PRINTED: 06/12/2025 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155412		A. BUIL	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		COMPLETED 05/23/2025		
	PROVIDER OR SUPPLIER	RID LIVING COMMUNITY		937 FR`	ADDRESS, CITY, STATE, ZIP COD Y RD IWOOD, IN 46142		
(X4) ID PREFIX TAG F 0000	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PF	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
Bldg. 00	Licensure Survey. Investigation of Co Complaint IN00455 related to the allegal Survey dates: May Facility number: 00 Provider number: 1002 Census Bed Type: SNF/NF: 94 Total: 94 Census Payor Type Medicare: 4 Medicaid: 74 Other: 16 Total: 94 These deficiencies accordance with 41 Quality review com	266620 : reflect State findings cited in	F 000	0	The plan of correction is to ser as Greenwood Health and Livi Community's credible allegatic compliance. Submission of this plan of correction does not constitute admission by Greenwood Hea and Living Community or its management company that the allegations contained in the sureport is a true and accurate portrayal of the provision of nucare and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations. Greenwood Health and Living Community is respectfully requesting consideration for desk review.	an alth arvey arsing	
F 0558 SS=D Bldg. 00	review, the facility	on, interview and record failed to provide reasonable needs for 1 of 19 reviewed for	F 055	8	F 558 Reasonable accommodations Needs/Preferences I. The corrective actions to be	De .	06/17/2025
LABORATOR	RY DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SIC	NATURE		TITLE		(X6) DATE

Dorian Mihay

06/11/2025

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.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		155412	B. W	ING	_	05/23	/2025
			-	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIEF	8		937 FR			
GREENV	VOOD HEALTH AN	ID LIVING COMMUNITY	GREENWOOD, IN 46142				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Einding ingludge				accomplished for those	_	
	Finding includes:				residents found to have been affected by the practice.	n	
	On 5/20/25 from 8:	35 a.m. to 8:40 a.m., Resident 73			anected by the practice.		
		ig in bed while eating			Resident 73s call light was pla	aced	
	breakfast. Resident 73's call light was observed approximately 3 feet to the left of the head of the bed. The call light cord and mechanism were				within reach.	100 u	
					II. The facility will identify		
		rom the wall to approximately 3			other residents that may		
	inches above the floor. The observed call light system was not within reach of the resident. During an interview at that time, Resident 73				potentially be affected by the	€	
					practice.		
	indicated he did not	t know where the call light was			Other residents were observed	d to	
	located.				ensure call lights were within		
					reach.		
	_	v on 5/20/25 at 8:43 a.m.,			III. The facility will put into		
		ed Resident 73's call light was			place the following systemat	tic	
	_	ach of the resident. Resident			changes to ensure that the		
	73 "sometimes wou	ald throw his call light around."			practice does not recur.		
	On 5/22/25 at 8:45	a.m., Resident 73 was observed			Staff are being educated to ke	ер	
	sitting in his wheel	chair that was positioned at the			call lights within reach of		
	foot end on the left	side of the bed. Resident 73			residents.		
		om the head of the bed.					
	_	d to the left of the head of the					
		dside table. The call light cord			IV. The facility will monitor th	ne	
		re observed hanging from the			corrective action by		
	_	to the floor to the left of the			implementing the following		
		observed call light system was			measures.		
		the resident. During an					
		ne, Resident 73 indicated he did			The DON, or designee, will ro		
	not where the call l	ight was located.			and observe residents to ensu		
	Dumin a a :: : '				call lights are being kept within		
	_	v on 5/22/25 at 8:47 a.m., Unit			reach daily for 4 weeks, week	-	
		d call lights were to be kept			for 12 weeks and then quarter	ıy	
	within reach of the resident. Resident 73 was known to "toss the call light around at times."				ongoing.		
