

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155070	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/30/2024
NAME OF PROVIDER OR SUPPLIER  Green Valley Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  3118 Green Valley Rd New Albany, IN 47150	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>34231</p> <p>Based on interview and record review, the facility failed to ensure misappropriation of resident property did not occur for 1 of 3 residents reviewed for misappropriation. (Resident D)</p> <p>Findings include:</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>The State incident report, dated 4/26/24, indicated a narcotic discrepancy had been identified on the Memory Care Unit for Resident D.</p> <p>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.</p> <p>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 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.</p> <p>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.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>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 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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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 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.</p> <p>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.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>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, 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</p> <p>3.1-28(a)</p>		