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	02/23/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
R 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00401690, IN00401349, and IN00393176. Complaint IN00401690 - Substantiated. State deficiencies related to the allegations are cited at R0091 and R0217. Complaint IN00401349 - Substantiated. State deficiencies related to the allegations are cited at R0217and R0240. Complaint IN00393176 - Substantiated. State deficiencies related to the allegations are cited at R0091, R0217, and R0240. Survey Dates: February 21, 22, and 23, 2023 Facility Number: 011799 Residential: 97 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on February 27, 2023	R 0000	**This plan of correction is submitted as required under State and Federal 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. Submission of this Plan of Correction also 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 proceeding on that basis. The Community 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.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Dana Milner	Executive Director	03/15/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	02/23/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
R 0091 Bldg. 00	410 IAC 16.2-5-1.3(h)(1-4) Administration and Management - Noncompliance (h) The facility shall establish and implement a written policy manual to ensure that resident care and facility objectives are attained, to include the following: (1) The range of services offered. (2) Residents' rights. (3) Personnel administration. (4) Facility operations. The policies shall be made available to residents upon request. Based on interview, and record review, the facility failed to report an injury of unknown origin, per policy, for 1 of 3 residents reviewed for abuse (Resident B) Findings include: The clinical record for Resident B was reviewed on 2/21/23 at 11:12 a.m. His diagnoses included, but were not limited to, dementia with behavioral disturbance. The 1/29/23 incident report was provided by the ED (Executive Director) on 2/21/23 at 1:55 p.m. It indicated on 1/29/23 it was reported that Resident B's daughter reported discoloration under his left eye, and that Resident D hit him when Resident B went into Resident D's room. Both residents resided in a secured memory care unit. An investigation was initiated. The 2/4/23 follow up section indicated neither resident had recollection of an altercation. Abuse inservicing continued. The investigative file into the above incident was provided by the ED on 2/21/23 at 1:55 p.m.	R 0091	R 091 1. ED reported the injury of unknown source for resident B to the Indiana Department of Health on 1/29. ED reported as soon as aware of the injury of unknown source. Reported on 1/29, but investigation revealed it occurred 1/23. 2. Executive Director or designee will educate nursing staff and Purpose shower aides on shower sheets being filled out each time with any new areas being brought to the nurse's attention. Completed sheets should be put into the shower binder on each nurse's station. 3. The Executive Director or designee will in-service all staff on Abuse Reporting Requirements and Injuries of an Unknown Source 4. Nursing leadership will review and audit shower sheets daily Monday – Friday for	04/01/2023

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	02/23/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	The file included a 1/29/23 written statement from QMA (Qualified Medication Aide) 2. It read, "On Monday January 23, 2023, I [name of QMA 2] walked into [name of Resident B's] room. When I looked at him, I observed that he had purple discoloration to his left eye. When I asked him what happened to his eye he stated he did not know how it happened. I continued to bring him to the dining room where I also had to [sic] other CNA [Certified Nursing Assistant] on duty [CNA 3] observe his eye as well. I then reported the discoloration to the QMA [QMA 4] on duty at the time." The file included a 1/30/23 written statement from CNA 3. It read, "On Monday January 23, 2023 I [name of CNA 3] was in the kitchen when [name of QMA 2] grabbed me to confirm that [name of Resident B's] left eye was bruised. [Name of QMA 2] and I both asked if [name of Resident B] remembered what incident may have happened to cause the bruising. He had no recollection of anything happening. It was then reported to the QMA on duty." The file included a written interview, conducted 1/30/23 by the ED, with QMA 4. It read, "She did report it but I completely forgot as I was passing meds [medications.] I think we did an incident report. "Did you call family?' No, I though [name of WD -Wellness Director] did." An interview was conducted with the ED on 2/21/23 at 3:39 p.m. She indicated QMA 2 was the first to notice the bruise to Resident B on 1/23/23. QMA 2 then informed CNA 3 and had her look at it. Both of them then informed QMA 4 of the bruising, but QMA 4 did not report it or fill out an incident report. Whichever staff member was first		compliance and notify family of any significant changes. Systemic Changes will be completed by April 1, 2023	