	KHOWH tO TOSS THE	can fight around at times.			The results of these reviews w	vill be	
	On 5/20/25 at 1·18	n m Resident 73's clinical	1		discussed at the monthly facili		
	On 5/20/25 at 1:18 p.m., Resident 73's clinical				Ouglity Assurance Committee	-	

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155412	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 05/23/2025	
	PROVIDER OR SUPPLIER	D LIVING COMMUNITY	937 FF	ADDRESS, CITY, STATE, ZIP COD RY RD NWOOD, IN 46142		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)	DATE	
	(paralysis) followin dominant right side The Annual Minimassessment, dated 4	hemiplegia and hemiparesis g a stroke affecting the um Data Set (MDS) /29/25, indicated Resident 73 ively impaired and was at risk		meeting monthly for 3 months then quarterly thereafter once compliance is at 100%. Frequency and duration of rewill be increased as needed, compliance is below 100%. V. Plan of Correction	views	
	During an interview on 5/22/25 at 8:29 a.m., the Administrator indicated the facility did not have a specific call light policy. The facility practice was that staff were to ensure the call lights were kept within reach of the residents. 3.1-3(v)(1)			completion date. Date of Compliance: 6/17/25 The Administrator will be responsible for ensuring the f is in compliance by date of compliance listed.	acility	
F 0602 SS=E Bldg. 00	Based on interview failed to protect the from misappropriatives idents reviewed a property. Narcotic in (Resident B, Resident F) Findings include: 1. On 5/20/25 at 12 record was reviewed were not limited to, disease and osteomy (inflammation of be spinal disc).	and record review, the facility resident's rights to be free ion of property for 5 of 5 for misappropriation of medications were missing. But C, Resident D, Resident E, 202 p.m., Resident B's clinical d. The diagnoses included, but hypertensive chronic kidney yelitis of vertebra one caused by infection of a	F 0602	F 602 Free from Misappropriation/Exploitation I. The corrective actions to accomplished for those residents found to have bee affected by the practice. There were no negative outcomelated to the incident for resident B, C, D, E, and F and resident were reimbursed if needed. II. The facility will identify other residents that may potentially be affected by the practice. Other carts were counted and	be en comes dents dents e	
	· ·	/7/25, indicated Resident B		Other carts were counted and medications were verified with other discrepancies.		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETED			
		155412	B. W	'ING		05/23/2025
	PROVIDER OR SUPPLIER	D LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP COD 937 FRY RD GREENWOOD, IN 46142			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	NEGLIDERIC IV. AND OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
	The Physician's Ord limited to: - Hydrocodone-aced medication) 5-325 a day for pain, initial 2. On 5/20/25 at 12 record was reviewe were not limited to, acute respiratory distributed indicated Resident of the Physician Order indicated the follow - Oxycodone-acetar medication) 5-325 a sa needed for acute 3. On 5/20/25 at 12 record was reviewe were not limited to, history of traumatic The Quarterly MDS indicated Resident I impaired. The Physician Order indicated the follow - Tramadol (narcotic times a day. 4. On 5/20/25 at 12	ders included, but were not taminophen (narcotic pain mg (milligrams), every six hours ated 3/27/24. 205 p.m., Resident C's clinical d. The diagnoses included, but osteomyelitis, pneumonia, and stress. 208 assessment, dated 5/1/24, C was cognitively intact. 219 report, dated 4/30/25, ving: 220 minophen (narcotic pain mg, one tablet every four hours pain. 230 p.m., Resident D's clinical d. The diagnoses included, but atrial fibrillation and personal elebrain injury. 24 assessment, dated 4/11/25, D was severely cognitively			III. The facility will put into place the following systemat changes to ensure that the practice does not recur. RNs, LPNs, and QMAs are be educated regarding medicatio storage and misappropriation property. IV. The facility will monitor the corrective action by implementing the following measures. The DON, or designee, will rethe sign in/out sheets and controlled drug sheets daily for weeks, weekly x4 weeks, Mor x3 months, and quarterly x3 months. The results of these reviews we discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months then quarterly thereafter once compliance is at 100%. Frequency and duration of reviewll be increased as needed, it compliance is below 100%. The DON, or designee, will rethe narcotic master sheet compared to narcotic dispensive report daily for 4 weeks, weeks weeks, monthly for 3 months then quarterly ongoing.	eing n of he view or 4 hthly vill be ity and views f views f views f

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLETED			LETED	
		155412	B. WIN	lG		05/23	/2025
				CTREET	ADDRESS SITY STATE ZID SOD		
NAME OF 1	PROVIDER OR SUPPLIE	ER		937 FR	ADDRESS, CITY, STATE, ZIP COD		
ODEEN	4/00D LIEAL T.L. A.	ALD LINVING COMMANDENITY					
GREEN	WOOD HEALTH AI	ND LIVING COMMUNITY		GREEN	IWOOD, IN 46142		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	F	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE.	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
	were not limited to	o, cerebral palsy, contracture of					
	right knee, and acu	ıte kidney failure.			The results of these reviews v	vill be	
					discussed at the monthly facil	ity	
	The Quarterly MD	S assessment, dated 5/16/25,			Quality Assurance Committee)	
	indicated Resident	E was moderately cognitive			meeting monthly for 3 months	and	
	impaired.				then quarterly thereafter once		
					compliance is at 100%.		
