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

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155188	A. BUILDING 00 B. WING	07/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREENFIELD HEALTHCARE CENTER	200 GREEN MEADOWS DR GREENFIELD, IN 46140

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00403838, IN00408249, IN00409754, IN00411601 and IN00411999. Complaint IN00403838 -- No deficiencies related to these allegations are cited. Complaint IN00408249 -- Federal/state deficiency related to the allegations is cited at F692. Complaint IN00409754 -- No deficiencies related to these allegations are cited. Complaint IN00411601 -- Federal/state deficiencies related to the allegations are cited at F610 and F689. Complaint IN00411999 -- No deficiencies related to these allegations are cited. Unrelated deficiency is cited. Survey dates: July 5, 6 and 7, 2023 Facility number: 000099 Provider number: 155188 AIM number: 100291140 Census Bed Type: SNF/NF: 120 Total: 120 Census Payor Type: Medicare: 4 Medicaid: 102 Other: 14 Total: 120	F 0000	Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. **The facility cordially requests paper compliance regarding alleged deficient practices.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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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	These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on July 12, 2023			
F 0558 SS=D Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.			
	Based on observation, interview and record review, the facility failed to ensure 1 of 7 residents reviewed for call light accessibility had their call light within reach. (Resident N) Findings include: On 7-5-23 at 10:41 a.m., During an environmental tour with the Interim Housekeeping on 7-5-23 at 10:41 a.m., Resident N was observed seated in her wheelchair , located to the left side of her bed and beside the privacy curtain on her left side. One call light was observed to be attached to the lowered side rail of her bed, but out of her reach. Another call light was affixed to the privacy curtain. The call light affixed to the privacy curtain was attached at approximately a height of 5 feet and approximately 18 to 24 inches behind where the resident was seated in her wheelchair and out of Resident N's reach. The Interim Housekeeping Supervisor indicated staff sometimes locate the call light on the privacy curtain in order to keep it off the floor while providing resident care and the staff may have forgotten to place it back within her reach. The	F 0558	1. Resident "N" was not harmed by the alleged deficient practice. The DON/designee has reviewed the room environment for comfort and reasonable accommodation for each resident. The call light was placed in reach of resident. The care plan for resident N has been reviewed and updated. All residents have the potential to be affected by same alleged deficient practice. All call lights have been observed to be within each residents reach to ensure residents ability to use call light provided. DON/Designee have educated all staff on the "Routine Resident Care" policy, with emphasis on "Call light placement and accessibility". This is to ensure all	07/28/2023

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	Interim Housekeeping Supervisor did relocate call light to within Resident N's reach at that time. In an interview with Resident N at this time, she indicated she didn't care and did not need the call light at that time. She indicated if she needed someone badly enough, she would "just yell for somebody." The clinical record of Resident N was reviewed on 7-7-23 at 8:57 a.m. Her diagnoses included, but were not limited to congestive heart failure, stage 3 chronic kidney disease, diabetes, high blood pressure and macular degeneration. Her most recent Minimum Data Set assessment, dated 6-20-23, indicated she is cognitively impaired, has highly impaired hearing and impaired vision, she requires supervision to extensive assistance with toileting and ambulation and uses a walker or wheelchair for mobility. On 7-7-23 at 1:35 p.m., the Wound Nurse provided a copy of a policy entitled, "Resident Rights." This undated policy was indicated to be the current policy utilized by the facility. This policy indicated, "It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. Safety of residents, visitors and employees is a top priority of care...To have a method to communicate needs to staff: Call light or bell access will be within reach of the resident as one method to communicate needs to staff..." 3.1-3(v)(1)		residents have a call light that is in reach at all times. DON/Designee will observe residents for call light within residents reach: 5 residents will be observed 5x wk x 4 wks, then 3 residents 3 x wk x 4 wks, then 3 residents 1 x wk x 4 wk. DON/Designee will report on audits monthly to the interdisciplinary team for 3 months during QAPI Meeting. The IDT will determine if the audits are necessary to continue after 6 months with 100% compliance achieved. Date of completion: 7/28/23	
F 0610 SS=D Bldg. 00	483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of			

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	abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			
	Based on interview and record review, the facility failed to complete a thorough investigation of an allegation of misappropriation of resident funds for 2 of 6 residents reviewed for thorough and accurate investigation and reporting of unusual occurrences. (Resident F and G) Findings include: 1. A Facility Reportable Incident, dated for 6/21/2023, indicated that Resident F and her POA (power of attorney) reported to the facility Resident G had used Resident F's cell phone to transfer money to Resident G's electronic funds account via an electronic transfer service. It was clarified this transfer of funds occurred prior to Resident F discharging from the facility on 6-15-23. In an interview with Resident G on 7-6-23 at 3:30 p.m., she indicated she had received verbal permission each time she had received money into	F 0610	1. Resident's G and F were not harmed by the alleged deficient practice. Resident F no longer resides at the facility. Resident G has been educated regarding not borrowing money from co-residents without staff approval/witness. All residents have the potential to be affected by the alleged deficient practice. The complete police report, including all statements from the involved parties have been obtained. Executive Director and DON have been educated regarding the Abuse/Misappropriation policy with an emphasis on thorough investigative practices. All residents and responsible parties have been educated regarding the facility policy on use of digital	07/28/2023