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	02/23/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	to see the injury should have informed her, but at the very least QMA 4 should have reported it to her and completed an incident report. QMA 4 started an incident report, but did not complete it, as it remained the nurse's station, unfinished, when the investigation began on 1/29/23. QMA 4 thought she reported it to the WD, but didn't. An interview was conducted with Family Member 5, Resident B's daughter, on 2/21/23 at 3:03 p.m. She indicated no one at the facility informed her of the bruising under Resident B's eye. She noticed it on 1/29/23 when she came to the facility for a visit. She stated, "He came out of the restroom and had a black eye." An interview was conducted with the WD on 2/21/23 at 3:35 p.m. She indicated normally, Family Member 5 would have been notified of Resident B's eye bruising when it was identified on 1/23/23. The Health Monitoring and Intervention policy was provided by the WD on 2/22/23 at 9:43 a.m. It read, "1. Community Team Members should monitor the Resident for changes in his/her status on an ongoing basis and report to the Wellness Director and/or the ED any changes noted. Examples of such changes might include: ...Rashes, bruising, skin tears, changes in skin condition, color and/or texture....2. Document any changes noted in the Resident's Service Notes, along with a summary of the Resident's condition and any action taken. Examples include communication with the Wellness Director regarding health issues, communication with home health, hospice or other third party provider." The Injuries of Unknown Source policy was provided by the ED on 2/21/23 at 3:49 p.m. It read,			

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	02/23/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	"An injury should be classified as an injury of unknown source when BOTH of the following conditions are met: The source of injury was not observed by any person or the source of injury could not be explained by the resident; AND The injury is suspicious because of the extent of the injury of the location (e.g. the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time. Examples of suspicious injuries: Black eye." The Abuse Prevention Policy was provided by the ED on 2/21/23 at 1:45 p.m. It read, "General Reporting Requirements: 1. All personnel must report the following: a. Knowledge of or reasonable cause to believe a resident has been or is being abused, mistreated, or neglected, including injuries of unknown source, or misappropriation of resident property; b. Knowledge that a resident has sustained a physical injury of unknown origin, or which is not reasonably explained by the history of injuries provided in the resident's medical record, even if abuse is not suspected. 2. The report must be made immediately to the Facility Administrator, the Director of Nursing or a direct supervisor. This initial report may be made orally, but must be followed up by a written report within 24 hours. The Facility must report the incident to the ISDH [Indiana State Department of Health] within 24 hours of learning of the occurrence." This Residential Tag relates to Complaint IN00401690 and IN00393176.			
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff			

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	02/23/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.			
	Based on observation, interview, and record review, the facility failed to revise residents' service plans regarding a resident's fall risk and a resident's behaviors for 1 of 3 residents reviewed for falls and 2 of 3 residents reviewed for abuse. (Residents B, D, and F) Findings include: 1. The clinical record for Resident B was reviewed on 2/21/23 at 11:12 a.m. His diagnoses included, but were not limited to, dementia with behavioral	R 0217	R 217 1. The Wellness Director or designee will update the service plans for resident B &D to include behaviors and interventions 2. The Wellness Director or designee will update the assessment and service plan for resident F to include risk for falls, use of rolling walker, and hearing aids. 3. The Wellness Director or	04/01/2023

