STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	12/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
EVERGREEN VILLAGE AT BLOOMINGTON	3607 SOUTH HEIRLOOM DRIVE BLOOMINGTON, IN 47401

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R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00418647. Complaint IN00418647 - State deficiencies related to the allegation are cited at R64. Survey date: December 7, 2023 Facility number: 014002 Residential Census: 114 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed December 12, 2023.	R 0000	Evergreen Village at Bloomington – Plan of Correction: Survey Date: 12/7/23 Citation: R0064: Based on observation, interview and record review, the facility failed to exercise reasonable care for the protection of the residents' medication from loss and theft for 2 of 2 residents reviewed. Controlled substance logs were not completed, and narcotic medications were missing. Our Plan of Correction for citation R0064: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Correction- Community upon discovery of these missing medications immediately notified the pharmacy and replacement medication was sent in order to ensure all residents affected had the proper medication. No adverse effects were reported. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. Correction- Facility completed an audit of all other resident medication at the time of	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Josh Dodds	Executive Director	12/27/2023

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			the incident. No other resident medication had any irregular concerns at the time of the audit. Correction- Community will begin a plan of correction that includes increased audits for an acceptable period of time by the Executive Director/DON or designee to ensure compliance. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. Correction-Community completed an in-service for all staff members to educate them on the procedure of signing off on the controlled substance log. Community completed education on ensuring narcotics counts are done properly according to protocol. Correction- Community will begin a plan of correction that includes increased audits for an acceptable period of time by the Executive Director/DON or designee to ensure compliance with this regulation. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Correction: Community will complete audits by the Executive Director/DON or designee of the	

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			controlled substance logs and narcotic count sheets to ensure compliance (3 times per week for 4 weeks, 2 times per week for 4 weeks and then 1 time per week for 4 weeks) to ensure compliance. Correction: Community QAPI program will review audit sheets monthly for 3 months in their meetings to ensure we are properly following our plan of correction. By what date the systemic changes will be completed. Correction: Community compliance date 12/27/23	
R 0064 Bldg. 00	410 IAC 16.2-5-1.2(hh) Residents' Rights- Noncompliance (hh) The facility shall exercise reasonable care for the protection of residents ' property from loss and theft. The administrator or his or her designee is responsible for investigating reports of lost or stolen resident property and that the results of the investigation are reported to the resident. Based observation, interview and record review, the facility failed to exercise reasonable care for the protection of the residents' medication from loss and theft for 2 of 2 residents reviewed. Controlled substance logs were not completed and narcotic medications were missing. (Resident B, Resident C) Findings include: 1. On 12/7/23 at 11:05 a.m., Resident B's clinical record was reviewed. The diagnoses included, but	R 0064	Evergreen Village at Bloomington – Plan of Correction: Survey Date: 12/7/23 Our Plan of Correction for citation R0064: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Correction- Community upon discovery of these missing	12/27/2023

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	were not limited to, diabetes mellitus, end stage renal disease, and pain. The September 2023 Physician Order indicated oxycodone (pain medication) 5 milligrams (mg) by mouth at bedtime. The September 2023 Medication Administration Record indicated oxycodone 5 mg by mouth at bedtime was "suspended" due resident was away on a medical leave of absence. The Communication Log, dated 9/24/23 at 1:58 p.m., indicated Resident B remained on medical leave of absence. The Communication Log, dated 9/25/23 at 12:50 p.m., indicated Resident B remained on medical leave of absence. Resident B's Narcotic Count sheet indicated the following: - On 9/24/23 at 8:00 p.m., oxycodone 5 mg was signed out. - On 9/25/23 at 8:00 p.m., oxycodone 5 mg was signed out. The September 2023 Controlled Substance Log for Floor 2 (where Resident B resided) indicated the following: - On 9/25/23, the first shift on lacked a signature. - On 9/25/23, the first shift off lacked a signature. - On 9/26/23, the second shift on lacked a signature. - On 9/26/23, the second shift off lacked a signature. - On 9/28/23, the first shift on lacked a signature. - On 9/28/23, the first shift off lacked a signature. - On 9/28/23, the second shift on lacked a		medications immediately notified the pharmacy and replacement medication was sent in order to ensure all residents affected had the proper medication. No adverse effects were reported. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. Correction- Facility completed an audit of all other resident medication at the time of the incident. No other resident medication had any irregular concerns at the time of the audit. Correction- Community will begin a plan of correction that includes increased audits for an acceptable period of time by the Executive Director/DON or designee to ensure compliance. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. Correction-Community completed an in-service for all staff members to educate them on the procedure of signing off on the controlled substance log. Community completed education on ensuring narcotics counts are done properly according to protocol. Correction- Community will	

