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	02/07/2023

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

(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
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00395378, IN00396020, IN00396482, IN00396440, IN00397427, IN00398226, & IN00399996. Complaint IN00395378 - Substantiated. Federal/State deficiency related to the allegations are cited at F-689. Complaint IN00396020- Unsubstantiated due to lack of evidence. Complaint IN00396482 - Substantiated. Federal/State deficiency related to the allegations are cited at F-809 Complaint IN00396440- Substantiated. Federal/State deficiencies related to the allegations are cited at F-676. Complaint IN00397427- Substantiated. Federal/State deficiency related to the allegations are cited at F-689. Complaint IN00398226 - Substantiated. Federal/State deficiencies related to the allegations are cited at F-676. Complaint IN00399996- Unsubstantiated due to lack of evidence. Unrelated deficiency is cited. Survey dates: February 2 through February 7th 2023. Facility number: 000099 Provider number: 155188	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
Andrew Clark	Executive Director	02/24/2023

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.

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	AIM number: 100291140 Census Bed Type: SNF/NF: 131 Total: 131 Census Payor Type: Medicare: 6 Medicaid: 100 Other: 25 Total: 131 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on February 9, 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 a call light was within reach of Resident J for 1 of 3 resident reviewed for accommodation of needs. Findings include: The clinical record for Resident J was reviewed on 2/3/2023 at 1:04 p.m. The medical diagnoses included anxiety and stroke. An Admission Minimum Data Set Assessment, dated 1/23/2023, indicated that Resident J was	F 0558	**F558** **Reasonable Accommodations Needs/Preferences** 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.	02/24/2023

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	cognitively intact and needed staff assistance with hygiene and bathing activities of daily living. An observation on 2/2/2023 at 1:04 p.m., indicated Resident J laying in bed with her call light to the left of the bed in the closed top drawer of the bedside table. An interview and observation 2/2/2023 at 1:36 p.m., indicated Resident J laying in bed with her call light to the left of the bed in the closed top drawer of the bedside table. When asked if she could reach it, she stated she could not reach her call light. She attempted to reach it but could only touch a cup and her glasses on the top of the bedside table and could not reach the handle of the drawer. An observation on 2/2/2023 at 1:46 p.m., indicated CNA 4 coming in to pass a lunch tray to Resident J. She set up the meal tray on the over the bed table and then left the room without ensuring the call light was within reach. The call light remained in the closed top drawer of the bedside table out of reach of Resident J. A policy entitled, "Resident Rights", was provided by the Director of Nursing on 2/7/2023 at 12:14 p.m. The policy indicated, " ...Call light or bell access will be within reach of the resident ..." 3.1-3(v)(1)		**The facility cordially requests paper compliance regarding alleged deficient practices.** Resident J was not harmed by the alleged deficient practice. The DON/designee audited the resident room to ensure the call light was within easy reach. The care plan for resident J has been reviewed and updated. All residents have the potential to be affected by same alleged deficient practice. An audit has been conducted on all residents to ensure call light placed within easy reach. DON/Designee have educated all staff on the “Routine Resident Care” policy, with emphasis on “encouraging maximum function for each resident” to ensure call light placement within easy reach for each resident. DON/Designee will observe call light placement within easy reach for 5 residents 3 x wk x 4 wks, then 3 residents 1 x wk x 8 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: 02/24/2023	
F 0676 SS=D	483.24(a)(1)(b)(1)-(5)(i)-(iii) Activities Daily Living (ADLs)/Mntn Abilities			

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Bldg. 00	§483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. Based on observation, interview, and record	F 0676	**F676** **Activities of Daily Living**	02/24/2023