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	02/23/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	disturbance. Resident B's 10/10/22 service plan indicated he had no behavior issues and did not have current or a history of disruptive, aggressive, verbal or socially inappropriate behavior. 2. The clinical record for Resident D was reviewed on 2/21/23 at 11:39 a.m. His diagnoses included, but were not limited to, dementia with behavioral disturbance. Resident D's 12/20/22 service plan indicated he had no behavior issues and did not have current or a history of disruptive, aggressive, verbal or socially inappropriate behavior. An observation and interview was conducted with CNA (Certified Nursing Assistant) 9 on 2/21/23 at 11:50 a.m. She indicated Resident B and Resident D used to be roommates, but Resident B was moved to another room down the hall about 3 months ago. The two of them would "get loud" with each other, because Resident B "has a way about himself that gets on everyone's nerves." CNA 9 began making a hoarse coughing sound as an example of one of the things Resident B displayed that annoyed others. She stated, "You'll hear him do it. It annoys people." An interview was conducted with CNA 6 on 2/21/23 at 12:11 a.m. She indicated Resident B would sometimes enter Resident D's room, uninvited. Resident D would redirect him out of the room, "sometimes aggressively, loudly." An interview was conducted with Resident D on 2/21/23 at 11:39 a.m. He indicated Resident B would come into his room by accident, and the 2 of them had gotten into altercations "a couple		designee will audit all assessments for residents to ensure all behaviors and all assistive devices are reflected in the assessment and service plans. 4. Wellness Director or designee will review all progress notes, physician summaries, and therapy notes daily Monday-Friday during clinical start up meeting to identify falls and new devices. Assessments and service plans will be updated accordingly. System Changes will be completed by April 1, 2023	

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	02/23/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	times." An interview was conducted with CNA 7 on 2/22/23 at 12:09 p.m. She indicated she'd worked at the facility for 3 years. Resident B would call out for his daughter a lot, coughed, and yelled out, which "sets the other residents off." The other residents would get annoyed with him. To prevent Resident B from entering Resident D's room accidentally, she would walk Resident B to his room instead. The 8/26/22 progress note read, "Resident continues to be difficult to redirect. Continues to be aggressive towards staff when attempting to redirect. Continues to yell out [name of Family Member 5."] An observation was made from the unit dining room on 2/23/23 at 11:15 a.m. Resident B could be heard yelling out from the restroom for his daughter. An interview was conducted with the ED (Executive Director) on 2/22/23 at 10:33 a.m. She indicated Resident B had a history of sleeping on the floor, urinating in trash cans, stealing stuff, and wandering, but was much better now. An interview was conducted with the WD (Wellness Director) on 2/21/23 at 3:35 p.m. She reviewed Resident B's and Resident D's service plans and indicated she didn't see anything on either service plan regarding yelling behaviors or going into other resident's rooms. 3. The clinical record for Resident F was reviewed on 2/21/23 at 11:40 a.m. Her diagnoses included, but were not limited to, dementia with behavioral disturbance, sensorineural hearing loss, and			

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	02/23/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	hypertension. The clinical record indicated she had falls on the following dates: 10/1/22, 11/10/22, 12/28/22, 1/28/23, and 2/10/23. The 2/16/23 service plan indicated she was not at risk for falls; did not reference her use of a rolling walker; and did not need hearing aides or other hearing care. An interview was conducted with the Memory Care Director on 2/22/23 at 12:07 p.m. She indicated Resident F had 2 falls recently. One was in her room, and the other was in another resident's room. An interview and observation was conducted with Family Member 8 and Resident F in Resident F's room on 2/22/23 at 12:40 p.m. Resident F had 2 large bruises and discoloration under both of her eyes. Resident F was not wearing hearing aides at this time, and asked for questions/statements to be repeated several times, directly into her ear. Family Member 8 indicated Resident F fell backwards in the the hallway and that's how she got the bruising and discoloration under her eyes. She had to go to the hospital for that fall and a previous one. She also fell once in another resident's room. Family Member 8 stated, "How did she fall in another resident's room? Isn't anyone watching them?" After one of the falls, Resident B informed him she laid on the floor for a long time. The facility had also lost her hearing aids multiple times. An interview was conducted with the ED (Executive Director) on 2/23/23 at 12: 10 p..m. She indicated she was unsure why the service plan would indicate she was not at risk for falls and			