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	signature. - On 9/28/23, the second shift off lacked a signature. - On 9/29/23, the third shift on lacked a signature. - On 9/30/23, the third shift off lacked a signature. - On 9/30/23, the first shift on lacked a signature. - On 9/30/23, the first shift off lacked a signature. - On 9/30/23, the second shift on lacked a signature. - On 9/30/23, the second shift off lacked a signature. - On 9/30/23, the third shift on lacked a signature. 2. On 12/7/23 at 11:10 a.m., Resident C's clinical record was reviewed. The diagnoses included, but were not limited to, congestive heart failure, arthritis, and pain. The September 2023 Physician Order indicated Norco (pain medication) 5-325 mg by mouth as needed twice a day. On 9/19/23, the pharmacy delivery sheet indicated Resident C received 60 pills. The September 2023 Medication Administration Record indicated Norco 5-325 mg was not taken. The October 2023 Medication Administration Record indicated Norco 5-325 mg was not taken. The clinical record lacked documentation of a Narcotic Count Sheet for the Norco 5-325 mg. The September 2023 Controlled Substance Log for Floor 1 (where Resident C resided) indicated the following: - On 9/20/23, the first shift on lacked a signature. - On 9/20/23, the first shift off lacked a signature. - On 9/22/23, the second shift on lacked a		begin a plan of correction that includes increased audits for an acceptable period of time by the Executive Director/DON or designee to ensure compliance with this regulation. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Correction: Community will complete audits by the Executive Director/DON or designee of the controlled substance logs and narcotic count sheets to ensure compliance (3 times per week for 4 weeks, 2 times per week for 4 weeks and then 1 time per week for 4 weeks) to ensure compliance. Correction: Community QAPI program will review audit sheets monthly for 3 months in their meetings to ensure we are properly following our plan of correction. By what date the systemic changes will be completed. Correction: Community compliance date 12/27/23	

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	signature. - On 9/22/23, the second shift off lacked a signature. - On 9/27/23, the second shift off lacked a signature. - On 9/27/23, the third shift on lacked a signature. - On 9/28/23, the third shift off lacked a signature. - On 9/29/23, the first shift on lacked a signature. - On 9/29/23, the first shift off lacked a signature. - On 9/29/23, the second shift on lacked a signature. - On 9/29/23, the second shift off lacked a signature. - On 9/29/23, the third shift on lacked a signature. - On 9/30/23, the third shift off lacked a signature. - On 9/30/23, the first shift on lacked a signature. - On 9/30/23, the first shift off lacked a signature. - On 9/30/23, the second shift on lacked a signature. - On 9/30/23, the second shift off lacked a signature. - On 9/30/23, the third shift on lacked a signature. During an interview on 12/7/23 at 11:00 a.m., the Director of Nursing (DON) indicated Resident B had missing oxycodone 5 mg and Resident C had missing Norco 5-325 mg. During an interview on 12/7/23 at 11:15 a.m., DON indicated Resident B had oxycodone 5 mg signed out on the Narcotic Count Sheet on 9/24/23 and 9/25/23 at 8:00 p.m. She should not have had any oxycodone signed out on those days because she was on a medical leave of absence. After Resident B had missing medication, the facility did an audit and realized Resident C had missing Norco 5-325 mg. The medication and the medication's narcotic count sheet was missing. Resident B and Resident C's medications were stored in a locked box in the medication room in the clinic room. The nurse or			

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	qualified medication aide (QMA) would count the medications stored in the locked box in the medication room and sign the Controlled Substance Log when they come on their shift and off their shift. On 12/7/23 at 12:15 p.m., the medication room in the clinic room was observed with the DON. The medication room was observed to have 3 doubled locked boxes. Licensed Practical Nurse (LPN) 1 indicated when they come on and off their shift, they count each medication in the locked boxes and sign the Controlled Substance log. At that time, LPN 1 was observed to sign the "first shift on" on the Controlled Substance Log. During an interview on 12/7/23 at 2:30 p.m., the DON indicated the September 2023 Controlled Substance Log had holes on the log. Even if the nurse or QMA worked a 12 hour shift, they should indicate the 12 hour shift on the log. On 12/7/23 at 2:30 p.m., the DON provided the facility's policy, "Medication Management, Administration, & Storage," dated 10/31/23, and indicated it was the policy being used by the facility. A review of the policy indicated, "...1. It is the responsibility of all authorized healthcare professionals to ensure that all medications are appropriately secured at all times except when authorized personnel are present..." This tag relates to Complaint IN00418647.			