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	08/21/2023

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 the investigation of Complaints IN00415023, IN00414879, and IN00412769. Complaint IN00415023 - Federal/State deficiency related to the allegation is cited at F812. Complaint IN00414879 - Federal/State deficiency related to the allegation is cited at F812. Complaint IN00412769- Federal/State deficiency related to the allegation is cited at F760. Survey date: August 21, 2023. Facility number: 000028 Provider number: 155070 AIM number: 100275370 Census Bed Type: SNF/NF: 118 Total: 118 Census Payor Type: Medicare: 7 Medicaid: 89 Other: 22 Total: 118 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 28, 2023.	F 0000		
F 0760 SS=G Bldg. 00	483.45(f)(2) Residents are Free of Significant Med Errors The facility must ensure that its- §483.45(f)(2) Residents are free of any			

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

Greg Dattilo | Executive Director | 09/13/2023

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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	significant medication errors. Based on record review and interview, the facility failed to ensure residents were free of significant medication errors which resulted in Resident D being hospitalized for hypoglycemia after receiving an anti-diabetic medication without a diagnosis of diabetes for 1 of 3 resident's whose medication regimens were reviewed. Findings include: The record for Resident D was reviewed on 8/21/23 at 10:00 a.m. The resident did not have any diagnoses related to or including diabetes. The record lacked documentation of any blood sugar monitoring orders or blood glucose levels in the last 12 months prior to 5/11/23. The physician's order, dated 5/11/23 at 5:42 p.m., indicated RN 4 input an order for the resident to have glipizide (anti-diabetic medication) 5 mg (milligrams) daily for diabetes. NP (Nurse Practitioner) 3 signed off on the order on 5/12/23 at 12:45 p.m. The order note, dated 6/30/23 at 11:52 a.m., indicated the resident was prescribed Bactrim DS (double strength) tablet 800-160 mg 1 tablet daily for a UTI (urinary tract infection) and it had triggered a drug-to-drug interaction. The interaction severity was moderate and indicated the hypoglycemic action of glipizide 5 mg could be increased by the use of Bactrim DS. The record lacked documentation of any notification to the physician of the drug-to-drug interaction or any blood glucose monitoring. The nurse's note, dated 7/3/23 at 12:43 p.m.,	F 0760	Past non-compliance	08/21/2023

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	indicated NP 3 ordered blood tests including a CBC (complete blood count), CMP (complete metabolic panel), and Vitamin D level due to the resident's family member having concerns that his shakiness was getting worse, however the resident did not feel it was. The laboratory report, dated 7/4/23, indicated the resident's blood glucose level was critically low at a value of 40 mg/dL (milligrams per deciliter). The report indicated a normal value for fasting glucose was 65 to 99 mg/dL and normal value for non-fasting glucose was 65 to 125 mg/dL. The nurse's note, dated 7/4/23 at 11:53 a.m., indicated the laboratory called with a critical glucose level of 48 mg/dL. The resident's blood sugar after breakfast was 146 mg/dL and he had no signs or symptoms of hypoglycemia. NP 3 was notified and gave new orders for a CBC, CMP, and Vitamin D in the morning. She would review all labs before making any adjustments. The record lacked documentation of any further glucose monitoring or changes to the resident's medication regimen. The nurse's note, dated 7/6/23 at 9:51 a.m., indicated the resident was up in his wheelchair at the nurse's station and was observed to have involuntary movements and jerking with his head, legs, arms, and eyes. The on-call NP was notified and gave orders for immediate lab testing and to send to the hospital if he got worse or did not get better. The POA (Power of Attorney) was notified. While on the phone the resident had increased movements and confusion and the POA requested he be sent to the hospital. 911 was called. The resident had episodes of movement and jerking for approximately 20 minutes then left			

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	via ambulance. The resident's vitals were 128/95 blood pressure, 86 heart rate, 96% O2, and 18 on respirations. A blood sugar level was not documented. The laboratory report from the specimens obtained on 7/5/23 resulted on 7/6/23 after the resident had gone to the hospital. The report indicated the resident's glucose was less than 32 mg/dL, which was flagged as a critical low value. The hospital discharge summary, dated 7/11/23, indicated the resident had presenting problems including bradycardia, hypoglycemia, and urinary tract infection. The resident had no documented history of diabetes but was found to have glipizide on his medication list from the facility. His A1C was 5.2. The glipizide was discontinued, and he required D10 (dextrose 5% IV fluids) briefly and D5W (dextrose 5% in water), both of which had been weaned off and the blood glucose had improved. The resident developed bradycardia overnight, which was likely secondary to hypoglycemia and sepsis. He had acute metabolic encephalopathy also likely secondary to hypoglycemia and his Parkinson' disease. He had presented to the emergency department with hypoglycemia. His family confirmed he was not a diabetic. The emergency department found he had a heart rate of 48 and a blood sugar of 28 mg/dL. The lab report from 7/6/23 at 11:35 a.m. indicated the resident's blood glucose was 26 mg/dL. The typed DON's statement indicated, on 7/12/23, she spoke with RN 4 via telephone related to the order for Resident D for glipizide 5 mg daily. RN 4 indicated she did not remember putting the order in. She had no idea where the order came from. She did not remember speaking to the physician or NP and receiving the order. She normally			