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	02/23/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	that it should reference her use of a hearing aide and rolling walker. The Service Planning Process policy was provided by the ED on 2/22/23 at 9:53 a.m. It read, Review the completed Service Plan to ensure: That all service areas documented on the CSL. Assessment have been addressed on the Service Plan. To include...any Behavior Management....See the Health Related Services Manual file folder. Additional Assessment Tools' folder: to include the Fall Management Program..." This Residential Tag relates to Complaint IN00401690, IN00401349, and IN00393176.			
R 0240 Bldg. 00	410 IAC 16.2-5-4(d) Health Services - Deficiency (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. Based on observation, interview, and record review, the facility failed to follow through with a nutrition recommendation; timely address a significant weight loss; and complete post fall assessments per policy for 2 of 3 residents reviewed for weight loss and 1 of 3 residents reviewed for falls. (Residents B and F) Findings include: 1. a) The clinical record for Resident F was reviewed on 2/21/23 at 11:40 a.m. Her diagnoses included, but were not limited to, dementia with behavioral disturbance, sensorineural hearing loss, and hypertension The 10/3/22, 3:27 p.m. progress note read, "Late note----10/1/2022---At approx [approximately] 6:30, resident had a fall. She was sent to the ER	R 0240	R 240 1. The Wellness Director or designee will in-service all clinical staff regarding 72-hour follow up charting. 2. The Wellness Director or designee will audit daily Monday-Friday for all assigned follow up charting. 3. Resident F and B weight losses were communicated to the MD/ NP and orders were updated. 4. The Wellness Director or designee will review all weights monthly and report any significant weight losses to the Registered Dietician and MD/ NP for recommendations.	04/01/2023

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	02/23/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	[emergency room] D/T [due to] lac [laceration] to back of head." The 10/3/22, 4:35 p.m. progress note read, "Late note------10/1/22 at approx 11:30 pm, resident returned from the ER. No new orders. All diagnostics were negative." There were no follow up assessments in Resident F's clinical record for the following 72 hours after her 10/3/22 fall. The 11/10/22, 1:47 p.m. progress note read, "Resident was getting onto elevator , slipped and fell. Resident stated she believes her shoes are slick. Dns [Director of Nursing Services] and Poa [power of attorney] notified. She has no complaints of pain. Her vitals were as follows: B/p [blood pressure] - 136/73, Resp [respirations]-17, O2 [oxygen saturations] -98, Temp [Temperature] -97.9." There were no follow up fall assessments in Resident F's clinical record for the following 72 hours. The 12/28/22, 10:18 p.m. progress note read, "Resident fell in common area, appeared to be walking towards her room wearing proper footware [sic] and was using her cane, resident lots balance and fell resident stated no pain VS [vital signs] normal." The 1/28/22, 1:58 p.m. progress note read, "CNA [Certified Nursing Assistant] reported to this writer the resident had fallen at 1:15pm today. The resident was found laying on the floor in the hallway without her cane beside her. Her cane was found in the room she was laying in front of. Resident was able to stand with some assistance and was educated on using her cane at all times. No complaints or concerns of pain from resident at this time. Vitals bp-130/77, p [pulse]-86, t-98.6, r-16, o -98. Family notified."		Systemic Changes will be completed by April 1, 2023.	

