

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155412 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 01/29/2016 |
|--|---|--|---|

| | |
|---|--|
| NAME OF PROVIDER OR SUPPLIER GREENWOOD HEALTH AND LIVING COMMUNITY | STREET ADDRESS, CITY, STATE, ZIP CODE 937 FRY RD GREENWOOD, IN 46142 |
|---|--|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|--|---------------|---|----------------------|
|--------------------|--|---------------|---|----------------------|

| | | | | |
|------------------------|--|--------|--|--|
| F 0000 Bldg. 00 | <p>This visit was for a Recertification and State Licensure Survey.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00191292.</p> <p>Survey dates: January 21, 22, 25, 26, 27, 28, and 29, 2016.</p> <p>Facility number: 000509 Provider number: 155412 AIM number: 100266620</p> <p>Census bed type: SNF: 02 SNF/NF: 84 Total: 86</p> <p>Census payor type: Medicare: 08 Medicaid: 67 Other: 11 Total: 86</p> <p>Greenwood Health And Living Community was found to be in substantial compliance with 42 CFR Part 483, Subpart B in regard to the Recertification and State Licensure Survey. This deficiency reflects State findings cited in accordance with 410</p> | F 0000 | | |
|------------------------|--|--------|--|--|

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

| | | | |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155412 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | X3) DATE SURVEY COMPLETED 01/29/2016 |
|--|---|---|---|

| | |
|---|--|
| NAME OF PROVIDER OR SUPPLIER GREENWOOD HEALTH AND LIVING COMMUNITY | STREET ADDRESS, CITY, STATE, ZIP CODE 937 FRY RD GREENWOOD, IN 46142 |
|---|--|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|----------------------------|---|---------------|---|----------------------|
| F 0278 SS=A Bldg. 00 | <p>IAC 16.2-3.1.</p> <p>Q.R. completed by 14466 on February 01, 2016.</p> <p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on interview and record review,</p> | F 0278 | The plan of correction is to serve | 02/12/2016 |

| | | | | | | | |
|---|--|---|---|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155412 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 01/29/2016 | |
| NAME OF PROVIDER OR SUPPLIER GREENWOOD HEALTH AND LIVING COMMUNITY | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 937 FRY RD GREENWOOD, IN 46142 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | | | |
| | <p>the facility failed to ensure Minimum Data Set (MDS) assessments accurately reflected the medications residents received for 2 of 5 residents who met the criteria for review of unnecessary medication use. (Resident #24 and Resident #69)</p> <p>Findings include:</p> <p>1. The clinical record review for Resident #24 was completed on 1/28/16 at 9:23 a.m. Diagnoses included, but were not limited to, anxiety and major depressive disorder.</p> <p>A quarterly MDS assessment dated 1/6/16, indicated the resident received an antianxiety medication only 3 out of 7 days and an antidepressant medication 0 out of 7 days. This MDS was signed by RN #1, verifying the accuracy of assessment.</p> <p>A review of the Medication Administration Record (MAR) (the documentation used for the medication assessment on the 1/6/16, MDS) dated 12/31/15 through 1/6/16, indicated Resident #24 received Ativan (a medication used to treat anxiety) and Celexa (a medication used to treat depression) daily between 12/31/15 and 1/6/16.</p> | | <p>as Greenwood Health and Living Community's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Greenwood Health and Living Community or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations. F 278 483.20(g)-(j) ASSESSMENT ACCURACY/CORRECTION/CERTIFIED</p> <p>I. The corrective actions to be accomplished for those residents found to have been affected by the practice. On 01/29/16 a correction request was submitted in regards to the quarterly assessment for resident #24. On 01/29/16 a correction request was submitted in regards to the annual assessment for resident #69. II. The facility will identify other residents that may potentially be affected by the practice. Residents who reside at Greenwood Health and Living Community and receive psychoactive medications have the potential to be affected. The MDS assessments for other residents receiving psychoactive medications will be reviewed for coding accuracy and correction requests will be submitted in accordance with RAI manual</p> | | | | |

| | | | |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155412 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | X3) DATE SURVEY COMPLETED 01/29/2016 |
|--|---|---|---|

| | |
|---|--|
| NAME OF PROVIDER OR SUPPLIER GREENWOOD HEALTH AND LIVING COMMUNITY | STREET ADDRESS, CITY, STATE, ZIP CODE 937 FRY RD GREENWOOD, IN 46142 |
|---|--|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|--|---------------|--|----------------------|
| | <p>On 1/29/15 at 2:48 p.m., the MDS Coordinator indicated Resident #24 did receive an antianxiety and antidepressant medication daily between 12/31/15 and 1/6/16. She indicated the MDS dated 1/6/16, section N, was coded incorrectly.</p> <p>2. The clinical record review for Resident #69 was completed on 1/28/16 at 11:37 a.m. Diagnoses included, but were not limited to, insomnia.</p> <p>An annual MDS assessment dated 11/5/15, indicated the resident did not receive a hypnotic medication.</p> <p>A review of the MAR (Medication Administration Record) dated 10/30/15 through 11/5/15, (the documentation used for the medication assessment on the 11/5/15, MDS) indicated Resident #69 received Lunesta (a medication to treat sleep problems) daily between 10/30/15 and 11/5/15.</p> <p>On 1/29/15 at 2:48 p.m., the MDS Coordinator indicated Resident #69 did receive a hypnotic medication daily between 10/30/15 and 11/5/15. She indicated the MDS dated 11/5/15, section N, was coded incorrectly.</p> <p>3.1-31(i)</p> | | <p>guidelines. III. The facility will put into place the following systematic changes to ensure that the practice does not recur.</p> <p>The MDS coordinator will be re-educated by the Clinical Navigation Specialist regarding coding medications accurately on MDS assessments. IV. The facility will monitor the corrective action by implementing the following measures. A CQI audit tool will be utilized by the Director of Nursing or designee to audit MDS assessments daily for those residents receiving psychoactive medications, when an assessment is completed, for 30 days. If 100% compliance is attained, the Director of Nursing or designee will then audit 3 MDS assessments weekly for 60 days.</p> <p>The Clinical Navigation Specialist will audit five MDS assessments for those residents receiving psychoactive medications monthly for a period of 12 months to ensure ongoing compliance. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. V. Plan of Correction completion date.</p> <p>Date of Compliance 02/12/2016 The Administrator will be</p> | |

| | | | | | |
|---|--|--|--|----------------------------|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155412 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | | X3) DATE SURVEY COMPLETED 01/29/2016 |
| NAME OF PROVIDER OR SUPPLIER GREENWOOD HEALTH AND LIVING COMMUNITY | | | STREET ADDRESS, CITY, STATE, ZIP CODE 937 FRY RD GREENWOOD, IN 46142 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| | | | responsible for ensuring the facility is in compliance by date of compliance listed. | | |