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	11/14/2023

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 a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on October 10, 2023. Survey date: November 14, 2023 Facility number: 000028 Provider number: 155070 AIM number: 100275370 Census Bed Type: SNF/NF: 117 Total: 117 Census Payor Type: Medicare: 10 Medicaid: 83 Other: 24 Total: 117 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on November 16, 2023.	F 0000		
F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals			

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

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	§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, record review, and interview, the facility failed to ensure appropriate storage of medications for 12 residents and 2 of 9 medication carts observed for medication storage. (200 Hall Short Medication cart and 500 Hall Medication cart) Findings include: 1. During an observation of the 200 Hall Short Medication cart on 11/14/23 at 12:21 p.m., with LPN (Licensed Practical Nurse) 5, located in the top drawer of the medication cart the nurse had two stacks of medication cups with various tablets inside them. The medication cups had resident's last names and administration times documented on the side of them in black permanent marker. The medications, which had been set up in advance, were confirmed as the following by the nurse: a. There was one medication cup with Resident 2's last name and "2 pm" written on the cup. Inside	F 0761	F 761 **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** The medications found for the 12 residents were discarded in accordance with our policy with the chemical solution and two witnesses. Residents # 2, 3, 4, 5, 6, 7, 8, 9, 10, and 11 had medications available and did not miss a medication dose as per current orders as result of the discarded medications. Resident # 12's insulin pen dated as opened on 9/29/23 was discarded in accordance with our policy. The resident did have another insulin pen available and in use at the time of locating the other	11/27/2023

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	the cup was one pink tablet imprinted with 125. Upon interview, LPN 5 indicated the pink tablet was Resident 2's 2:00 p.m. dose of Depakote. The record for Resident 2 was reviewed on 11/14/23 at 1:00 p.m. The diagnosis included, but was not limited to, dementia. The physician's order dated 10/13/23, indicated the resident received Depakote 125 mg (milligrams) three times daily for her mood. The next dose was scheduled to be given on 11/14/23 at 2:00 p.m. b. There was one medication cup with Resident 3's last name and "2 p" written on the cup. Inside the cup were two white round tablets imprinted with OPC 77. Upon interview, LPN 5 indicated the white tablets were Resident 3's sodium bicarbonate. The record for Resident 3 was reviewed on 11/14/23, at 1:05 p.m. The diagnosis included, but was not limited to, chronic kidney disease. The physician's order, dated 9/22/23, indicated the resident received sodium bicarbonate 650 mg three times daily for chronic kidney disease. The next dose was scheduled to be given on 11/14/23, at 12:00 p.m. c. There was one medication cup with Resident 4's last name and "4 p" written on the cup. Inside the cup were a white capsule and a small white tablet. There was a second medication cup with the resident's last name and "6 p" written on the side of the cup. Inside the cup was one white tablet with an imprint of M367 on it.		insulin pen. Resident #12 did not miss any insulin doses as scheduled/ordered. Resident #13's insulin pen was dated as opened on 11/14/23 by the licensed nurse as the pen was stored on the medication cart following the medication cart review. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** The Nursing Administration team, consisting of the Director of Nursing, Unit Managers, and Staff Development Coordinator completed a one-time review of medication carts on each unit to validate there were no other preset medications, or insulins out of date or not dated as placed on cart. Disciplinary action was determined necessary with pre-setting medications. The Licensed Supervisory Nurses have been provided re-education on medication storage policy and procedures, to set up medications one person at a time, dating insulins upon placement in medication cart, and discarding out of date insulins. **What measures will be put into place or what systemic changes will be made to**	

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	Upon interview, LPN 5 indicated the medications in the first cup were Resident 4's 4:00 p.m. medications, including carvedilol and Neurontin 100 mg, and the medication in the second cup was his 6:00 p.m. dose of Norco 10/325 mg. The record for Resident 4 was reviewed on 11/14/23 at 1:10 p.m. The diagnoses included, but were not limited to, chronic pain and hypertension. The physician's order, dated 7/30/23, indicated the resident received carvedilol 3.125 mg twice daily for hypertension. The next dose was scheduled to be given on 11/14/23 at 5:00 p.m. The physician's order, dated 7/31/23, indicated the resident received Neurontin 100 mg three times daily for neuropathy. The next dose was scheduled to be giving on 11/14/23 at 2:00 p.m. The physician's order, dated 7/30/23, indicated the resident received Norco 10/325 mg every 6 hours for chronic pain. The next dose was scheduled to be given on 11/14/23 at 6:00 p.m. d. There was one medication cup with Resident 5's last name and "2 p" written on the cup. Inside the cup was one orange round tablet. Upon interview, LPN 5 indicated the medication was Resident 5's 2:00 p.m. dose of hydralazine. The record for Resident 5 was reviewed on 11/14/23 at 1:15 p.m. The diagnosis included, but was not limited to, hypertension. The physician's order, dated 5/15/23, indicated the resident received hydralazine 25 mg three times		**ensure that the deficient practice does not recur?** Review of the policy and procedure for medication storage has been completed with no recommended changes. The Director of Nursing/designee will be responsible for auditing medication carts on each unit 5 times a week for 2 weeks, 3 times a week for 6 weeks, weekly for 4 weeks, and then monthly for 3 months to validate medications are not preset, insulins are dated upon opening, and removed from the med cart at time of expiration. Any issues identified will be immediately corrected, 1:1 re-education completed with staff personnel as identified, with disciplinary action completed as determined necessary by the Director of Nursing and/or Administrator. **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?** The Administrator/designee will be responsible for reviewing the completed audits as per the schedule above. The results of these reviews will be discussed at the monthly facility Quality	