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	review, the facility failed to document the type of bathing provided to Resident J and K and failed to complete hair care for Resident J for 2 of 5 residents reviewed for showering and bathing activities of daily living. Findings include: 1. The clinical record for Resident J was reviewed on 2/3/2023 at 1:04 p.m. The medical diagnoses included anxiety and stroke. An Admission Minimum Data Set Assessment, dated 1/23/2023, indicated that Resident J was cognitively intact and needed staff assistance with hygiene and bathing activities of daily living. An interview and observation with Resident J on 2/3/2023 at 1:36 p.m., indicated that she had been here for 2 going onto 3 weeks at this time. She reported she only gets bed baths because that's all the staff will assist her with, and she had not had her hair shampooed since she was admitted. Resident J's hair was very stringy and greasy at this time with a slight odor. She indicated she would like to have a shower and her hair washed at least twice a week. Electronic charting to Resident J indicated she receive a bed bath on 1/20/2023 with no other bathing listed between time of admission to review. Paper shower sheets were provided for Resident J dated for 1/18/2023, 1/21/2023, 1/25/2023, 1/28/2023, and 2/1/2023 all without the indication of type of bathing care nor documentation of shampooing completed. 2. The clinical record for Resident K was reviewed		**(ADL's)/Mntn Abilities** 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.** Residents J and K were not harmed by the alleged deficient practice. Resident J has been provided a shower and hair wash. Resident K has been provided a shower based on her voiced preferences. Care plans have been reviewed and updated accordingly. All residents have the potential to be affected by same alleged deficient practice. Resident preferences have been updated for all residents to reflect preferred bathing choice. The shower schedule for each resident has been updated according to resident preferences. The ADL care plans have been reviewed and updated, for each resident, to reflect resident choice. DON/Designee has educated all members of the nursing staff on the Routine Resident Care Policy with a focus on resident	

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	on 2/3/2023 at 11:45 a.m. The medical diagnosis included spinal stenosis. An Admission Minimum Data Set Assessment, dated 1/25/2023, indicated that Resident K was cognitively intact and needed staff assistance for hygiene and bathing/showering activities of daily living. An interview and observation with Resident K on 2/2/2023 at 1:05 p.m. indicated she had been here for two weeks at that time and during those two weeks she had received one shower a week. She indicated the staff are too busy so on the other days, they will just help her to the bathroom and wash her up there. The electronic medical record indicated that Resident K had a complete shower on 1/18/2023 and 1/25/2023 as well as a bed bath on 1/20/2023. Paper shower sheets were provided for Resident K dated 1/18/2023, 1/21/2023, 1/28/2023, and 1/30/2023 without the indication of type of shower/bathing provided. A shower sheet, dated 1/25/2023, indicated "shower" for Resident K. An interview with the Director of Nursing on 2/7/2023 at 10:45 a.m. indicated that it is the expectation that hair care and shampooing is provided during showering unless clinical contraindicated or refused by the resident. A policy provided by the Executive Directed on 2/7/2023 at 11:49 a.m. indicated " ...Routine care provided by a nursing assistance includes ...bathing ...Observing and documenting all aspects of care ..." This Federal tag relates to Complaint IN00398226		preference. DON/Designee will observe that a shower/bath has been provided based on resident preference for 5 residents 3 x wk x 4 wks, then 1 x wk x 8 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: 2/24/23	

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	and IN00396440. 3.1-37(a)(3)(B)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review, the facility failed to complete an assessment after Resident H experiences a fall and subsequently develop post-fall interventions for 1 of 3 residents reviewed for falls. Findings include: The clinical record for Resident H was reviewed on 2/7/2023 at 10:51 a.m. The medical diagnoses included long term use of anticoagulants and osteoarthritis. An interview with Resident H's family member on 2/2/2023 at 2:42 p.m. indicated that she was told by the transportation drive on 11/9/2022 that Resident H had a fall in the van right as they were going to leave the facility. The driver indicated to the family member that Resident H was checked by the nurse at the facility and was okay to go to her appointment. An interview with Transporter 1 indicated she had	F 0689	**F689** **Free of Accident Hazards/Supervision Devices** 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.** Resident H not harmed by the alleged deficient practice. Resident room was audited to ensure that all post- fall care plan interventions were implemented per the resident specific plan of care.	02/24/2023

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	taken Resident H to her appointment on 11/9/2022. She assisted Resident H into the vehicle and strapped in her Resident H's wheelchair then double checked all the straps as she always does. She then went to take off and she believes Resident H had unsnapped the front strap which caused Resident H to tip back in her wheelchair and hit her head on the floor of the vehicle. She called the facility and was unable to reach her direct report. She then called and the nurse from the facility, an agency nurse that she didn't know the name of, came out to help her get Resident H up, "checked her over", and took vitals before telling Transporter 1 that Resident H was okay to go to her appointment. Transported 1 stated she told the family member about the fall when they arrived at the MD (medical doctor) visit. An MD note, dated 11/9/2022, indicated " ...On the way to the office, patient reports she fell off her wheelchair and hit her head against the floor of the van. Mild pain behind the neck but no bumps ..." This MD ordered a computerized tomography (CT) scan of the head to be completed for Resident H. A CT scan of the head and brain, dated 11/9/2022, indicated no acute changes for Resident H. No nursing assessment or progress notes were documented regarding the fall on 11/9/2022 nor were specialized interventions put into place regarding this fall. An interview with the Executive Director on 2/6/2023 at 1:31 p.m. indicated he was not made aware of Resident H having a fall during her transportation on 11/9/2022. To his knowledge, no further incidents during transport have had happened since 11/9/2022.		All residents have the potential to be affected by same alleged deficient practice. The fall care plans for each resident have been reviewed to ensure all current post- fall interventions have been implemented DON/Designee has educated all members of the IDT team and all licensed nurses on the Fall Prevention and Management Policy with emphasis on “care plan and post fall intervention”. DON/Designee will observe post-fall intervention implementation for each fall occurrence 3 x wk x 4 wks, then 1 x wk x 8 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: 2/24/2023	