	The Physician Ord	ler Report, dated 3/28/25			Frequency and duration of rev	/iews	
	indicated the follo	wing:			will be increased as needed, i		
					compliance is below 100%.		
	- Hydrocodone-acc	etaminophen 5-325 mg tablet			·		
	oral tab three times	s a day.			V. Plan of Correction		
					completion date.		
	5. On 5/20/25 at 12:15 p.m., Resident F's clinical						
	record was review	ed. The diagnoses included, but			Date of Compliance: 5/29/25		
	were not limited to	o, chronic obstructive pulmonary			·		
	disease, physical d	lebility, and type 2 diabetes					
	mellitus.						
	The Admission M	DS assessment, dated 4/28/25,					
	indicated Resident	F was moderately cognitive					
	impaired.						
	The Physician Ord	ler Report, dated 4/21/25					
	indicated the follo	wing:					
	- Hydrocodone-aco	etaminophen 5-235 mg, one by					
	mouth every six ho	ours as needed.					
	During an intervie	w on 5/21/25 at 2:18 p.m., the					
	Director of Nursin	g (DON) and Administrator					
	indicated that on 5	/7/25 it was brought to their					
	attention that there	e were a few discrepancies in					
	the narcotic count.	During the facility					
	investigation it wa	s discovered that on 5/5/25,					
	LPN 4 took posses	ssion of 30 tablets of					
	hydrocodone-aceta	aminophen 5-325 mg and a card					
	of Ambien prescri	bed for Resident B. LPN 4 did					
	return the Ambien	for destruction but indicated					
1	she did not know v	what happened to Resident B's					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155412		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 05/23/2025	
	ROVIDER OR SUPPLIER	D LIVING COMMUNITY	937 FF	ADDRESS, CITY, STATE, ZIP COD RY RD NWOOD, IN 46142	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE COMPLETION
	she had removed for Administrator indicalso signed out an omer for Resident C. at that time. It was a tablet was obtained an as needed medic D did not have an oronly scheduled time Administrator indical revealed hydrocodowas missing from the Resident E. Resident hydrocodone-acetar was placed on leave and terminated. The indicated she accide hydrocodone-acetar facilities lock box a construction of the missing narreviewed. The investigation of the resident should hydrocodone-acetar cart. The tablets we resident C Oxyco one tablet every four pain. The facility in medication was missing the resident D's Tramer.	ated that further investigation me-acetaminophen 5-325 mg me narcotic lock box for at E was missing 44 minophen 5-325 mg. LPN 4 minophen 5-325 mg. LPN 4 minophen 5-325 mg from the modernally took the 44 minophen 5-325 mg from the modernally took the 44 minophen 5-325 mg from the modernally investigation modernally inves			

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155412	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/23/2025
	PROVIDER OR SUPPLIEF	D LIVING COMMUNITY	937 FR	ADDRESS, CITY, STATE, ZIP COD YY RD NWOOD, IN 46142	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	mg tablet, oral tab t investigation indica	brocodone-acetaminophen 5-325 hree times a day. The facility ted one minophen was missing.			
	mg, one by mouth, facility investigation	every six hours as needed. The n indicated that 44 minophen were missing.			
	10 indicated that wl destroyed the Unit l	on 5/22/25 at 10:34 a.m., LPN nen narcotics needed to be Manager was notified and if a arcotic, then two nurses ne destruction.			
	indicated the DON narcotics unless it v	on 5/22/25 at 10:55 a.m., RN 12 took care of destruction of was a single dose refusal then ff on the destruction.			