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	her "cash app" from Resident F. She indicated around the end of April or May of the current year, she had asked Resident F to lend her some money. She indicated Resident F had given her money several times via the cash app and this was always done in Resident F's room and with the use of Resident F's phone to send to her phone's cash app and with Resident F's permission "for about 6 or 7 times." Resident G was observed to access her cash app on her cell phone which was on her person. She then accessed her transactions that she allowed this writer to view on her phone of the following transactions of: -First transaction 5-31-23 of $40.00 -6-3-23 of $40.00 -6-4-23 of 40.00 -6-6-23 of $80.00 -6-9-23 of $60.00 -6-10-23 of $60.00 for a total of $320.00. Resident G indicated she had found on her app previously that she had received a total of $360.00 total from her peer, but was unable to demonstrate those totals. She indicated she does plan to pay Resident F back and has already "cash app'd her $25 on 6-25-23." She indicated the facility's Executive Director (ED) told her he would be willing to be the person to receive any of her payments for Resident F to place in a envelope and to call Resident F to have her pick up the payments. She indicated she spoke to Resident F about the ED's offer and indicated Resident F told her not to involve the ED with payments, but to just to call her directly and she would meet her at a near by store and then she would pick up the money directly from her. She indicated that some officer came to talk with her about all of this a shortly after Resident F discharged from the facility. "As far as I know, they [the police] haven't charged me with anything, because I		currency platforms amongst residents. All staff has been educated on electronic funds transfers/use of cash app. RDCO will audit every unusual occurrence for a thorough and complete investigation weekly x 8 weeks. The Executive Director will report on audits monthly to the interdisciplinary team for 3 months during QAPI Meeting. The IDT will determine if the audits are necessary to continue after 6 months with 100% compliance achieved. Date of completion: 7/28/2023	

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	didn't steal anything from her, she gave me permission to borrow the money." In an interview with the Staff Development staff member on 7-7-23 at 12:30 p.m., he indicated the facility did not conduct any post-investigation training about sharing of funds between residents. He indicated he does conduct abuse prohibition training and that includes misappropriation, but the current policies do not address electronic fund transfers. In an interview on 7-7-23 at 11:20 a.m., with the Corporate Nurse, the Interim Director of Nursing and Social Services Designee (SSD), they indicated the manner in which they became aware of the situation was after Resident F discharged, she and her POA (power of attorney) came in to report money missing from her bank account, on 6-21-23. The ED immediately reported it to the local police department and the ED told us that since he turned it over to the police department, he was just waiting for the police report. The Corporate Nurse indicated she remembered talking to the ED about this after the fact and he said once the rumors started getting around about this, none of the staff said they were aware of the residents borrowing money. Since Resident F was already discharged, we didn't add anything to her chart. The ED said there was no indication of any other staff being involved. The police report has the only actual interview documented with the resident and her POA. We did not receive the actual police report until this morning, after you [surveyors] requested it yesterday afternoon. The SSD indicated during resident interviews, she focused more on the residents on the alert and oriented of the unit in which both residents resided. The Corporate Nurse indicated other residents from other units were also included in			

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	the interviews. The clinical record of Resident G was reviewed on 7-6-23 at 2:39 p.m. Her diagnoses included, but were not limited to hemiplegia & hemiparesis post CVA (stroke), hypertensive heart disease without heart failure, chronic pain, peripheral vascular disease, anxiety, depression and polyneuropathy. Her most recent Minimum Data Set assessment, dated 5-3-23, indicated she is cognitively intact.2. The clinical record for Resident F was reviewed on 7/6/2023 at 2:33 p.m. The medical diagnoses included Parkinson's disease and hallucinations. An Admission Minimum Data Set Assessment, dated for 3/18/2023, indicated Resident F was cognitively intact. A Facility Reportable Incident, dated for 6/21/2023, indicated that Resident F and her POA reported that Resident G had used Resident F's phone to transfer money to Resident G's account via an electronic transfer service. An interview with the Corporate Nurse on 7/7/2023 at 11:18 a.m. indicated that staff statements were not completed because the staff were not aware of the incident. Statements were not obtained from Resident G, Resident F, or Resident F's POA because they would be within the police report. She verified that the facility did not have the police report from 6/21/2023 until 7/6/2023. An interview with the Executive Director on 7/7/2023 at 12:24 p.m. indicated that he did speak with Resident F on 6/21/2023 and when she disclosed that Resident G had used her phone to make transfers, he immediately reported it to the police. He indicated a police officer came out and			

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took statements from Resident F, Resident F's POA, and Resident G regarding the event. He did not write his own statements but was waiting for the police report. The facility was unable to obtain the police report during the initial five day follow up due to the police report being still under investigation and other circumstances.

