STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155788	A. BUILDING 00 B. WING	09/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREENWOOD MEADOWS	1200 N STATE ROAD 135 GREENWOOD, IN 46142

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: September 17, 18, 19, 20 and 23, 2024 Facility number: 012564 Provider number: 155788 AIM number: 201018510 Census Bed Type: SNF: 16 SNF/NF: 117 Total: 133 Census Payor Type: Medicare: 9 Medicaid: 78 Other: 46 Total: 133 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed September 27, 2024.	F 0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Desk Review in lieu of a Post Survey Revisit on or after 10/22/24,	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) Based on interview and record review, the facility failed to notify a provider of laboratory results that fell outside of clinical reference ranges for 1 of 5 residents reviewed for unnecessary medications. (Resident 105) Findings include:	F 0580	p paraid="706511490" paraeid="{e779a333-47fd-44aa-8191-7f10310d4079}{71}" >F580 (D) Notify of Changes What corrective action(s) will be accomplished for those residents	10/22/2024

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

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	On 9/20/24 at 1:58 p.m., Resident 105's clinical record was reviewed. The diagnoses included, but were not limited to, type 2 diabetes mellitus (DM) with diabetic neuropathy, peripheral vascular disease, and surgical amputation of the right leg (below the knee). A review of the current, September, 2024, physician's orders indicated: On 7/4/24, the resident was ordered insulin aspart U-100 (medication used to treat DM) per sliding scale, at bedtime, 8:00 p.m. The order specified to contact the MD (medical doctor) if blood sugar was great than 400. The resident's blood sugar results on the Electronic Medical Record (EMAR) and vitals login included, but were not limited to: -On 9/8/24 at 9:37 p.m., the resident's blood glucose was 421 mg/dL (milligrams per deciliter). The physician was not notified. -On 8/29/24 at 8:33 p.m., the resident's blood sugar was 414 mg/dL. The physician was not notified. -On 8/29/24 at 7:40 p.m., the resident's blood sugar was 423 mg/dL. The physician was not notified. -On 7/29/24 at 8:11 p.m., the resident's blood sugar was 420 mg/dL. The physician was not notified. -On 7/28/24 at 8:38 p.m., the resident's blood sugar was 437 mg/dL. The physician was not notified. A review of the resident's progress notes, from July to September, 2024, did not indicate a reason why the physician was not notified of any glucose result greater than 400 mg/dL.		found to have been affected by the deficient practice? Nursing staff the blood glucose and insulin orders of 105 with MD/NP. All licensed nurses re-educated by DNS/designee on blood glucose/insulin orders/MD notification for changes. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents with blood glucose and insulin orders have the potential to be affected by the alleged deficient practice. All residents with blood glucose and insulin orders will be reviewed by the Nurse Management team and MD. DNS/Designee will conduct an in-service with licensed nursing staff on blood glucose and insulin orders and MD notification of changes. What measures will be put into place or what systemic changes	

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	On 9/23/24 at 3:53 p.m., the Director of Nursing (DON) indicated the resident blood sugars were documented under a few different spots and the staff would call the on-call provider if the resident had a blood glucose out of parameters. On 9/24/24 at 4:25 p.m., the DON provided the facility policy, "Blood Glucose Monitoring," revised on 2/2015, and indicated it was the policy currently being used. A review of the policy indicated, "... Residents who have a physician's order to obtain routine capillary blood glucose will have a physician's order specifying the blood glucose parameters requiring physician notification ... The physician will be notified when the resident's blood glucose is outside the physician stated parameters ..." 3.1-5(a)(3)		make to ensure that the deficient practice does not recur? DNS/Designee will conduct an in-service with all licensed nurses on blood glucose and insulin orders and MD notification of changes. The facility activity report and EMAR will be reviewed by DNS/designee during clinical meeting. A daily review tool including blood sugars requiring MD notification will be utilized by the Nurse Management team. How be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Annual POC QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director ul class="BulletListStyle1 SCXW34846054 BCX0" role="list" style="-webkit-user-drag: none; -webkit-tap-highlight-color:	

