STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENBRIAR VILLAGE	8800 SPOON DR, INDIANAPOLIS, , 46219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for the Investigation of Intake IN00465148 and Intake IN00465055. Intake IN00465148 - No deficiencies related to the allegations are cited. Intake IN00465055 - No deficiencies related to the allegations are cited. Unrelated deficiency is cited. Survey dates: October 1 and 2, 2025 Facility number: 011799 Residential Census: 93 These State Residential findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on October 6, 2025.	R 0000	This Plan of Correction is submitted as required under State law. The submission of this Plan of Correction does not constitute an admission on the part of Greenbriar Village as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. The submission of this Plan of Correction does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures, as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any judicial and/or administrative	

			proceeding on that basis. The Community also submits this Plan of Correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.	
R 0216	Evaluation - Noncompliance 410 IAC 16.2-5-2(c)(1-4)(d) (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on observation,	R 0216	R216 1 Resident D’s medications will not be left in her apartment since she is unable to self-administer medication. 2 The Community reviewed each resident’s record to determine which residents, if any, could be affected by the alleged deficient practice. 3 The Executive Director or designee will conduct in-services to educate all QMAs and nurses on proper medication administration. The QMA who left the medication unattended was	10/26/2025

	interview, and record review, the facility failed to ensure a self-medication assessment was completed prior to leaving medication in a resident's apartment for 1 of 1 resident randomly observed for self-medication (Resident D). Findings include: The clinical record for Resident D was reviewed on 10/2/25 at 11:30 a.m. The resident's diagnoses included, but were not limited to, hypertension and dementia. A service plan, dated 5/12/25, indicated Resident D required assistance with medication management. The goal was for the care team to support her in the 7 rights of medication management including storing and receiving her medications in a safe and timely manner. On 10/2/25 at 1:12 p.m., Resident D was observed in her room. She was sitting in a recliner chair and there was a plastic medication cup sitting on the end table beside her. The plastic medication cup had HS (at hour of sleep) written on the outside of the cup. There was 1/2 of a while tablet inside of the cup. Resident D indicated the nurse had left it for her to take later. On 10/2/25 at 1:22 p.m., Resident D was observed with		educated on the seven rights to medication before working. 4 The Wellness Director or designee will perform a medication administration audit on 2 staff members a week for 1 month, then 2 staff members a month for 5 months. 5 Systemic changes will be completed by October 26, 2025.	

the Wellness Director (WD) in her room. Resident D was lying in bed. The plastic medicine cup was sitting on the end table in her living room. The WD asked Resident D who had left the pill for her to take. Resident D indicated it was a female nurse. The WD removed the pill from Resident D's room.

During an interview on 10/2/25 at 1:24 p.m., the WD indicated Resident D should not have medication left in her room for her to take independently. Resident D was confused and unable to self-medicate. Resident D did not have a self-medication assessment in her medical record.

During an interview 10/2/25 at 2:10 p.m., the WD indicated the facility did not have a Self-Medication policy. They followed the State regulations.

Based on observation, interview, and record review, the facility failed to ensure a self-medication assessment was completed prior to leaving medication in a resident's apartment for 1 of 1 resident randomly observed for self-medication (Resident D).

Findings include:

The clinical record for Resident D was reviewed on 10/2/25 at 11:30 a.m. The resident's diagnoses included, but were

not limited to, hypertension and dementia.

A service plan, dated 5/12/25, indicated Resident D required assistance with medication management. The goal was for the care team to support her in the 7 rights of medication management including storing and receiving her medications in a safe and timely manner.

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On 10/2/25 at 1:22 p.m., Resident D was observed with the Wellness Director (WD) in her room. Resident D was lying in bed. The plastic medicine cup was sitting on the end table in her living room. The WD asked Resident D who had left the pill for her to take. Resident D indicated it was a female nurse. The WD removed the pill from Resident D's room.

During an interview on 10/2/25 at 1:24 p.m., the WD indicated Resident D should not have

	medication left in her room for her to take independently. Resident D was confused and unable to self-medicate. Resident D did not have a self-medication assessment in her medical record. During an interview 10/2/25 at 2:10 p.m., the WD indicated the facility did not have a Self-Medication policy. They followed the State regulations.			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATUREDana	TITLEMilner	(X6) DATE10/16/2025