the page 2 of the controlled substance record on 4/23/24 at 8:00 a.m. On 4/30/24 at 3:13 p.m., the Director of Nursing indicated an in-service was completed for the QMA's on 3/8/24. They had noticed QMA 9 had been administering more of the as needed narcotic medications to the residents who did not normally request as needed narcotic medications. On 4/30/24 at 12:10 p.m., the Director of Nursing provided a current copy of the document titled "Abuse - Identification of Types" dated 10/4/22. It included, but was not limited to, "Policy...Misappropriation of Resident Property...the deliberate misplacement,			

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	exploitation, or wrongful, temporary, or permanent use of a resident property...without the resident's consent...Misappropriation of Property...Examples of misappropriation of resident property include but are not limited to...Missing prescription medications or diversion of resident's medication...." 3.1-28(a)			