STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155070	A. Building B. Wing	08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Green Valley Care Center	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)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155070	A. Building B. Wing	08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Green Valley Care Center	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)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free from misappropriation of medications for 1 of 4 residents reviewed for misappropriation. (Resident D)Findings included: The record for Resident D was reviewed, on 8/4/25 at 12:37 p.m. The diagnoses included, but were not limited to, anxiety disorder, bipolar disorder, generalized anxiety disorder, unspecified intellectual disabilities, major depressive disorder, front-temporal neurocognitive disorder, and dementia. The Quarterly Minimum Data Set (MDS) Assessment, dated 5/12/25, indicated the resident was severely cognitively impaired. The review of the incident report, dated 7/27/25, indicated a staff member was suspected of taking narcotic medications from the resident for her personal use. The staff member involved was a Licensed Practical Nurse (LPN). During an interview on 8/4/25 10:13 a.m., Certified Nurse aide 4 (CNA) indicated that the resident does not show signs of pain most of the time, but does get agitated from time to time. CNA 4 would let the nurse know if the resident needed something for pain or agitation. The CNA 4 indicated the resident was non-verbal and fully dependent on staff members for assistance. The review of the police report on 8/4/25 at 12:45 p.m., indicated that a police department had been notified of a misappropriation of narcotic medication at the facility. The physicians order dated 4/1/25 indicated on 8/4/25 at 12:47 p.m., the resident was to receive LORazepam Concentrate 2 milligrams/milliliter (MG/ML) 0.25 milliliter by mouth every six hours as needed for anxiety or restlessness. The physician order dated 7/14/25, indicated Morphine Sulfate (Concentrate) Oral Solution 100 MG/5ML Give 0.5 ml by mouth every 2 hours as needed (PRN) for shortness of breath or pain. The record indicated that Morphine Sulfate (Concentrate) Oral Solution 100 MG/5ML 0.5 ml by mouth two times a day for pain.During an observation, on 8/4/25 at 10:00 a.m., the Assistant Director of Nursing (ADON) and Licensed Practical Nurse (LPN) 5 were observed doing a narcotic count on the 100 hall. No discrepancies were observed.During an interview on 8/4/25 at 10:10 a.m., The ADON indicated management would randomly go to the units and do a narcotic count as part of their audit. She indicated they were doing the random counts because a staff nurse was caught stealing narcotics. She indicated on the 200 hall the Qualified Medication Aide 7 (QMA) observed LPN 6 going into resident room [ROOM NUMBER]. When the QMA entered the room, she did not see the LPN 6 in the resident room. After being in the room for 15 to 20 minutes, QMA 7 left the room and walked across the hallway and observed LPN 6 coming out of the resident's bathroom. She indicated LPN 6 was not acting right at that time. At 5:15 p.m., LPN 6 indicated to QMA 7 she accidentally urinated on herself and needed to go home. QMA 7 indicated LPN 6 wanted her to do a narcotic count with her. QMA 7 informed LPN 6 she could not do a narcotic count because she was not a nurse. The LPN 6 had signed out the Ativan tablets for a resident that was not in the building. LPN 6 wanted another nurse to count the narcotics at shift change because she was leaving the facility. The staff members refused to count the narcotics. When the night shift nurse came on duty and did the count the narcotic count was not accurate, and the liquid Ativan was removed, and the container was filled with water. LPN 6 was removed from the facility, and the police and management were notified.The Abuse, Neglect and Exploitation policy, provided on 8/4/25 at 1:20 p.m. by the Executive Director included, but was not limited to, .1. Misappropriate of property.deliberate misplacement, exploitation or wrongful of resident property without their consent.3. Examples of misappropriation.l. Missing prescription medication or diversion of a resident's medication included, but were not limited to controlled substances for staff use. The deficiency cited was past non-compliance, on 7/29/25 when the facility had completed staff education 7/29/25 related to abuse and misappropriation of medication; narcotic count at shift change policy; and education on medication documentation. Additionally, the Director of Nursing/Assistant Director of Nursing will audit narcotic count sheets twice a day for 14 days, and weekly for 2 weeks and report back to the Quality Assurance and Performance Improvement (QAPI) team weekly for 4 weeks.3.1-28 (a)