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	A policy entitled, "Fall Prevention and Management", was provided by the Executive Director on 2/3/2023 at 11:00 a.m. The policy indicated, " ...If the resident hits their or it was unwitnessed fall begin neurochecks ...Once a resident is safely transferred, a fall investigation should begin ...Attempt to put an intervention in place that could prevent further falls ... Document all interventions and family/physician notification ..." The policy also instructed for documentation to require a complete "Post Fall Assessment", if the resident hit their head, neurological checks if indicated, if there was an injury, fall follow up assessments, a report in Risk Watch, and updated care plan. This Federal tag relates to Complaint IN00397427 and IN395378. 3.1-45(a)(2)			
F 0809 SS=D Bldg. 00	483.60(f)(1)-(3) Frequency of Meals/Snacks at Bedtime §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span.			

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	§483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. Based on observation, interview and record review the facility failed to serve lunch timely for 1 of 2 observations (Resident K, Resident J and Resident E). Findings include: During an observation and interview with Resident K on 2/2/23 at 1:05 p.m., the resident indicated meals were always served late. The resident indicated lunch was usually served between 1:30 p.m. to 2:30 p.m., Resident J had not been served her lunch tray at this time. The Admission Minimum Data Set (MDS) assessment for Resident K, dated 1/25/23, indicated the resident was cognitively intact for daily decision making, the resident was consistent and reasonable. During an observation and interview with Resident J on 2/2/23 at 1:36 p.m., indicated she usually received her lunch tray around 2:00 p.m., the resident was observed not to have her lunch tray at this time. The Admission MDS assessment for Resident J, dated 1/26/23, indicated the resident was cognitively intact for daily decision making, the resident was consistent and reasonable. During an observation on 2/2/23 at 2:15 p.m., LPN	F 0809	**F 809** **Frequency of Meals / Snacks at Bedtime** 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.** No residents were identified as being harmed by the alleged deficient practice. All residents have the potential to be affected by the same alleged deficient practice. The ED / Designee have in-serviced the dietary and nursing employees regarding the Meal Time Delivery Schedule. The ED / Designee will monitor and audit the Meal Time Delivery Schedule according to the following schedule: 2 meals observed for timely delivery 3 days x a week for 4 weeks, then 1 day	02/24/2023

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	3 was passing lunch trays on the Brookshire unit. Review of the facility dining service schedule provided by the Administrator on 2/3/23 at 11:00 a.m., indicated Brookshire unit cart one would be served at 11:15 a.m., and the Brookshire unit cart two would be served at 12:20 p.m. During an observation and interview with Resident E on 2/3/23 at 11:30 a.m., indicated meals were usually late and were served between a two hour window. The resident indicated lunch could be served between 12:00 p.m., to 2:00 p.m. The resident was observed not to have been served his lunch at this time. Review of the record of Resident E on 2/3/23 at 1:35 p.m., indicated the resident's diagnosis included, but were not limited to, diabetes mellitus. The Quarterly MDS assessment for Resident E, 1/24/23, indicated the resident was cognitively intact for daily decision making, the resident was consistent and reasonable. The resident required supervision and setup help only. During an interview with LPN 3 on 2/3/23 at 12:10 p.m., indicated the reason lunch trays were passed late on 2/2/23 on the Brookshire unit was because dietary had brought the food carts to the unit late. During an interview with the Dietary Manager on 2/7/23 at 1:07 p.m., indicated the reason the Brookshire unit lunch trays were passed late on 2/2/23 was because the dietary department had staffing issues and had staff walk out in the past month. This Federal tag relates to Complaint IN00396482.		x a week for 8weeks. The ED / Designee will provide a report on a monthly basis at the QAPI Meeting to the interdisciplinary team. The audits will be reviewed and trended in QAPI for 6 months and randomly thereafter to ensure compliance achieved. Date of completion: 02/24/2023	

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	1.3-21(c)			