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	daily for hypertension. The next dose was scheduled to be given on 11/14/23 at 2:00 p.m. e. There was one medication cup with Resident 6's last name and "2 pm" written on the cup. Inside the cup was a small red tablet and a white tablet imprinted with tv53. Upon interview, LPN 5 indicated the medications were Resident 6's 2:00 p.m. dose of iron and Buspar. The record for Resident 6 was reviewed on 11/14/23 at 1:20 p.m. The diagnoses included, but were not limited to, iron deficiency anemia and depression. The physician's order, dated 8/14/23, indicated the resident received Buspar 5 mg three times daily for anxiety. The next dose was scheduled to be given on 11/14/23 at 2:00 p.m. The physician's order, dated 11/17/22, indicated the resident received iron 325 mg twice daily for low hemoglobin. The next dose was scheduled to be given on 11/14/23 at 4:30 p.m. f. There was one medication cup with Resident 7's last name written on the cup. Inside the cup was one round orange tablet. Upon interview, LPN 5 indicated the medication was Resident 7'a 2:00 p.m. dose of hydralazine. The record for Resident 7 was reviewed on 11/14/23 at 1:25 p.m. The diagnosis included, but was not limited to, hypertension. The physician's order, dated 10/2/22, indicated the resident received hydralazine 25 mg three times		Assurance Committee meeting monthly for three months and then quarterly thereafter for a total of 6 months. Re-education, frequency and/or duration of reviews will be increased as needed if any areas of noncompliance are identified during the auditing process until compliance has been reached. **Date of Compliance: 11/27/23**	

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	daily for hypertension. The next dose was scheduled to be given on 11/14/23 at 2:00 p.m. g. There was one medication cup with Resident 8's last name and "2 pm" written on the cup. Inside the cup was a small yellow capsule and a red round tablet imprinted with "xa". Upon interview LPN 5 indicated the medications were Resident 8's 2:00 p.m. doses of Neurontin and Xarelto. The record for Resident 8 was reviewed on 11/14/23 at 1:30 p.m. The diagnoses included, but were not limited to, diabetes mellitus type 2 with polyneuropathy and atrial fibrillation. The physician's order, dated 10/18/23, indicated the resident received Xarelto 15 mg daily for atrial fibrillation. The next dose was scheduled to be given on 11/14/23 at 1:00 p.m. The physician's order, dated 10/18/23, indicated the resident received Neurontin 300 mg three times daily for neuropathy. The next dose was scheduled to be given on 11/14/23 at 2:00 p.m. h. There was one medication cup with Resident 9's last name and "2 p.m." written on the cup. Inside the cup were three yellow tablets imprinted m721, one small white tablet imprinted 585, one white oblong tablet imprinted APO 033, one white oblong tablet imprinted M365, and one small round tablet imprinted 833. There was a second cup with the resident's last name and "4 p.m." written on the cup. Inside the cup was one large white, oblong tablet, imprinted with TEVA, and one small, round, white tablet imprinted with TEVA.			

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	Upon interview, LPN 5 indicated the medications in the first cup were Resident 9's 2:00 p.m. medications, which included three tablets of Sinemet, midodrine, pentoxifylline, Norco, and clonazepam and the medications in the second cup were her 4:00 p.m. doses of Carafate and Reglan. The record for Resident 9 was reviewed on 11/14/23 at 1:35 p.m. The diagnoses included, but were not limited to, chronic heart disease, Parkinson's disease, polyneuropathy, bipolar disorder, generalized anxiety disorder, hypertension, esophagitis, and chronic pain. The physician's order, dated 9/19/23, indicated the resident received Carafate 1 gram three times daily for GERD (gastroesophageal reflux disease). The next dose was scheduled to be given on 11/14/23 at 5:00 p.m. The physician's order, dated 9/19/23, indicated the resident received Sinemet 25/100 mg three times daily for Parkins's disease. The next dose was scheduled to be given on 11/14/23 at 2:00 p.m. The physician's order, dated 9/19/23, indicated the resident received Reglan 10 mg for GERD. The next dose was scheduled to be given on 11/14/23 at 4:00 p.m. The physician's order, dated 9/19/23, indicated the resident received midodrine 5 mg three times daily for low blood pressure. The next dose was scheduled to be given on 11/14/23 at 2:00 p.m. The physician's order, dated 9/19/23, indicated the resident received pentoxifylline 400 mg three times daily for peripheral artery disease. The next dose was scheduled to be given on 11/14/23 at 2:00 p.m.			