	provided the facility Misappropriation P. Policy," with a revi indicated it was the by the facility. A re"It is the policy of and its member Corresident with an environment.	a.m., the Administrator (ADM) y policy, "Abuse, Neglect, and rohibition and Prevention sion date of 6/4/19, and policy currently being used view of the policy indicated, f CarDon & Associates, Inc. mmunities to provide each vironment that is free tion of their property"			
	provided the facility Procedure for Scher indicated it was the by the facility. A re 2, 2.3, Discontinued drugs are to be dest	a.m., the Administrator (ADM) y policy, "Clinical- Policy and duled Drugs," undated, and policy currently being used view of the policy indicated, ". d schedule II, III, IV and V royed in the Community in the ector of Nursing ("DON") or			

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	NSTRUCTION	(X3) DATE :	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		155412	B. WI	NG		05/23/	2025
	ROVIDER OR SUPPLIER	D LIVING COMMUNITY	<u> </u>	937 FR	ADDRESS, CITY, STATE, ZIP COD Y RD IWOOD, IN 46142		
			ID			1	(7/5)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	DATE
F 0656 SS=E Bldg. 00	designee and a regis Community and the accordance with the controlled drugs as 4.1, At the beginnin must be count and a drugs, including refi outgoing associate. associate's shift they all scheduled drugs, with the oncoming a This citation relates 3.1-28(a) 483.21(b)(1)(3) Develop/Implemer Based on observation review, the facility of 5 of 19 residents revi developed for skin of wheelchair, and non Resident 28, Reside 74) Finding includes: 1. On 5/20/25 at 8:3 the hallway. Reside his manual wheelch was wearing short p were noted on his bi open area was observ dressing was observer.	stered nurse employed by ir disposal record in procedures for destruction of provided in section 3. ". 4, g of an associate's shift they ecount for all scheduled rigerated drugs with the 4.2, At the end of an must count and account for including refrigerated drugs associate". It to the Complaint IN00459109. The Comprehensive Care Plan on, interview, and record failed to develop care plans for riewed. Care plans were not conditions, use of an electric ecompliance. (Resident F, ant 73, Resident 56, Resident F ants. Multiple dried scabs illateral lower extremities. An eved on his left knee and no ed. To no 5/20/25 at 9:30 a.m., the facility took his electric	F 06		F 656 Develop/Implement Comprehensive Care Plan I. The corrective actions to be accomplished for those residents found to have been affected by the practice. Resident F, 28,73, 56, and 74' care plans were reviewed and updated as needed. II. The facility will identify other residents that may potentially be affected by the practice. Other residents care plan's habeen audited and updated as needed.	s	06/17/2025

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	00	COMPLETED	
		155412	B. W	'ING		05/23/2025	
NAME OF D	ROVIDER OR SUPPLIER)		STREET A	ADDRESS, CITY, STATE, ZIP COD	-	
				937 FR			
GREENV	VOOD HEALTH AN	ID LIVING COMMUNITY	GREENWOOD, IN 46142				
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	*	CY MUST BE PRECEDED BY FULL		PROVIDERS PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
	O:- 5/20/25 -4 10:00) Desident Elections			III. The facility will put into		
On 5/20/25 at 10:00 a.m., Resident F's clinical				place the following systematic	tic		
	record was reviewed. The diagnoses included, but were not limited to, physical debility and muscle weakness.				changes to ensure that the		
					practice does not recur.		
	Weakiness.				Nurses who intiate care plans	and	
	An Admission Assessment, dated 4/21/25, indicated Resident F arrived to the facility with a				Social Services are being		
					educated regarding		
	motorized wheelcha	air.			implementation of the individu	al	
					plan of cares.		
	An Admission Minimum Data Set (MDS)						
assessment, dated 4/28/25, indicated Resident F was cognitively intact.							
				IV. The facility will monitor the	ne		
					corrective action by		
	•	r, dated 4/13/25 with no end			implementing the following		
		n open scab on left knee every			measures.		
	•	nal saline and cover with a					
	_	ry evening and every shift as			The DON, or designee, will re		
	needed for soilage of	or dislodgement.			careplans for new residents o	r	
	A O (* 177)	N 1 1 15/15/25			residents with changes of		
	_	herapy Note, dated 5/15/25, F had several incidents where			condition ensure that care pla		
		ects with his power wheelchair.			have been implemented week	aly for	
	-	prohibit the use of the electric			12 weeks and then quarterly		
		rther assessments and training			ongoing.		
	were completed.	ruici assessments and training			The results of these reviews v	vill he	
	or o compressed.				discussed at the monthly facil		
	The clinical record	lacked a comprehensive care			Quality Assurance Committee	•	
		ise of Resident F's electric			meeting monthly for 3 months		
	wheel and skin con-				then quarterly thereafter once		
					compliance is at 100%.		
	During an interview	y on 5/21/25 at 1:00 p.m., the			Frequency and duration of rev	views	
	Administrator indic	ated the electric wheelchair			will be increased as needed, i		
	was taken away for	safety issues. Resident F was			compliance is below 100%.		
	to be evaluated by (Occupational Therapy to					
	determine if the res	ident was safe to use the					
	electric wheelchair.				V. Plan of Correction		
					completion date.		
