STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	12/21/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: December 20 and 21, 2023 Facility number: 011799 Residential Census: 97 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on January 2, 2024	R 0000	**This plan of correction is submitted as required under State and Federal law. The submission of this Plan of Correction does not constitute an admission on the part of Greenbriar Village as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this Plan of Correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Dana	Milner	01/11/2024

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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R 0042 Bldg. 00	410 IAC 16.2-5-1.2(p) Residents' Rights - Noncompliance (p) Residents have the right to the examination of the results of the most recent annual survey of the facility conducted by the state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. Based on observation and interview, the facility failed to ensure a resident's right to examine the results of the most recent annual survey of the facility conducted by the state surveyors, any plan of correction in effect, and any subsequent surveys but not having the survey binder readily accessible to resident and/or visitors. This had the potential to affect all 97 residents residing in the facility. (Facility) Findings include: An environmental tour with Maintenance Director (MD) was conducted on 12/21/23 at 10 a.m. It was at the beginning of the environmental tour that it was observed that the facility's survey binder was not visible nor was there a sign to indicate where the survey binder was located. Upon further inspection of a cabinet near the front entrance, the survey binder was found to be located inside of the cabinet. An interview conducted with Marketing Manager (MM) conducted on 12/21/23 at 11:30 a.m. indicated, the facility's survey binder should be in a place that is readily accessible to the residents and/or visitors without having to ask where it was located or requesting it.	R 0042	**This plan of correction is submitted as required under State and Federal law. The submission of this Plan of Correction does not constitute an admission on the part of Greenbriar Village as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this Plan of Correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action**	02/01/2024

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			against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies. 1 The Sales Director ("SD") immediately placed the Survey Binder in the main lobby. 2 The Executive Director will include the Survey Binder location in the upcoming facility Newsletter to all residents that will go out by Friday, January 12, 2024. 3 The Executive Director or designee will conduct an in-service with all staff on proper location of the survey binder and availability to all residents, visitors, and staff. 4 The facility will take the following step to monitor adherence: Executive Director or designee will check placement of Survey Binder in front lobby weekly for one month, then monthly thereafter for a total of 3 months. 5 Systemic changes will be completed by February 1, 2024.	
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows:			

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	(1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on record review and interview, the facility failed to attempt to hold their fire and disaster drills in conjunctions with the local fire department at least every six months. This had the potential to affect all 97 residents residing at the facility. (Facility) Findings include: On 12/20/23, the facility provided copies of the facility's Monthly Fire Drill Reports for 2023. On the fire drill report, there was a section indicating "involvement" with three options: "Monitoring", "Fire Department", and "residents". None of the monthly fire drill reports indicated, the Fire Department had been been involved. An interview conducted with Maintenance Director (MD) on 12/20/23 at 3:31 p.m. indicated, he had not attempted to conduct any of the	R 0092	1 The Executive Director contacted the local fire department to request their participation in an upcoming fire drill. Documentation of this request will be kept in TELS Maintenance System. 2 The Executive Director or designee will in Service the Maintenance Director and Maintenance Assistant on the Fire Drill policy, including the requirement to have local fire department participation at least once every six months. 3 The Executive Director or designee will audit for completion during Quality Assurance (QA) completion each month.	02/01/2024

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	monthly fire drills in conjunction with the fire department. When asked why he did not attempt to involve the local fire department, he indicated, he just kept it "in house". A Fire Drill policy/procedure was received on 12/21/23 at 11:31 a.m. from Marketing Manager (MM). It indicated, "Steps: Perform a fire drill...2. Inform fire station/ monitoring company of the test...5. Test the system by activating a smoke detector, pull station, or other trigger in the proper zone...File written documentation in the safety binder..."		4 Systemic changes will be completed by February 1, 2024.	
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties			

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	shall conform with written job descriptions. Based on interview and record review, the facility failed to have 1 staff member certified in CPR (Cardio-Pulmonary Resuscitation) and First Aide for each shift for the 1-week period reviewed which had the potential to effect 97 of 97 residents residing at the facility (facility). Findings include: The schedule as worked for 12/10/23 through 12/16/23 was provided by the DON (Director of Nursing) on 12/20/23 at 1:18 p.m. The schedule as worked indicated there was not an employee working which was certified in CPR on the following days and time: 12/10/23- night shift, 12/11/23- evening shift, 12/12/23- evening shift, 12/13/230 evening and night shift, 12/14/23- evening shift, and 12/16/23- night shift. The schedule as worked indicated there was not an employee working which was certified in First Aide on any shift from 12/10/23 through 12/16/23. During an interview on 12/21/23 at 12:12 p.m., the DON indicated the facility did not have a policy on CPR certification and First Aide. The facility followed the state guidelines.	R 0117	1 The Wellness Director or designee will complete an CPR/ First Aide completion audit of all care staff. 2 The Wellness Director or designee will schedule CPR/ First Aide classes for current care staff. 3 The Scheduler will ensure that at least 2 qualified staff members are in the building at all times. The Wellness Director or designee will obtain current certification or ensure that care staff new hires complete CPR/ First Aide certification within 60 days of hire. 4 The Wellness Director of designee will audit the shift logs weekly for two months to ensure that at least 2 qualified staff members were in the building at all times. 5 The Wellness Director or designee will keep an CPR/ First Aide binder with all certification and expiration dates. 6 Systemic changes will be completed by February 1, 2024	02/01/2024
R 0148 Bldg. 00	410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may			

