		X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER			00	COMPLETED		
155788		B. W.	B. WING			03/13/2024		
	PROVIDER OR SUPPLIER			1200 N	ADDRESS, CITY, STATE, ZIP COD STATE ROAD 135 NWOOD, 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	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
F 0000								
Bldg. 00	IN00428632 and IN  Complaint IN00428 related to the allegal F610.  Complaint IN00429 allegations are cited Survey date: March Facility number: 01 Provider number: 1 AIM number: 2010  Census Bed Type: SNF/NF: 114 SNF: 19 Total: 133  Census Payor Type Medicare: 10 Medicaid: 73 Other: 50 Total: 133  These deficiencies: accordance with 41	8632 - Federal/State deficiencies ations are cited at F600 and  9267 - No deficiencies related to d.  113, 2024  12564 55788 118510	F 00	000	The creation and submission this Plan of Correction does not constitute an admission by this provider of any conclusion set in the statement of deficiencies of any violation of regulation. This provider respectfully require that the 2567 Plan of Corrective considered the Letter of Credible Allegation and requed Desk Review in lieu of a Post Survey Revisit December on after April 6, 2024	ot s forth s, or uests on sts a		
F 0600	483.12(a)(1)							
SS=D	Free from Abuse	•						
Bldg. 00	_	from Abuse, Neglect, and						
	Exploitation	the right to be free from						
1	i ne resident nas i	the right to be free from	- 1		1		l	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement 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 disclodays 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: FEZ211 Facility ID: 012564 If continuation sheet Page 1 of 7

STATEMENT OF DEFICIENCIES  AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  00			(X3) DATE SURVEY COMPLETED	
155788			B. WI			03/13/2	
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD STATE ROAD 135		
GREENWOOD MEADOWS			_	GREEN	WOOD, IN 46142		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG				TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
	abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.  §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or						
	failed to protect a r verbal abuse by a s	sion; y and record review, the facility resident's right to be free from taff member for 1 of 3 residents . (Resident B, CNA 1)	F 06	500	F600- Free from abuse		04/05/2024
	Finding includes:				and neglect		
	Administrator indicapproximately 3:30 report CNA 1 for u 1 was providing car Resident B's room providing care. LP Resident B's room nurse's station. LP Resident B then LF told LPN 1 that CN When LPN 1 told leave the facility, C went to other staff called the police. T 1 left the facility as working for the face	w on 3/13/24 at 8:46 a.m., the cated, on 2/29/24 at 0 a.m. LPN 1 called the DON to using foul language when CNA re to Resident B. LPN 1 entered and stopped CNA 1 from N 1 asked CNA 1 to leave and wait for LPN 1 at the N 1 finished providing care to PN 1 called the DON. The DON JA 1 had to leave the facility. CNA 1 that CNA 1 needed to CNA 1 did not leave. CNA 1 and called LPN 1 names. LPN 1 The Administrator believed CNA is the police arrived. CNA 1 quit callity when CNA 1 would not ministrator's phone calls during			What corrective action(s) will be accomplished for those residents found to have bee affected by the deficient practice?  Resident B was monitored and showed no psychosocial distress.  CNA 1 was suspended the time of the occurrence and no longer employed.  How will you identify other residents having the potentiat to be affected by the same deficient practice and what corrective action will be taken and the potential to be affected by this deficient practice.  All staff will be educated on abuse policy by ED/Design	ed at d is	

FEZ211

CENTERS FOR	R MEDICARE & MEDIC					_	IB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIF	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDI	NG	00	COMPI	LETED
155788		B. WING			03/13/2024		
NAME OF I	PROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP COD		
					STATE ROAD 135		
GREENV	VOOD MEADOWS		GF	REEN	WOOD, IN 46142		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID				(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL	PREF		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION	TA		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
1110		0 a.m., the Administrator	171		on or before 4/5/24.		DATE
		statement, dated 2/29/24, the					
	_	LPN 1 overheard CNA 1 using			- Abuse questions were		
					completed with all interviewal	oie	
		n CNA 1 was speaking to			residents on unit showing no		
		entered Resident B's room and			concerns with abuse.		
		m providing care. CNA 1 exited			What measures will be put in	nto	
		CNA 1 was instructed to clock			place or what systemic		
		uilding. CNA 1 became			changes you will make to		
	-	ly aggressive toward staff.			ensure that the deficient		
		DON and called the police for			practice does not recur?		
	assistance. CNA 1	exited the facility.			All staff educated on ab	use	
					policy ED/Designee on or bef	ore	
	The clinical record	for Resident B was reviewed			4/5/24		
	on 3/13/24 at 10:02	a.m. The diagnoses included,			ED and/or designee will		
	but were not limited	d to, diabetes, hip fracture, and			audit all abuse reportables to		
	anxiety.	•			ensure compliance.		
					ED to attend resident		
	An Admission MD	S (Minimum Data Set)			council with permission to		
		1/13/24, indicated Resident B			encourage residents to voice		
	was severely cogni				concerns immediately		
	was severely cogin	irvery impuned.			How the corrective action (s	١	
	Δ progress note da	ated 2/29/24 at 3:45 a.m.,			will be monitored to ensure	•	
		vith care noted related to			deficient practice will not	uie	
		ne physician and family were			-		
		nistrator and DON were			recur, i.e., what quality	4	
		to observe Resident B and			assurance program will be p	ut	
					into place?		
	report any changes	to the physician.			·The Abuse QAPI Tool		
	D	2/12/24 / 12/45   I DD			(F600/F610) will be utilized by		
	_	v on 3/13/24 at 12:45 p.m., LPN			ED/designee weekly x 4 week		
		/24 at approximately 3:00 a.m.,			monthly x 6 months, and quai	-	
	_	at the nurse's station and			thereafter for one year with re		
		ell Resident B to get his dirty			reported to the Quality Assura		
		ff of CNA 1. LPN 1 walked to			and Performance Improveme	nt	
		yay, which was approximately			Committee overseen by the		
		rse's station. By the time LPN 1			Executive Director		
	~	doorway, CNA 1 told Resident			·If a threshold of 100% is no	ot	
	B to get his dirty "f	***** hands" off of CNA 1			achieved, an action plan will b	oe	
	two more times. LF	PN 1 asked CNA 1 to stop			developed to ensure complian	nce	
		exit Resident B's room. Once			•		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