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			transparent; margin: 0px; padding: 0px; user-select: text; cursor: text; font-family: verdana; overflow: visible;" If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance Based on observation, interview and record review, the facility failed to monitor weights and implement interventions for a resident with assessed significant weight loss for 1 of 4 residents reviewed for nutrition. (Resident 27) Findings include: On 9/19/24 at 10:18 am, Resident 27 was observed in her bed. Her wrists were small with bony prominence's, and her face showed indications of emaciation with sunken cheeks and hollow eye sockets. On 9/19/24 at 10:40 am, Resident 27's clinical record was reviewed. The diagnoses included, but were not limited to, dementia, hypothyroidism, and vitamin D deficiency. The quarterly review Minimum Data Set assessment, dated 6/3/24, indicated the resident was severely cognitively impaired. The Care Area Assessment Detail Worksheet, dated 3/8/24, indicated the resident had a history of significant weight loss in the prior 180 days. On 4/3/24 the resident weighed 95 pounds.	F 0692	p="" paraid="1109753383" paraeid="{e779a333-47fd-44aa-8191-7f10310d4079}{243}">Greenwood Meadows requests additional evidentiary information be considered to delete F 692, from the 2567. The current statement of deficiencies on the 2567 omits significant facility information and therefore misrepresents the care and services administered by the provider to its residents. p="" paraid="1109753383" paraeid="{e779a333-47fd-44aa-8191-7f10310d4079}{243}"> p="" paraid="1109753383" paraeid="{e779a333-47fd-44aa-8191-7f10310d4079}{243}">F692 (D) Nutrition/Hydration Status Maintenance What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? IDT to schedule care plan review with resident and family by 10/21/24. Super Cereal added to resident's nutritional care	10/22/2024

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	On 7/4/24 the resident weighed 93 pounds. On 8/1/24 the resident weighed 87 pounds, which indicated a significant weight loss of 11.58 percent in 120 days and a significant weight loss of 6.45 percent in 28 days. No weights were recorded between 7/4/24 and 8/1/24. On 8/7/24 the resident weighed 90 pounds. On 9/3/24 the resident weighed 84 pounds, which indicated a significant weight loss of 6.67 percent in 26 days. No weights were recorded between 8/7/24 and 9/3/24. A Follow Up Nutrition Review, dated 9/4/24, indicated, "...loss of 5% or more in the last month or loss of 10% or more in the last 6 months...not assessed...", and "...gain of 5% or more in the last month or 10% in the last 6 months...yes, on physician-prescribed weight-gain regimen...resident continues on a regular diet..." A Dietitian Review, dated 9/9/24, indicated, "...resident is at nutritional risk d/t [due to] unintentional weight loss...resident is on regular diet...hx [history] of benecalorie [an unflavored supplement that could increase the calorie and protein content of most foods and beverages] supplement in oatmeal which was providing additional 330 kcals [kilocalories]. Resident stopped eating her oatmeal with benecalorie in it..." Physician orders indicated the resident was prescribed benecalorie to be added to her oatmeal		plan. Resident 27 to continue bi-monthly weights until stable. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? ALL residents with weight loss have the potential to be affected by the alleged deficient practice. All residents with significant weight loss will be reviewed by the IDT team during NAR. Interventions will be reviewed and updated as needed.The IDT team will be educated by the Regional RD/designee on NAR meetings and nutritional care planning. What measures will be put into place or what systemic changes make to ensure that the deficient practice does not recur? The IDT team will be educated by the Regional RD/designee on NAR meetings and nutritional care planning. Residents with significant weight loss will have bi-monthly weights completed and reviewed during NAR. Interventions will be reviewed and added by team as needed. How be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Annual POC QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance	

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	from 6/12/24 until discontinued on 8/15/24. No further dietary, nutritional, or pharmacological interventions were ordered or implemented after 8/15/24. The resident was not on a physician-prescribed weight-gain regimen after 8/15/24. On 9/23/24 at 4:20 p.m., the Director of Nursing provided the Resident Weight Monitoring policy, revised 9/2024, and indicated this was the policy used by the facility. A review of the policy indicated, "...bi-monthly weights will be obtained at a minimum for...residents who have experienced a significant weight loss of 5% in 30 days, 7.5% in 90 days or 10% in 180 days..." During an interview on 9/23/24 at 4:22 p.m., the Director of Nursing indicated residents identified with significant weight loss underwent a minimum of bi-monthly weight monitoring. 3.1-46(a)(1)		Improvement Committee overseen by the Executive Director ul="" role="list" If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	
F 0800 SS=D Bldg. 00	483.60 Provided Diet Meets Needs of Each Resident Based on interview and record review, the facility failed to ensure a resident with a diagnosis of type 2 diabetes mellitus (chronic high blood sugar which could be controlled with diet, exercise, and some medications) received a therapeutic diet for 1 of 7 residents reviewed for food. (Resident 283) Findings include: During an interview on 9/18/24 at 11:34 a.m., Resident 283 indicated she was a "diabetic" and was getting cakes with frosting and doughnuts. She should not be getting those desserts because	F 0800	p paraid="1161115826" paraeid="{b7786c5f-2357-44ab-b007-6ae5260559a5}{124}" >Greenwood Meadows requests additional evidentiary information be considered to delete F 800, from the 2567. The current statement of deficiencies on the 2567 omits significant facility information and therefore misrepresents the care and services administered by the provider to its residents.	10/22/2024