	-	on 5/21/25 at 1:33 p.m., the					
	Administrator indic	ated the clinical record lacked			Date of Compliance: 6/17/25		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION TOTAL SERVICES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155412		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/23/2025		
	PROVIDER OR SUPPLIER	RID LIVING COMMUNITY	937 FR	ADDRESS, CITY, STATE, ZIP COD Y RD NWOOD, IN 46142		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL DUSC DEPUTIENT OF DEFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)		(X5) COMPLETION
TAG	a care plan regarding a care plan regarding During an interview Director of Nursing lacked a care plan reconditions. 2. On 5/24/25 at 12 Resident 74 was regincluded but was not and type 2 diabetes. A Skin Assessment open area on Resident A Physician's order cleanser right heel we cleanser. Pat dry at ABD pad and wrap The clinical record pressure ulcer on Resident on S/24/25 the Adr was unable to locat included the pressure ulcer on Resident on S/24/25 from 56 was observed regions observed regions observed to be in the approximately 40 in handheld bed contribed and within react were visible in the san interview at that she liked the bed bed served to be defined and within react were visible in the san interview at that she liked the bed bed served.	R LSC IDENTIFYING INFORMATION Ing the electric wheelchair. In on 5/24/25 at 2:33 p.m., the graindicated the clinical record regarding Resident F's skin 2:00 p.m., the clinical record of viewed. The diagnoses of limited to, vascular dementia mellitus. In dated 2/26/25, indicated an ent 74's right heel. In dated 3/29/25, indicated, with normal saline or wound and paint with betadine pad with with kerlix. I lacked a care plan related to the esident 74's right heel. ministrator indicated the facility e a current skin care plan that are ulcer on Resident 74's right 9:40 a.m. to 9:50 a.m., Resident sting in bed. The bed was	TAG	The Administrator will be responsible for ensuring the is in compliance by date of compliance listed.		DATE
	On 5/19/25 from 11	1:25 a.m. to 11:35 a.m Resident	1			1

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56 was observed resting in bed. The bed was

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i f		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	
		155412	B. WI	ING		05/23	/2025
NAME OF P	DOMDED OF CURPUSE		1	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER			937 FR			
GREENV	VOOD HEALTH AN	D LIVING COMMUNITY		GREEN	IWOOD, IN 46142		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	observed to be in th	R LSC IDENTIFYING INFORMATION	<u> </u>	TAG	DEI ICIERCI I		DATE
		nches above the floor. The					
	* *	ol device was observed on the					
		h of the resident. No staff					
	were visible in the area during that time. During an interview on 5/19/25 at 11:37 a.m., LPN 5 indicated she did not know the reason for						
		have been left in the highest					
	•	as observed exiting Resident					
	56's room without le	owering the height of the bed.					
	During an interview	v on 5/19/25 at 11:37 a.m., CNA					
	_	at 56's bed was not usually kept					
	in the highest positi	on and there were times when					
		adjust the height of the bed.					
		ed adjusting the bed into a					
	lower position.						
	On 5/19/25 at 11:45	5 a.m., Resident 56's clinical					
		d. The diagnoses included,					
	but were not limited	d to, dementia, mood					
	disturbance, and an	xiety.					
	The Quarterly Mini	mum Data Set (MDS)					
		/4/25, indicated Resident 56					
	was severely cognit	tively impaired.					
	The clinical record	lacked a care plan related to					
		compliance with keeping the					
	bed in the low posit	tion.					
	During an interview	on 5/21/25 at 4:15 p.m., the					
		rated Resident 56's care plan					
		ed her non-compliance with					
	keeping the bed in t	the low position.					