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	always notified family and put in progress notes with any new orders or changes. During an interview on 8/21/23 at 11:43 a.m., NP 3 indicated she did not order glipizide for the resident, however she would take fault that she signed off on the order. She was only signing orders every month or so, and was not reviewing every single order. She missed it. She would not use glipizide as a first line medication for diabetes, and if she did order something she would document that she was ordering it and why. She did not see the resident and did not order the medication. She did not know how he got it. She was not aware of the drug-to-drug interaction warning for Bactrim and glipizide and should have been made aware. She would have written to monitor his blood sugars. In passing the nurse told here the resident had a critical glucose level and had just rechecked it and it was 168 mg/dL. She ordered to repeat the lab testing. From his record he did not have diabetes. They had not identified issues with the drug-to-drug interactions and that would have to be corrected. During an interview on 8/21/23 at 12:45 p.m., the ED (Executive Director) indicated they were unable to figure out how or why the resident ever received an order for glipizide. They could not locate any documentation to indicate any orders for glipizide for any other residents in the facility for the dates of the original order on Resident D. He did not know what had happened. The Physician Orders policy included, but was not limited to, "... A physician, physician assistant, or nurse practitioner must provide orders for the resident's immediate care and ongoing care of the resident... 9. Any orders written by a consulting physician must be			

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	reviewed and signed by the resident's attending physician..." The LTC Facility's Pharmacy Services and Procedures Manual, included but was not limited to, "... 6.3 Orders that may not be accepted by the pharmacy from the electronic medical record system include... Orders with missing diagnoses... 12. Facility should review any Pharmacy communication letters attached to medications dispensed by Pharmacy including... 12.1 Drug-drug interaction monographs providing resident monitoring information and adjust the resident's care plan, if necessary... Moderate Interaction... Assess risk to patient and take action as needed... 13.5 Facility should ensure that the person receiving a verbal order immediately records it in the resident's chart or electronic order system, including the date and time of the order, the name of the Physician/Prescriber, and the signature of the person receiving the orders... 14. Facility should be able to identify the original Physician/Prescriber when the original Physician/Prescriber is someone other than the attending physician..." The General Dose Preparation and Medication Administration policy included, but was not limited to, "... 4. Prior to administration of medication, Facility staff should take all measures required by facility policy and Applicable Law, including, but not limited to the following... Facility staff should... Verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route,, at the correct rate, at the correct time, for the correct resident..." The deficiency cited was past non-compliance when the facility completed staff education,			

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	residents medication order audit, physician order process reviewed and monitored prior to the entrance of the survey. This Federal tag relates to Complaint IN00412769. 3.1-48(c)(2)			
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation and interview, the facility failed to ensure the kitchen was maintained in a sanitary manner, disposal of expired food, and maintain repairs for 2 of 2 observations. This deficient practice had the potential to affect all 118 residents currently residing at the facility.	F 0812	This plan of correction is to serve as Green Valley Care Centers credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Parkview Care Center Community or its	08/30/2023

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	Findings include: During the initial tour of the kitchen on 8/21/23 at 9:20 a.m., the following concerns were observed: - The paper towel dispenser was not working and there was no trash can by the sink for disposal of the paper towels. - One knife, two plastic tray lids, and several plastic bowl covers were on the floor under steam table and coffee table. - In the reach in fridge there were several salads dated 8/20, unidentifiable leftovers dated 8/20/23, mashed potatoes dated 8/20/23, and several sandwiches in the bin were dated 8/22. - The Dietary Cook 7 indicated the leftovers were dated on the date they were prepared; the sandwiches had the expiration date 8/22/23. - Inside the walk in refrigerator, a container of chicken salad was dated 8/22, a container of macaroni and cheese was dated 8/18/23, strawberry swirl pudding was dated 8/17/23, green jello with pineapples in it was dated 8/18/23, pudding was dated 8/18. None of the dates indicated whether they were preparation dates or expiration dates. - There were 11 cartons of whipping cream with an expiration date of 8/17/23. The cartons were bulging. - There were 10 bunches of celery in a box, starting to wilt and turning brown, the date on the box indicated 7/11. - There were 6 moldy wilting cabbages in a box dated 6/27/23. - The walk-in freezer handle was broken off inside the freezer. - The milk refrigerator floor was extremely sticky. There was a puddle of milk on floor, a musty odor, and grime was built up along the walls and corners.		management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility, nor does this submission constitute an agreement or admission of the survey allegations. Green Valley Care Center would like to request paper compliance via a desk review. F 812 **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?**On 8/21/23, the ED/designee completed an audit and ensured that food has been properly dated with preparation dates and expiration dates and disposed of any food items that were expired and/or was not properly labeled/dated. Paper Towel dispenser replaced and a trash can was placed by the sink to dispose of paper towels. Milk was cleaned up and the freezer was cleaned. Items that were located under the steam and coffee tables were removed, and the floors were swept and cleaned. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be**	