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	adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected. Based on interview and record review, the facility failed to ensure the facility's heating and ventilating systems had been inspected at least yearly. This had the potential to affect all 97 residents residing within the facility. (Facility) Findings include: An environmental tour with Maintenance Director (MD) was conducted on 12/21/23 at 10 a.m. During the tour, an interview with MD was conducted concerning when the facility's heating and ventilation systems had been last inspected. MD indicated, he was not sure and that information was probably known by the facility's Executive Director. At the time of the survey, the facility's Executive Director was not available, but the Marketing Manager (MM) would look into it. An interview, with MM conducted on 12/21/23 at 12:29 p.m. indicated, they were unable to produce evidence of an inspection of the facility's yearly heating and ventilation system prior to the close of the survey.	R 0148	1 ED or designee will in service the Maintenance Director on preventative maintenance requirements. 2 Maintenance Director or designee will schedule a licensed HVAC company to come in and perform inspection by February 1, 2024. 3 ED or designee will add to TELS Maintenance System to trigger annually. 4 Systemic changes will be completed by February 1, 2024	02/01/2024

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R 0154 Bldg. 00	410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24. Based on observation and interview, the facility failed to ensure dumpster ground area was free of rubbish debris. This had a potential to affect 97 of 97 residents that reside in the facility. Findings include: During a kitchen tour with the Dietary Manager (DM) on 12/20/23 at 1:46 p.m., the closed dumpster area was observed. The ground on the sides and behind the dumpster had qtips, disposable gloves, over-the-counter medications, paper towels, cardboard boxes, tomatoes, pop cans and food debris. An interview was conducted with the DM on 12/20/23 at 1:50 p.m. She indicated the facility staff, and the residents utilize the dumpster. The maintenance department was to keep the ground area around the dumpster clean.	R 0154	1 Dumpster area has been cleaned of any debris. 2 ED or designee will in service all staff on maintaining the area around the dumpster and ensuring no debris is present. 3 Maintenance Director or designee will audit the dumpster area daily Monday through Friday to ensure compliance. 4 Systemic changes will be completed by February 1, 2024.	02/01/2024
R 0155 Bldg. 00	410 IAC 16.2-5-1.5(l) Sanitation and Safety Standards - Deficiency (l) The facility shall have an effective garbage and waste disposal program in accordance with 410 IAC 7-24. Provision shall be made for the safe and sanitary disposal of solid waste, including dressings, needles, syringes, and similar items. Based on observation, interview, and record review, the facility failed to ensure the kitchen was clean and in good repair. This had a potential to affect 97 of 97 residents that eat food prepared in	R 0155	1 The kitchen area was deep cleaned. The hole under the dishwasher was repaired. The ventilation slates and the door	02/01/2024

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	the kitchen. Findings include: An observation was made of the kitchen with the Dietary Manager (DM) on 12/20/23 at 10:20 a.m. During the tour, the stove area was observed with grease splatter above the stove on the hood, on the back wall and on an appliance behind the steamer. Clean dishes were placed on a rolling cart sitting next to a vented door that had dark black grayish grime in the vented slates. The dishwasher area was observed with stained brown splatter, and the dry wall was coming away from the bottom trim with a gap big enough to see inside the wall. An observation was made of the kitchen with the DM on 12/20/23 at 1:46 p.m. The dishwasher area was observed with a large gap in between the drywall and the bottom trim. A rolling cart of clean dishes were observed next to a door that was vented. The vented slates on the door had black gray grime. The hood above the stove, the appliance behind the steamer, and the wall behind stove had yellow grease splatter. An interview was conducted with the DM on 12/20/23 at 1:50 p.m. She indicated the dietary staff have daily cleaning task, and she has someone come in to deep clean the kitchen every other week. She does not require the staff to utilize cleaning logs when they have completed a cleaning task or deep cleaned. She was unaware how long the wall was unattached to the bottom trim behind the dishwasher. A kitchen sanitation policy was provided by the DM on 12/20/23 at 2:46 p.m. It indicated "...5. A monthly cleaning schedule for deep cleaning		were replaced. 2 The Dining Services Manager will initiate cleaning daily, weekly, and monthly cleaning logs for all areas of the kitchen. 3 The Dining Services Manager will in-service dining staff on the cleaning log requirements. 4 ED or designee will audit the cleaning logs and inspect the cleanliness of the kitchen weekly for one month, then monthly thereafter. 5 Systemic changes will be completed by February 1, 2024.	