	4. On 5/20/25 from	8:35 a.m. to 8:40 a.m., Resident					
		sting in bed while eating					
	breakfast. Resident	t 73's call light was observed					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155412		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	COM	(X3) DATE SURVEY COMPLETED 05/23/2025	
	PROVIDER OR SUPPLIER	D LIVING COMMUNITY	937 FR	ADDRESS, CITY, STATE, ZIP CO Y RD NWOOD, IN 46142	D	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	approximately 3 fee bed. The call light observed hanging fi inches from the floor system was not with During an interview indicated he did not located. During an interview Scheduler 7 indicate to be kept within re 73 "sometimes wou On 5/22/25 at 8:45 sitting in his wheeler foot end of the left; was facing away from Against the wall and bed was a small bed and mechanism were wall to the floor to 10. The observed call light was located time, Resident 73 in call light was located within reach of the known to "toss the control of the known to "toss the control of the contr	et to the left of the head of the cord and mechanism were from the wall to approximately 3 or. The observed call light nin reach of the resident. The observed call light nin reach of the resident of the the call light was ach of the resident. Resident 73's call light was ach of the resident. Resident light around." The a.m., Resident 73 was observed thair that was positioned at the side of the bed. Resident 73 om the head of the bed. It is the left of the head of the light cord re observed hanging from the left of the bedside table. The call light cord re observed hanging from the left of the bedside table. In the left of the bedside table. The call light cord re observed hanging from the left of the bedside table. The call light cord re observed hanging from the left of the bedside table. The call light cord re observed hanging from the left of the bedside table. The call light cord resident an interview at that redicated he did not where the left. The observed hanging from the light cord resident. Resident 73 was call light around at times." The diagnosis included, but the miplegia and hemiparesis gas troke affecting the				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155412		ľ í	JILDING	nstruction <u>00</u>	(X3) DATE (COMPL 05/23 /	ETED		
NAME OF PROVIDER OR SUPPLIER GREENWOOD HEALTH AND LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP COD 937 FRY RD GREENWOOD, IN 46142					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION TO Falls.		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	address Resident 73 call light beyond hi light. 5. During an observed.	al record lacked a care plan to B's behavior for throwing the s capacity to retrieve the call vation on 5/21/25 at 11:00 a.m.,						
	were observed as obs Manager 8 was obs with normal saline, collagen sheet with Unit Manager 8 wa	ex and right ankle treatments redered by the physician. Unit erved cleansing the right ankle patting it dry, and applying a silver and covering the area. s also observed applying a thin d dressing to Resident 28's						
	On 5/21/25 at 9:23 a.m., Resident 28's clinical record was reviewed. The diagnoses included, but were not limited to, sepsis, disorder of the muscle and abnormal posture.							
	Current Physician Orders included, but was not limited to, the following:							
	"Cleanse wound to	h no end date noted, indicated [right] ankle with [normal oly collagen sheet with silver, ressingdaily"						
	"triad wound dressi	h no end date noted, indicated ng paste, thin amount - layer to [moisture associated y shift"						
	indicated Resident 2 impaired. Section I Resident 28 was at	Assessment, dated 3/3/25, 28 was moderately cognitively M: Skin Conditions indicated risk of developing pressure v had one stage 2 pressure						

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155412	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/23/2025		
NAME OF PROVIDER OR SUPPLIER GREENWOOD HEALTH AND LIVING COMMUNITY			937 FR	ADDRESS, CITY, STATE, ZIP COD Y RD IWOOD, IN 46142			
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION			CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	ulcer and one stage	3 pressure ulcer.					
	provided a copy of and Management Strompleted by the Wreview of the document of the document of the wounds had be and were considered. Resident 28's clinication for the two pressures. During an interview Director of Nursing	v on 5/21/25 at 4:15 p.m., the g indicated Resident 28's care flected the coccyx and right					
F 0684	provided a copy of Person-Centered po and indicated it was by the facility A re included, "A com care plan that including timetables to meet to psychosocial and furand implemented for of the residents are revised as information residents' condition 3.1-35(a)	p.m., the Administrator the Care Pans, Comprehensive blicy, dated December 2016, s the current policy being used view of the document prehensive, person-centered des measurable objectives and the resident's physical, unctional needs is developed or each residentassessments ongoing and care plans are ion about the residents and the change"					
SS=D Bldg. 00	Quality of Care						

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155412	B. Wl	NG		05/23/2	2025
NAME OF	DROTADED OF GLEDY IE.			STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF I	PROVIDER OR SUPPLIEI	X.		937 FR	Y RD		
GREENWOOD HEALTH AND LIVING COMMUNITY				GREEN	WOOD, IN 46142		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG	Based on observation, record review, and		F 04	TAG			DATE
		ity failed to provide care in	F 06	084	F 684 Quality of care		06/17/2025
		e plan of care for 1 of 1			I. The corrective actions to	ho	
	residents reviewed	-			accomplished for those		
		were not followed for skin			residents found to have been affected by the practice.		
	treatments. (Reside						
	,	,			· · · · · · · · · · · · · · · · · · ·		
	Finding includes:				Resident Fs Physician orders		
					were reviewed and updated p	er	
		a.m., observed Resident F in the			physician.		
	_	F was observed sitting in his					
		all way. Resident F was			II. The facility will identify		
	wearing short pants. Multiple dried scabs were				other residents that may	_	
	observed on both of his legs. An open area was observed on his left knee. No dressing was				potentially be affected by th	e	
	observed.				practice.		
	observed.				Other residents wound orders	.	
	On 5/21/25 at 9:00	a.m., observed Resident F in the			were reviewed to ensure	'	
		ort pants. Multiple dried scabs			treatments were being comple	eted	
		is both of his legs. An open			per physician orders.	10.0	
		on his left knee. No dressing			III. The facility will put into		
	was observed.				place the following systema	tic	
					changes to ensure that the		
	On 5/22/25 at 9:18	a.m., Resident F was observed			practice does not recur.		