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	02/23/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	An interview was conducted with the ED (Executive Director) on 2/22/23 at 1:25 p.m. She indicated 72 hour alert charting was to be completed and documented in the progress notes, including vital signs. There was no verification the post fall assessments were completed for her 10/3/22, 12/28/22, or 1/28/22 falls. The Fall Management Handbook was provided by the Marketing Director on 2/21/23 at 11:41 p.m. It read, "Post-fall Interventions...Monitor the resident and place the resident on 'Alert Charting' (HotBox Charting', for 72 hours following a fall." b.) The weight log for Resident F was provided by the ED (Executive Director) on 2/22/23 at 3:14 p.m. It indicated the following weights for the following months: September, 2022 - 96.2 pounds, October, 2022 -96.3 pounds, November, 2022-97.2 pounds, December, 2022-98.8 pounds, January, 2023-93.4 pounds, February, 2023-91.2 pounds. The weight loss between December, 2022 and January, 2023 was 5.4%. An interview was conducted with the ED on 2/22/23 at 3:09 p.m. She indicated the RD (Registered Dietician) came to the facility monthly to review weights and address any weight losses. It looked like just over a 5% loss from December, 2022 to January, 2023, but the RD (Registered Dietician) was not in the facility in January, 2023 to review it. An interview was conducted with the ED on 2/23/23 at 9:57 a.m. She indicated weights are obtained monthly, by the 10th of the month, generally by a CNA (Certified Nursing Assistant.) After Resident F's January, 2023 weight was obtained, the process was to give the weight to			

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	02/23/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	the Wellness Director, who was responsible for addressing it. In Resident F's case, it would have been there previous WD, and there was no verification to show it was ever addressed. She just spoke with the nurse practitioner earlier, who informed her they could offer Resident F a supplement one to two times a day. 2. The clinical record for Resident B was reviewed on 2/21/23 at 11:12 a.m. His diagnoses included, but were not limited to, dementia with behavioral disturbance. The weight log for Resident B was provided by the ED (Executive Director) on 2/22/23 at 3:14 p.m. It indicated the following weights for the following months: September, 2022 - 125.4 pounds, October, 2022 -126.9 pounds, November, 2022-134.8 pounds, December, 2022-135.8 pounds, January, 2023-129.2 pounds, February, 2023-124.6 pounds. An interview was conducted with the ED on 2/22/23 at 3:09 p.m. She indicated the RD (Registered Dietician) came to the facility monthly to review weights and address any weight losses. To her knowledge, Resident B was not on any nutrition supplements. The 10/20/22 Nutritional Assessment Recommendations form was provided by the ED on 2/23/23 at 10:19 a.m. For Resident B, it read, "Resident reviewed with near sig [significant] wt [weight] loss of 6 lbs./4.6% Aug [August] to [September] BMI [body mass index] is underweight @ 17.5 and resident meets clinical characteristics for malnutrition dx [diagnosis.] Recs [Recommendations] were made 8/18/22 for addition of supple [supplement.] Continue to monitor wt. [weight] @ least monthly or per MD			

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	02/23/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	request." The response section, written by the previous Wellness Director, indicated on 10//20/22 she spoke with Resident B's daughter, Family Member 5, regarding supplements and the family was agreeable. There was no information in Resident B's clinical record to indicate follow up to the 10/20/22 conversation about the nutritional supplement. An interview was conducted with Family Member 5 on 2/23/23 at 10:26 a.m. She indicated the facility was supposed to get Resident B some Boost shakes through Medicaid and would give him some leftover Boost they had at the facility in the meantime. She hadn't spoken to the facility about it since the conversation with the previous WD in October, 2022. She hadn't seen any Boost in the facility for him and she visited twice a week, so she would know if he was getting it. The previous WD never followed up with her about it and whether Medicaid approved the supplement or not. If they didn't, she could provide it, and she informed the previous WD of that back in October, 2022 when it was discussed. The Measuring Weight policy was provided by the ED on 2/21/23 at 1:55 p.m. It read, "Report any abnormal results to the Wellness Director or designee, who will determine if the physician contact is needed. (i.e. increased or decreases of more than 5 in 30% days or 10% in 180 days)....Record any follow-up actions needed/taken in the Resident's Service Notes and as indicated on the back of the medication/treatment sheet." This Residential Tag relates to Complaint IN00401349 and IN00393176.			