STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	09/09/2025

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 IN00464377. Intake IN00464377 - State deficiencies related to the allegations are cited at R0052. Survey date: September 9, 2025 Facility number: 011799 Residential Census: 97 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on September 10, 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 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on interview and record review, the facility failed to ensure a resident remained free from abuse by a staff member for 1 of 3 residents reviewed for abuse. (Resident B) Findings include: The clinical record for Resident B was reviewed on 9/9/25 at 11:00 a.m. The diagnoses included, but were not limited to,	R 0052	1 Resident B is free from abuse. A head-to-to-toe skin assessment of Resident B was completed with no injuries or areas of concern. In addition, CNA 2 was terminated based on the investigation’s findings. 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 staff on abuse prevention and the Community’s	09/22/2025

	dementia, muscle weakness, and cognitive impairment. A service plan, dated 4/18/25, indicated Resident B had disorientation, memory loss, and difficulty completing tasks. Resident B was independent with transfers, independent with mobility, and was identified as a fall risk. An incident reported to the Indiana Department of Health Survey Report System, dated 8/25/25 at 9:21 p.m., indicated camera surveillance identified a resident (Resident B) on the ground in their room. "Upon reviewing the footage, prior to the fall, resident [name of Resident B] was observed on her roommate's [Resident C] side of the room going through the chest of drawers. CNA [Certified Nurse Aide 2] entered the room escorting the resident [Resident C]...to her bed. In a attempt to redirect [Resident B] out of the room, it was determined that [CNA 2] caused resident [Name of Resident B] to fall on her right anterior side due to mishandling and improper redirection technique. Resident [B] resides in a secure memory care unit...." The follow up, dated 8/29/25, indicated CNA 2 was terminated from the facility. The investigation file for the incident regarding Resident B		abuse policy and reporting guidelines. 4 The Wellness Director or designee will question random team members on abuse prevention and the Community's abuse policy and reporting guidelines once per week for one month, then monthly for five months.	

and CNA 2 was provided by the Executive Director (ED) on 9/9/25 at 11:15 a.m. The file included, but was not limited to, the following:

A written statement signed by the ED, dated 8/25/25, indicated a telephone interview was conducted with the ED and CNA 2. CNA 2, when asked about Resident B's fall, on 8/25/25, CNA 2 stated "nothing, she threw herself on the floor".

A Daily Shower Sheet form, dated 8/25/25 at 10:00 p.m., indicated no skin concerns to Resident B but a comment of "states minor pain on left arm at time of fall but not after a few minutes. No bruises."

Camera footage of Resident B's room during the time of the incident, dated 8/25/25 from 9:20 p.m. to 9:22 p.m., was reviewed with the ED on 9/9/25 at 10:30 a.m. On 8/25/25 at 9:20 p.m., Resident B was observed entering the room she resided in but on her roommate's (Resident C's) side of the room. Resident B moved Resident C's pillows around on the bed along with pulling Resident C's covers back on the bed. Resident B proceeded to go towards the corner of the room, adjacent to the window, to where a dresser was located. Resident B moved the bedside table to gain access to the

dresser. Resident B removed some articles of clothing, folded them, and placed them back in Resident C's dresser drawer. At 9:21 p.m., CNA 2 then entered Resident C's room while pushing Resident C in her wheelchair and after entering, CNA 2 took her hands off of the wheelchair handles, while the wheelchair was still moving, and proceeded to walk towards the corner of Resident C's room where Resident B was at. The wheelchair, with Resident C still sitting in, continued to move until Resident C's knees made contact with the foot of her bed and caused the wheelchair to stop moving. CNA 2 went towards Resident B and CNA 2 placed both of her hands on each side of Resident B's torso, while attempting to move Resident B. Resident B then fell onto the floor, lying on her stomach, and her facing her head towards the left side. At 9:22 p.m., CNA 2 placed both of her hands on each side of Resident B, just underneath her armpits, and picked her up off of the floor. Resident B was able to place her feet onto the floor and hold herself up while being lifted by CNA 2 and Resident B found her foot placement. Resident B then proceeded to walk out of the room. During the observation of the video footage, the ED indicated CNA 2 stated Resident B put herself onto the floor. The ED indicated

she believed that was not the best approach with redirecting a resident with dementia. The ED could not tell if CNA 2 intentionally pushed the resident or if Resident B's legs gave out while CNA 2 was attempting to redirect Resident B out of Resident C's side of the room. CNA 2 was terminated after the video footage was reviewed by the ED and the corporate office.

A telephone interview was conducted with CNA 2 on 9/9/25 at 11:05 a.m. She indicated Resident B "kind of laid on the ground". Resident B had behaviors with her dementia that were consistent with wandering and taking items out of her roommate's room. CNA 2 was attempting to lay down Resident C and saw Resident B by the dresser on Resident C's side of the room. CNA 2 attempted to get close to the dresser to close it and that's when Resident B laid herself on the ground.

A policy entitled ABUSE PREVENTION POLICY, dated 8/10/18, was provided by the ED on 9/9/25 at 11:15 a.m. It indicated the policy was to protect residents from abusive acts. The definition of abuse was the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse also

included the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Physical abuse included, but was not limited to, hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment. The staff would be trained to identify behaviors which could potentially lead to abuse. Behaviors which will not be tolerated by the facility include being disrespectful, inappropriate gestures, arguing with a resident, roughness while providing physical assistance and care, lack of patience, and/or making remarks which frighten a resident.

This citation relates to Intake IN00464377.

Based on interview and record review, the facility failed to ensure a resident remained free from abuse by a staff member for 1 of 3 residents reviewed for abuse. (Resident B)

Findings include:

The clinical record for Resident B was reviewed on 9/9/25 at 11:00 a.m. The diagnoses included, but were not limited to, dementia, muscle weakness, and cognitive impairment.

A service plan, dated 4/18/25,

indicated Resident B had disorientation, memory loss, and difficulty completing tasks. Resident B was independent with transfers, independent with mobility, and was identified as a fall risk.

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The investigation file for the incident regarding Resident B and CNA 2 was provided by the Executive Director (ED) on 9/9/25 at 11:15 a.m. The file included, but was not limited to,

the following:

A written statement signed by the ED, dated 8/25/25, indicated a telephone interview was conducted with the ED and CNA 2. CNA 2, when asked about Resident B's fall, on 8/25/25, CNA 2 stated "nothing, she threw herself on the floor".

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intentionally pushed the resident or if Resident B's legs gave out while CNA 2 was attempting to redirect Resident B out of Resident C's side of the room. CNA 2 was terminated after the video footage was reviewed by the ED and the corporate office.

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	physical, mental, and psychosocial well-being. Physical abuse included, but was not limited to, hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment. The staff would be trained to identify behaviors which could potentially lead to abuse. Behaviors which will not be tolerated by the facility include being disrespectful, inappropriate gestures, arguing with a resident, roughness while providing physical assistance and care, lack of patience, and/or making remarks which frighten a resident. This citation relates to Intake IN00464377.			

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 SIGNATUREMelusine McDaniel	TITLERegional Director of Operations	(X6) DATE09/26/2025