	_	ay in his wheelchair wearing					
		rainage was observed on his			Nursing staff are being educa		
	left leg. Open area's	s on both legs and his left knee			to follow wound treatments pe	er the	
	were observed to be	e exposed.			physician order.		
	On 5/23/25 at 0.49	a m Resident E's alinical record					
	On 5/23/25 at 9:48 a.m., Resident F's clinical record was reviewed. The diagnosis included, but was not limited to, type 2 diabetes mellitus with				IV. The facility will monitor t	ho	
					corrective action by	116	
	neuropathy.				implementing the following		
	F ,				measures.		
	A Physician's Orde	r, initiated 4/13/25, indicated to					
	I	on the left knee every other			The DON, or designee, will re	view	
	_	line and cover with a border			5 residents with wounds to er		
	dressing every ever	ning and every shift as needed			treatments were done per		
	for soilage or dislo	dgement.			physician order daily for 4 we	eks,	
				weekly for 12 weeks and ther			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155412		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/23/2025		
NAME OF PROVIDER OR SUPPLIER GREENWOOD HEALTH AND LIVING COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP COD 937 FRY RD GREENWOOD, IN 46142				
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	During an interview on 5/22/25 at 1:30 p.m., the Director of Nursing indicated the facility was to follow the physicians orders for the treatment of Resident F's lower extremities and should have had a dressing as ordered by the physician. 3.1-37(a)		quarterly ongoing. The results of these reviews we discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months then quarterly thereafter once compliance is at 100%. Frequency and duration of revisible will be increased as needed, if compliance is below 100%.	and iews		
F 0693 SS=D	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills		V. Plan of Correction completion date. Date of Compliance: 6/17/25 The Administrator will be responsible for ensuring the fais in compliance by date of compliance listed.	ncility		
Bldg. 00	Based on observation, interview, and record review, the facility failed to ensure a resident's enteral feeding (tube feeding) was signed and dated for 1 of 1 resident reviewed for enteral feeding devices. (Resident 253) Finding includes: On 5/19/25 at 11:45 a.m., Resident 253's clinical record was reviewed. The diagnoses included, but were not limited to, atherosclerotic heart disease (a build-up of plaque in artery walls) and unspecified dysphagia (difficulty swallowing).	F 0693	F 693 Tube Feeding Mgmt/Restore eating skills I. The corrective actions to be accomplished for those residents found to have been affected by the practice. Resident 253's tube feeding we signed and dated. II. The facility will identify other residents that may potentially be affected by the	ras		
	Physician's Orders indicated Resident 253 had an		practice.			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 05/23/2025 155412 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 937 FRY RD GREENWOOD HEALTH AND LIVING COMMUNITY GREENWOOD, IN 46142 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE order for Osmolite 1.2 (a type of enteral tube feeding) to run at 65 mL/hr (milliliters per hour) Other residents will be audited to and H20 (water) at 53 mL/hr bolus (dose) to run ensure tube feeds are signed and continuously on each shift. dated. III. The facility will put into On 5/19/25 at 12:45 p.m., Resident 253 was place the following systematic observed resting in bed. Next to the bed was an IV changes to ensure that the pole with an electronic pump device connected to practice does not recur. Resident 253. The device was noted to be running at the time of observation. The tube feeding Nursing staff are being educated container running into the pump device was to sign and date tube feedings. labeled as Osmolite 1.2 roughly three fourths full of a tan colored liquid and an unlabeled bag filled with clear liquid also running into the pump IV. The facility will monitor the device. The feeding container had areas where corrective action by staff could sign and date it, but they were blank. implementing the following The clear plastic bag of clear fluid was also measures. unlabeled or dated. The tubing itself was unlabeled or dated. The DON, or designee, will audit residents on tube feeds for On 5/20/25 at 8:40 a.m., Resident 253 was signature and date daily for 4 observed sitting up in his wheelchair. Next to the weeks, weekly for 12 weeks and wheelchair was an electronic pump device then quarterly ongoing. connected to Resident 253. The device was noted to be running at the time of observation. The tube The results of these reviews will be feeding container running into the pump device discussed at the monthly facility was an Osmolite 1.2 mostly full of a tan colored **Quality Assurance Committee** liquid and an unlabeled bag filled with clear liquid meeting monthly for 3 months and also running into the pump device. The feeding then quarterly thereafter once container had areas where staff could sign and compliance is at 100%. date it, but they were blank. The clear plastic bag Frequency and duration of reviews of clear fluid was also unlabeled or dated and the will be increased as needed, if top of the bag was open. The tubing itself was compliance is below 100%. unlabeled or dated. During an interview on 5/20/25 at 8:58 a.m., LPN 9 V. Plan of Correction indicated that the feeding container and water completion date. flush bag should both be labeled, and that the flush bag should not be open. LPN 9 closed the Date of Compliance: 6/17/25 water flush bag and indicated another nurse had The Administrator will be

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	· /	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER 155412		A. BUILDING <u>00</u> B. WING		COMPLETED 05/23/2025	
133412			D. W	_		03/23/	2023
NAME OF P	ROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
GREENV	VOOD HEALTH AN	ID LIVING COMMUNITY		937 FRY RD GREENWOOD, IN 46142			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	responsible for ensuring the fa	o oilitu	DATE
	started Resident 253's tube feeding earlier, but LPN 9 would find out when it was signed out and			is in compliance by date of		acility	
	have it labeled appr				compliance listed.		
