STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155188	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenfield Healthcare Center	200 Green Meadows Dr Greenfield, IN 46140

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. 36942 Based on interview and record review, the facility failed to ensure misappropriation of residents' medication did not occur for 1 of 3 residents reviewed for medication administration. (Resident C) Findings include: The clinical record for Resident C was reviewed on 9/5/24 at 2:00 p.m. The diagnoses included, but were not limited to, hemiplegia and hemiparesis following cerebrovascular disease. An incident report, dated 7/24/24, indicated a discrepancy in the narcotic sign off sheet for Resident C that involved Registered Nurse (RN) 2. A physician order, dated 7/16/24, indicated to administer hydrocodone-acetaminophen (narcotic pain relief medication) 10-325 milligrams (mg) every four hours, scheduled, for pain. A controlled drug administration record, dated July 2024, for Resident C's hydrocodone-acetaminophen 10-325 mg tablet indicated the following discrepancies signed off by RN 2: - 7/17/24 at 8:00 a.m., the amount went from 79 to 77 tablets, - 7/19/24 in the morning., the amount went from 68 to 66 tablets, & - 7/22/24 at 8:00 a.m., the amount went from 48 to 46 tablets. A written statement by Qualified Medication Aide (QMA) 3, undated, indicated there were three open bottles of hydrocodone but only one was in use. QMA 3 reviewed the narcotic log and found a count error on several occasions and reported such to the Director of Nursing. A telephone interview conducted with RN 2, on 9/5/24 at 2:16 p.m., indicated he would remove two hydrocodone-acetaminophen 10-325 milligram tablets for Resident C. He would administer one to Resident C and take one for himself. There were five to six instances of RN 2 taking two tablets of narcotic pain medication to administer one to Resident C and keep one for himself. Resident C did not go without his narcotic pain medication. (continued on next page)

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

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview conducted with the Executive Director (ED), on 9/5/24 at 12:50 p.m., indicated when QMA 3 noticed the discrepancy, they notified the ED and the Director of Nursing. The narcotic logs were reviewed, and all medication carts were audited to ensure no further concerns with residents' narcotic medications. The ED spoke with RN 2, and he admitted to taking Resident C's narcotic pain medication on more than one occasion. A policy titled Medication Controlled Drugs and Security, undated, was provided by the ED on 9/5/24 at 1:55 p.m. The policy indicated, .Procedure .d. Drug diversion will be treated as misappropriation of Resident Property and the Board of Nursing will be notified as appropriate for known drug diversions or suspected drug diversion after careful review and evidence collection A policy titled Abuse & Neglect & Misappropriation of Property, undated, was provided by the ED on 9/5/24 at 1:55 p.m. The policy indicated the following, .It is the intent of this facility to prevent the abuse, mistreatment, or neglect of residents or the misappropriation of their property .provide guidance to direct staff to manage any concerns or allegations of abuse, neglect or misappropriation of their property The Past Noncompliance began on 7/17/24. The deficient practice was corrected on 7/24/24 after the facility implemented a systemic plan that included the following: audits completed of all medication carts that contained narcotic medication; nurses and qualified medication aides were educated of medication administration, misappropriation of property, and abuse policy; and medication was reordered from the pharmacy and billed to the facility to cover the cost of the medication. This citation relates to Complaint IN00439505. 3.1-28(a)