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	- A large container containing approximately 2 quarts of orange juice was dated 8/5 only. There was no indication of open, preparation or expiration date. - In the dry storage area there was Worcestershire sauce in a gallon container which was opened 12/23/22 with an expiration date of 6/9, pancake and waffle syrup, dated 12/18/22 had no expiration date, a jug of soy sauce which had been open and partially used had no open or expiration date, a jug of teriyaki sauce which had been opened and partially used was dated 2/22 with no expiration date. During an interview on 8/21/23 at 9:38 a.m., the Assistant Dietary Manager indicated there was a lot of stuff not dated. He would add the date when the food was received. He would put the date when the food was opened and when the food expired. For the sandwiches he would put the date it went bad. The food should have both the date prepared and the date to use by. He had made the chicken salad himself. He indicated he had started writing the expiration dates on the foods he prepared because one day a lady had gotten a bologna sandwich with a date that was 3 days prior and she thought it was expired, but what was written on the sandwich was the date it was prepared. They were supposed to put both the prepared date and the expiration date on foods. The produce was good for 7 days, and should have been pulled after that. The cabbages were probably horrible. He indicated they should have been pulled. During an interview on 8/21/23 at 10:17 a.m., Resident F indicated the food was not the best. During an interview on 8/21/23 at 10:30 a.m., Resident E indicated she had concerns with the		**taken?**Residents who receive food from our Dietary Department have the potential to be effected The Dietary Manager/.designee will provide education to the Dietary Manager and the dietary dept associates and will complete routine auditing on the requirement to ensure items are dated/labeled correctly, that expired food and items not appropriately labeled/dated are being disposed of, trash cans and paper towel dispensers are accessible to the sinks and in good working order, that the freezers and refrigerators are routinely cleaned thoroughly and maintained, to ensure handles for refrigerators and freezers are working properly, and that the maintenance requests protocol is being followed and are addressed timely. **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 Dietary Manager/.designee will provide education to the Dietary Manager and the dietary dept associates and will complete routine auditing on the requirement to ensure items are dated/labeled correctly, that expired food and items not appropriately labeled/dated are being disposed of, trash cans and paper towel dispensers are accessible to the sinks and in good working order, that the	

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	food. The food had been cold. A couple weeks ago she asked for a fried bologna sandwich, and they couldn't do it, the next day she asked for another one, and the kitchen sent her a plain bologna sandwich. She gave the sandwich to her nurse, and the nurse asked her where she got it. The nurse indicated the sandwich was outdated and she took it back to the kitchen. The kitchen staff said no it wasn't outdated, they had seven days from the day they made it before it went bad. The very next day she asked for yogurt, the top was bowed, and the date was expired. During an interview on 8/21/23 at 1:14 p.m., the Dietary Manager indicated the kitchen was cleaned daily and there were assignments made for each employee for cleaning the equipment. A trash can with a foot pedal to raise the lid should have been at the sink so employees didn't need to touch the trash can lid. The fresh produce should be kept for 5 days and then thrown away. He was not sure what was going on with the Worcestershire sauce, syrup, soy sauce and teriyaki sauce containers. He wasn't sure why the date on them indicated December and February of 2022. If the gallon containers were open, they would have expired in 7 days and should have been thrown out. Some of the items were there when he started. When the delivery man brought the milk, he just sat it on the floor in the refrigerator and there was usually a leak. Milk then spilled onto the floor. Staff should be marking both the expiration date and the open dates on the food. They needed a consistent process when it came to dating the foods. The facility could not provide a policy for specific guidance on expiration and open dating of foods or expiration of produce. The Executive Director indicated they would follow State guidance.		freezers and refrigerators are routinely cleaned thoroughly and maintained, to ensure handles for refrigerators and freezers are working properly, and that the maintenance requests protocol is being followed and are addressed timely. Any findings will be addressed. /p **The results of these reviews will be discussed at the monthly facility Quality 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.** .	

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