	11						
	During an interview on 5/22/25 at 9:00 a.m., the						
		Nursing) and Administrator					
		ibe feeding bag should have					
	been signed and dated.						
	3.1-47(a)(2)						
F 0880	483.80(a)(1)(2)(4)(e)(f)						
SS=D	Infection Prevention & Control						
Bldg. 00							
	Based on interview	and record review, the facility	F 0	880	F 880 Infection Prevention &		06/17/2025
	failed to ensure residents were provided a				Control		
		skin test upon admission for 1					
	of 5 resident reviewed for tuberculin skin tests.				I. The corrective actions to	be	
	(Resident 50)				accomplished for those		
	Finding includes:				residents found to have been affected by the practice.		
	rinding includes:				anected by the practice.		
	On 5/19/25 at 12:4:	45 p.m., Resident 50's clinical			Resident 50's Second step TB		
	record was reviewe	d. The diagnoses included, but			test was completed.		
		imited to, chronic respiratory failure,					
	chronic pulmonary edema (an abnormal build up				II. The facility will identify		
	_	s), and type 2 diabetes mellitus			other residents that may		
		n causes high blood sugar			potentially be affected by the	е	
	levels).				practice.		
	Resident 50 had an	admission date of 3/29/25.			Other residents are being aud	lited	
		Resident 50's TB (Tuberculin) test administration			to ensure the two step TB tes		
	Resident 50's TB (7				are completed.		
	history indicated that resident had a first step TB				III. The facility will put into		
		red on 3/29/25 and a first step		place the following systema		tic	
	TB skin test administered on 4/30/25. The two skin				changes to ensure that the		
	tests were each read with negative results and				practice does not recur.		
	•	ered 32 days apart. Both tests			Numaina ataff cua hairan a l	41	
		system as first step TB skin			Nursing staff are being educa		
tests and there was no timely second step		1		regarding the two step TB tes	ເວ		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/12/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	a. building <u>00</u>			COMPLETED		
155412		B. W	B. WING			05/23/2025		
NAME OF PROVIDER OR SUPPLIER GREENWOOD HEALTH AND LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP COD 937 FRY RD GREENWOOD, IN 46142					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX				PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	associated with either.			and timely administration.				
	DON (Director of 150's two step TB sk the first two were a chronologically. On 5/22/25 at 9:22 provided a copy a provided a copy a provided it was the facility. A revies Screening Admission first TST [tuberculifollow-up TST will	v on 5/22/25 at 9:00 a.m., the Nursing) indicated that Resident tin tests were being repeated as dministered too far apart a.m., the Administrator policy titled "Tuberculosis rogram", dated October 2017, as the policy currently in use by the work of the policy indicated, "A. tons or Readmissions4. If the maskin test] is negative, a labe administered 1 to 3 weeks			IV. The facility will monitor to corrective action by implementing the following measures. The DON, or designee, will at new admissions TB tests dail 4 weeks, weekly for 12 weeks then quarterly ongoing. The results of these reviews to discussed at the monthly faciling Quality Assurance Committees.	udit y for s and will be lity		
	after the initial test is read." 3.1-18(f)				meeting monthly for 3 months then quarterly thereafter once compliance is at 100%. Frequency and duration of rewill be increased as needed, compliance is below 100%.	views		
					V. Plan of Correction completion date.			
					Date of Compliance: 6/17/25 The Administrator will be responsible for ensuring the first in compliance by date of compliance listed.	acility		

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