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The physician's order, dated 9/19/23, indicated the resident received clonazepam 1 mg three times daily for anxiety. The next dose was scheduled to be given on 11/14/23 at 2:00 p.m.

The physician's order, dated 10/30/23, indicated the resident received Norco 5/325 mg every six hours as needed for pain. The last dose was documented on the Medication Administration Record as being administered on 11/14/23 at 8:00 a.m.

i. There was one medication cup with Resident 10's last name and "4" written on the cup. Inside the cup was one large white tablet.

Upon interview, LPN 5 indicated the medication was Resident 10's 4:00 p.m. dose of Carafate.

The record for Resident 10 was reviewed on 11/14/23 at 1:40 p.m. The diagnosis included, but was not limited to, GERD.

The physician's order, dated 10/11/23, indicated the resident received Carafate 1 gram before meals and at bedtime for GERD. The next dose was scheduled to be given on 11/14/23 at 4:00 p.m.

j. There was one medication cup with Resident 11's last name and "2 p" written on the cup. Inside the cup was one small, white, round tablet, and another small, white, oblong tablet.

Upon interview, LPN 5 indicated the tablets were Resident 11's 2:00 p.m. doses of baclofen and carvedilol.

The record for Resident 11 was reviewed on 11/14/23 at 1:45 p.m. The diagnoses included, but

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	were not limited to, heart failure and pain in left knee. The physician's order, dated 11/14/23, indicated the resident received baclofen 5 mg twice daily for muscle spasms. The next dose was scheduled to be given on 11/14/23 at 2:00 p.m. The physician's order, dated 1/9/23, indicated the resident received carvedilol 6.25 mg twice daily for hypertension. The next dose was scheduled to be given on 11/14/23 at 5:00 p.m. During an interview on 11/14/23 at 11:30 a.m., LPN 5 indicated she had gotten very busy and she pulled all her medications. During an interview on 11/14/23 at 1:14 p.m., Unit Manager 3 indicated during her audits of the medication carts she had not identified any concerns with nurses setting up their medications in advance. They were not supposed to do that. They were only supposed to pull them when they administered them, and then check them off after they administered them. During an interview on 11/14/23 at 2:12 p.m., the Director of Nursing (DON) indicated nurses should not ever set their medications up in advance. It was not allowed and there was no reason for it. She didn't know why LPN 5 set up her medications, she was usually one of their stronger nurses. Controlled substances should be under a double lock. The most current General dose Preparation and Medication Administration policy included, but was not limited to, " ... 3.2 Facility staff should only prepare medications for one resident at a time ..."			

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	2. During an observation of the 500 Hall Medication Cart on 11/14/23 at 12:40 p.m., with Unit Manager 4, the following concerns were observed: a. There was one Lantus insulin pen belonging to Resident 12 in the medication cart with an open date of 9/29/23 written on the pen in black marker. The pen had been used, with approximately 20 units remaining in the pen. The record for Resident 12 was reviewed on 11/14/23 at 1:50 p.m. The diagnosis included, but was not limited to, diabetes mellitus type 2. The physician's order, dated 8/31/23, indicated the resident received Lantus pen injector 40 units daily for diabetes. The last dose was documented as administered on 11/14/23 at 8:00 a.m. b. There was one Novolog insulin pen belonging to Resident 13 in the cart. There was no open date on the insulin pen. The pen appeared to be full. Upon interview, Unit Manager 4 indicated the insulin pen was full, but since the medication was on the cart it should have had an open date. The insulin pens were to be dated as opened when they came out of the fridge. Upon interview, LPN 6 indicated she had pulled the insulin pen out of the medication room earlier that same day, just a little bit ago. She did not put an open date on it. She had gotten stopped with a request to go do a treatment on a resident. The record for Resident 13 was reviewed on 11/14/23 at 1:55 p.m. The diagnosis included, but was not limited to, diabetes mellitus type 2.			

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	The physician's order, dated 6/13/22, indicated the resident received NovoLog pen injector per sliding scale before meals and at bedtime for diabetes. The medication was last documented as administered on 11/14/23 at 12:00 p.m. The Medication Cart Audit forms indicated the 500 Hall cart had last been audited by Unit Manager 3 on 11/8/23 with no issues identified. During an interview on 11/14/23 at 11:58 a.m., the DON indicated they had a total of 9 medication carts in the building. Unit Manager 3 was responsible for conducting their plan of correction audits. The unit managers were also to check their medication carts daily. Then Unit Manager 3 would audit 50% of the medication carts daily. During an interview on 11/14/23 at 12:07 p.m., Unit Manager 3 indicated they checked four medication carts daily to make sure they got rid of expired medications, and that medications were stored how they were supposed to be. During an interview on 11/14/23 at 1:14 p.m., Unit Manager 3 indicated she thought she had checked all the medication carts, but she had missed the expired insulin pen. It should have been found and removed on the audit conducted on 11/8/23. This deficiency was cited on 10/10/23. The facility failed to implement a systemic plan of correction to prevent recurrence. The most current Insulin Administration policy, included, but was not limited to, " ... Insulin glargine [Lantus] ... discard opened pens kept at room temperature after 28 days ..."			

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	3.1-25(j)			