STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155625	A. Building B. Wing	07/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Grove Village	1021 E Central Ave Greensburg, IN 47240

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. Based on record review and interview, the facility failed to ensure misappropriation of resident's medications did not occur for 2 of 3 residents reviewed for misappropriation. (Resident B and Resident C) Findings include:1. During an interview, on 07/18/25 at 9:18 A.M., Registered Nurse (RN) 2 indicated that Resident B requested pain medication on 06/19/25 around 10:00 P.M While administering the medication she noticed the pills popped out of the card lightly. Upon observation, she identified tape on the back of the card holding in the two pills she had dispensed. Both pills were different shapes and upon observation one had a small, scratched mark in the center of it to make it appear scored. She immediately contacted the Director of Nursing (DON) and notified her of the findings. After she checked the entire medication cart for other discrepancies, she determined Resident C also had a medication taped back into his narcotic medication card. The clinical record for Resident B was reviewed on 07/18/2025 10:20 AM. A Quarterly Minimum Data Set (MDS) assessment, dated 07/02/25, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, hypertension, malnutrition, and Parkinson's disease. A current physician's order, with a start date of 04/07/25, indicated that staff were to administer Norco (a narcotic pain medication), 5-325 milligrams (mg), 2 tablets by mouth every six hours as needed for pain. A controlled drug record for Norco for Resident B, dated 05/30/25, indicated the medication was signed out by RN 4 on 06/19/25 at 05:00 P.M. changing the quantity from 15 pills to 13 pills. On 06/19/25 at 11:00 P.M. RN 2 changed the quantity remaining to 11 pills, after discovering the two pills packaging for #13, and #12 were altered and they were not the correct medication. Then reduced it into 9 pills remaining after administrating two unaltered pills to the resident. During an interview, on 07/18/2025 10:49 AM., Resident B indicated she usually asked for pain medicine at night before bed and just took a Tylenol during the day if she was feeling some pain. During an interview, on 07/17/2025 10:50 AM, Licensed Practical Nurse (LPN) 3 indicated she was orienting RN 4 on 06/19/25. It was RN 4's first day on orientation, so that morning she just watched LPN 3 pass morning medications. Around 10:00 A.M. RN 4 asked to have the keys to the medication cart so that she could familiarize herself with the cart. LPN 3 gave RN 4 the keys to the cart. Later, RN 4 asked if she could do some insulins before lunch and LPN 3 allowed her to. Then she returned the keys back to her before they left for lunch. After lunch RN 4 asked for the keys to the cart again to administer an oral medication that a resident took after lunch. An extended period of time went by after RN 4 went to give the oral medication, so LPN 3 went looking for her. LPN 3 could not find RN 4. During a second attempt with additional staff, they located her in a resident's bathroom. RN 4 stated she had washed her hands. Later that evening RN 4 questioned LPN 3 asking if she was pretty good at memorizing her pills. LPN 3 stated she never administered the medications without the Medication Administration Record in front of her to prevent any errors. During evening shift change the narcotic medications were counted with on coming staff. RN 4 counted with night shift, and all counts appeared correctly because there were pills in each bubble. They never looked (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: 155625	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/18/2025
NAME OF PROVIDER OR SUPPLIER Arbor Grove Village		STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E Central Ave Greensburg, IN 47240	

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	at the backside of the cards. LPN 3 stated RN 4 should have never been in the narcotics box at all during their shift. Only one narcotic was administered that day and it was that morning and LPN 3 administered it herself. During an interview, on 07/17/2025 at 10:09 AM, the Director of Nursing (DON) indicated that when she called RN 4 in to investigate the missing narcotics, she admitted to taking the medications. RN 4 stated she replaced the pills with other medications, and stated she checked the resident's allergies to make sure it wouldn't cause a reaction when they received the wrong medication. After they finished their investigation, RN 4 was terminated. 2. The clinical record for Resident C was reviewed on 07/17/2025 3:19 P.M. A Significant Change in Status MDS assessment, dated 06/19/25, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, malnutrition, asthma, and diabetes. A current physician's order, with a start date of 05/16/25, indicated the staff were to administer Norco 5-325 mg, 1 tablet by mouth every six hours as needed for pain to Resident C. A controlled drug record for Norco for Resident C, dated 05/26/25, indicated the medication was signed out by RN 4 on 06/19/25 at 05:10 P.M. changing the quantity from 25 pills to 24 pills. On 06/19/25 at 11:30 P.M. RN 2 corrected the quantity remaining to 23 pills after discovering the #24 pill was not the correct medication and the packaging had been altered. The current facility policy titled, Abuse Prohibition, Reporting, and Investigation, with a revision date of June 2023, was provided by the DON on 07/17/25 at 11:20 A.M. The policy indicated, .the policy. to provide each resident with an environment free from abuse, neglect, misappropriation of resident property.misappropriation of resident funds or property - deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's property or money without the resident's consent . This deficient practice was corrected on 07/09/25 after the facility reviewed records, assessed residents, educated staff, discharged the staff member, and added new audits for monitoring narcotic counts. This citation relates to Complaint 1808214. 3.1-28(a)