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	should be maintained and followed. All items on the cleaning schedule must be completed as scheduled and checked off..."			
R 0302 Bldg. 00	410 IAC 16.2-5-6(c)(6) Pharmaceutical Services - Deficiency (6) Over-the-counter medications must be identified with the following: (A) Resident name. (B) Physician name. (C) Expiration date. (D) Name of drug. (E) Strength. Based on observation, interview, and record review, the facility failed to label over the counter medications with the resident's name, apartment number, and date the medication was opened for 1 of 5 residents randomly reviewed for medication administration (Resident 11). Findings include: The clinical record for Resident 11 was reviewed on 12/21/23 at 9:20 a.m. The Resident's diagnosis included, but were not limited to, hypertension. Resident 11 was observed receiving her medication from QMA (Qualified Medication Aide) 1. QMA 1 removed a bottle of presser-vision vitamins from the medication cart, the bottle did not contain Resident 11's name or room number. QMA 1 opened the bottle, removing the safety seal and dispensed on table into a medication cup. QMA 1 then removed an individual packet of MiraLAX (laxative) from a box in the medication cart, the box was observed to be without Resident 11's name or room number. QMA opened the packet of MiraLAX and added it to a glass of water. QMA 1 then administered	R 0302	1 The Wellness Director or designee labeled the medication for resident 11. 2 The Wellness Director or designee will audit all medication carts for unlabeled medications and label them accordingly. 3 The Wellness Director or designee will educate all QMAs and nurses on the Medication Labeling Policy. 4 The Wellness Director or designee will audit the medication cart for unlabeled medication weekly for one month and then monthly thereafter. 5 Systemic changes will be completed by February 1, 2024	02/01/2024

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	the medication to Resident 1. During an interview on 12/21/23 at 9:25 a.m., QMA 1 indicated that the presser-vision and MiraLAX were available over the counter and did not have a pharmacy label. On 12/21/23 at 10:35 a.m., the Director of Nursing provided the current Medication Labeling Policy which read "...If a Resident has his/her over-the-counter medication stored in the medication room, each OTC medication must be labeled with the Resident's name, apartment number and date the medication was opened. Follow the state licensing regulation requirements for OTC labeling..."			
R 0354 Bldg. 00	410 IAC 16.2-5-8.1(g)(1-7) Clinical Records - Noncompliance (g) A transfer form shall include the following: (1) Identification data. (2) Name of the transferring institution. (3) Name of the receiving institution and date of transfer. (4) Resident ' s personal property when transferred to an acute care facility. (5) Nurses ' notes relating to the resident ' s: (A) functional abilities and physical limitations; (B) nursing care; (C) medications; (D) treatment; and (E) current diet and condition on transfer. (6) Diagnosis. (7) Date of chest x-ray and skin test for tuberculosis. Based on interview and record review, the facility failed to ensure a resident who was sent to the hospital had a transfer form for 1 of 2 closed records reviewed. (Resident 9)	R 0354	1 The Wellness Director will create a communication document to be sent along with the Transfer/ Discharge and Bedhold Policy,	02/01/2024

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	Findings include: The clinical record for Resident 9 was reviewed on 12/20/23 at 11:30 a.m. His diagnoses included, but were not limited to, diabetes and depression. The 11/25/23 Incident Report indicated Resident 9 was transferred to the hospital on 11/25/23 at 10:20 p.m. There was no information in the clinical record to indicate what information was sent to the hospital with Resident 9, including the nursing notes. An interview was conducted with the DON (Director of Nursing) on 12/20/23 at 11:50 a.m. She indicated Resident 9 was sent to the hospital on 11/25/23 and went to another facility from there. When a resident was sent to the hospital, nursing staff printed out the resident's face sheet and physician order sheet to send with them to the hospital. She reviewed Resident 9's clinical record and indicated night shift nursing staff did not document they sent that information with him to the hospital. The facility did not use a specific transfer form that included a resident's medications or condition upon transfer when sending a resident out to the hospital. Resident 9's face sheet and physician order sheet did not include the name of the receiving institution and date of transfer, Resident 9's personal property when transferred, or notes relating to his functional abilities and physical limitations.		Face Sheet, and physician's order summary. 2 The Wellness Director or designee will educate the QMAs and nurses on Transfer/Discharge protocol. 3 The Wellness Director or designee will review all transfers and discharges Monday- Friday for proper documentation. 4 Systemic changes will be completed by February 1, 2024.	