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	she was a diabetic. On 9/20/24 at 10:25 a.m., Resident 283's clinical record was reviewed. The diagnoses included, but were not limited to, left femur fracture and type 2 diabetes mellitus with diabetic neuropathy (pain and numbness in hands and feet). The After Visit Summary, dated 9/12/24 at 3:28 p.m., indicated diet instructions were "progress as tolerated." The After Visit Summary lacked documentation of Resident 283's diet as regular. The dietary order, dated 9/12/24, indicated a regular diet. The Discharge summary, dated 9/12/24 at 10:39 a.m., indicated she had diagnosis of diabetes mellitus for 25 years. Her glucose was 183 on 9/10/24 and 163 on 9/9/24. Her diet was a diabetic diet. The Hospitalist Post-Acute Care Note, dated 9/13/24, indicated the resident had diagnosis of diabetes mellitus. The note lacked documentation of resident's diet. The Hospitalist Post-Acute Care Note, dated 9/16/24, indicated the resident had blood sugars of 140-260. The note lacked documentation of resident's diet. The Initial Nutrition Review, dated 9/16/24 at 1:19 p.m., indicated the current diet order was a regular diet. The special diet prior to admission was "low sugar." The clinical record lacked documentation once the facility received the discharge summary and saw the diet was a diabetic diet they clarified the diet		F800 (D) Provided Diet Meets Needs of Each Resident What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? MD to review diet order of resident 283. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? ALL residents admitting with special diets have the potential to be affected. Admission orders will be reviewed the following business day by the nurse management team for accuracy. Discharge summaries will be requested by Medical Records Nurse/designee if not available at time of discharge. Order discrepancies between the AVS and discharge summary will be reviewed with the MD for clarification and documented.	

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	with the doctor. During an interview on 9/23/24 at 2:45 p.m., Resident 283 indicated when she was at home prior to her admission to the facility her accu-checks were 130-180 mg/dl (milligrams/deciliter). Since she had been at the facility and was getting regular desserts, her accu-checks had been higher. The other day, she received a sugar cream pie. She was unsure if it was a diabetic pie or regular pie, ate the pie, and her accu-check was around 260 mg/dl. During an interview on 9/23/24 at 2:54 p.m., the Director of Nursing Services (DON) indicated when a resident was discharged from the hospital, they would follow the diet they had in the hospital. The facility's diet for diabetics was carbohydrate controlled diet. During an interview on 9/23/24 at 4:24 p.m., the DON indicated when Resident 283 was admitted, they only had the After Visit Summary. They did not receive the Discharge Summary until the next morning. She indicated she did not have any documentation of notifying the doctor of the diet which was on the discharge summary or that he wanted to continue with the regular diet after the discharge summary was received. On 9/23/24 at 4:30 p.m., the DON provided the facility's policy, "Nursing Admission/Return Admission Policy and Procedure," dated 7/2024 and indicated it was the policy being used by the facility. A review of the policy indicated "...b. Diet - transcribe the diet using the correct terminology...1. Resident being admitted from the hospital must have a discharge summary. If not present at admission, contact the transferring facility for a copy..."		What measures will be put into place or what systemic changes make to ensure that the deficient practice does not recur? The IDT team will be educated by the Regional Director of Clinical Services/designee on Admission diet review using the AVS and discharge summary. Admission orders will be reviewed the following business day by the nurse management team for accuracy. Discharge summaries will be requested by Medical Records Nurse/designee if not available at the time of discharge. Order discrepancies between the AVS and discharge summary will be reviewed with the MD for clarification and documented. The CDM/designee will complete the Initial Nutrition Review observation upon admission. How be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?	

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	1.3-20(a)		ul class="BulletListStyle1 SCXW90923442 BCX0" role="list" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px; user-select: text; cursor: text; font-family: verdana; overflow: visible;" The Annual POC QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	