An interview with the Staff Development Coordinator on 7/7/2023 on 12:28 p.m. indicated that he did not have anything to document education of staff or residents regarding this particular incident. He indicated he does educate staff yearly and at hire in regard to misappropriation of resident's funds, but it does not include electronic money transfers.

A policy entitled, "INDIANA Abuse & Neglect &Misappropriation of Property", was provided by the Interim DON on 7/5/2023 at 11:37 a.m. The policy indicated, " ...Accurate and timely reporting of incidents, both alleged and substantiated ..." Under investigation of incidents, indicated that " ...Statements will be obtained from the residents or from the reporter of the incident, in writing whenever possibly by the Executive Director or designee ...Documentation of the facts and findings will be completed in each residents medical record ..."The policy further indicated that under reporting, the "Follow up report (if not included with initial information) must be submitted within 5 working days after the initial report ...The Follow up report information should include the following; Results of the investigation ..."

This Federal tag relates to Complaint IN00411601.

3.1-28(a)
3.1-28(d)

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	3.1-28(e)			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.			
	Based on interview and record review, the facility failed to ensure 1 of 6 residents with weight loss had a notification to the attending physician and was monitored for weekly weights and had routinely documented meal intakes. (Resident B) Findings include: The clinical record of Resident B was reviewed on 7-5-23 at 1:45 p.m. It indicated she was admitted to the facility on 4-11-23 and had diagnoses which included, but were not limited to multiple open skin wounds, muscle wasting and atrophy, pulmonary embolism, borderline personality	F 0692	1. Resident "B" was not harmed by the alleged deficient practice. Resident "B" has since discharged. All residents have the potential to be affected by same alleged deficient practice. Each resident has been weighed and any weight losses have been calculated per facility policy. The physician and responsible parties have been notified with any significant weight losses noted. Supplements and diet changes have been	07/28/2023

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	disorder, diabetes, peripheral vascular disease, congestive heart failure, bipolar disorder, morbid obesity, skin picking disorder, suicidal ideation and unspecified cocaine use in remission. Her 4-11-23 admission weight of 180 pounds was identified as incorrect and was re-checked on 4-14-23 as 230 pounds. The next weight on 4-24-23, was listed as 218.46 pounds, or a weight loss of 11.54 pounds in a 10 day period, or a 5 percent weight loss within the 10 day period. In an interview with the Interim Director of Nursing (IDON) on 7-7-23 at 12:15 p.m., she indicated she would need to look into the 11 pound weight loss within 10 days. A review of Resident B's meal intakes for her time in the facility of 4-11-23 to 4-27-23, there were 17 of 37 or 45.9 percent of meals documented for percentage of each meal eaten. In an interview with the IDON on 7-7-23 at 12:55 p.m., she indicated Resident B was a very ill person who was in the facility for less than one month and had been sent out to the hospital twice during her stay, with the second time, did not return to the facility. She added that during her hospitalization around 4-20-23, her weights varied. She indicated with a new admission of a resident, the resident typically is placed on weekly weight checks and will only start on IDT (interdisciplinary team) review if there are any weight concerns. She indicated she could not find that anything had been documented about her weight loss or IDT review or notification to the doctor. This Federal tag relates to complaint IN00408249.		implemented as ordered per the physician and consumption is being recorded per facility policy. All appropriate care plans have been implemented, reviewed and updated per facility policy to reflect a resident centered plan of care. DON/Designee has educated all members of the nursing staff, the Interdisciplinary Team and the Registered Dietician on the Clinical Documentation Standards policy and Resident Height and Weight Policy with emphasis on "Meal Consumption Documentation." DON/Designee has educated all members of the Interdisciplinary Team and the Registered Dietician have been educated on the Resident Height and Weight Policy with an emphasis on "obtaining admission weights and unstable residents will be weighed weekly", "weight loss concerns will be discussed in weekly clinical meeting". DON/Designee will audit all resident weights that are clinically indicated for weekly weights 1 x wk x 12 wks in clinical meeting to ensure they have been obtained and physician/responsible party have been notified of any changes. DON/Designee will audit the Meal Consumption documentation for 10 residents to ensure meal consumption documentation is completed 5 x wk x 4 wks, then 5 resident's 3 x wk x 4 wks, then 1	

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	3.1-46(a)(1) 3.1-46(a)(2)		x wk x 4 wks. DON/Designee will report on audits monthly to the interdisciplinary team for 3 months during QAPI Meeting. The IDT will determine if the audits are necessary to continue after 6 months with 100% compliance achieved. Date of completion: 7/28/23	