CNA 1 was out of Resident B's room, LPN 1 asked

FEZ211 F

Facility ID: 012564

If continuation sheet

Page 3 of 7

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

PRINTED: 05/17/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155788		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE COMPL 03/13/	ETED				
NAME OF PROVIDER OR SUPPLIER  GREENWOOD MEADOWS			1200 N	STREET ADDRESS, CITY, STATE, ZIP COD 1200 N STATE ROAD 135 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		(X5) COMPLETION DATE			
F 0610 SS=D	CNA 1 to wait in the return. LPN 1 entered providing care to Refinished providing cowalked away from the another staff member conversation with Composition to leave the facility. The refused to leave. CNA 1 to leave the to call the police. CNA 1 to leave the to call the police. CNA 1 to leave the to call the police. CNA 1 to leave the to call the police. CNA 1 to leave the to call the police. CNA 1 to leave the to call the police. CNA 1 to leave the to call the police. CNA 1 to leave the to call the police. CNA 1 to leave the to call the police. CNA 1 to leave the to call the police. CNA 1 to leave the to call the police. CNA 1 to leave the to call the police. CNA 1 to leave the to call the police spoke with her considerable the police of a facility policy, and the policy of the facility an environment free the considerable the police of the facility and environment free the considerable the police of the facility and environment free the considerable the police of the facility and environment free the considerable the police of the facility and environment free the considerable the police of the facility and the facili	e nurse's station for LPN 1 to ed Resident B's room to finish esident B. When LPN 1 was eare to Resident B, LPN 1 he nurse's station to get er to witness LPN 1's ENA 1. When LPN 1 returned and told CNA 1 she needed CNA 1 became upset and NA 1 walked to two other halls staff. LPN 1 repeatedly asked facility and finally LPN 1 had NA 1 left the facility before the er.  a.m., the DON provided a copy dated 2/2010, titled Abuse ng, and Investigation, and ne current policy used by the f the policy indicated it was the for to provide each resident with e from abuse.  to IN00428632.							
Bldg. 00	abuse, neglect, ex the facility must:	onse to allegations of ploitation, or mistreatment,							
	. , , ,	e evidence that all alleged oughly investigated.							
	- ',','	vent further potential abuse, on, or mistreatment while s in progress.							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

FEZ211

Facility ID: 012564

If continuation sheet

Page 4 of 7

05/17/2024 PRINTED: FORM APPROVED

OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 03/13/2024 155788 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1200 N STATE ROAD 135 **GREENWOOD MEADOWS** 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 §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 F 0610 04/05/2024 Greenwood Meadows requests failed to follow the abuse policy and ensure an additional evidentiary information alleged perpetrator of abuse was immediately be considered to reduce severity removed from the facility for 1 of 3 allegations of or delete F610 from the 2567. The abuse reviewed. (CNA 1) current statement of deficiencies on the 2567 omits facility Finding included: information and therefore misrepresents the care and During an interview on 3/13/24 at 8:46 a.m., the services administered by the Administrator indicated, on 2/29/24 at provider to its residents. approximately 3:30 a.m., LPN 1 called the DON to F610report CNA 1 for using foul language when CNA 1 was providing care to Resident B. LPN 1 entered Investigate/Pre Resident B's room and stopped CNA 1 from providing care. LPN 1 asked CNA 1 to leave vent/Correct Resident B's room and wait for LPN 1 at the nurse's station. LPN 1 finished providing care to **Alleged** Resident B then LPN 1 called the DON. The DON told LPN 1 that CNA 1 had to leave the facility. **Violation** When LPN 1 told CNA 1 that CNA 1 needed to leave the facility, CNA 1 did not leave. CNA 1 What corrective action(s) will went to other staff and called LPN 1 names. LPN 1 be accomplished for those called the police. The Administrator believed CNA residents found to have been 1 left the facility as the police arrived. affected by the deficient practice? During an interview on 3/13/24 at 12:45 p.m., LPN - Resident B was monitored 1 indicated on 2/29/24 at approximately 3:00 a.m. and showed no psychosocial LPN 1 was sitting at the nurse's station and distress overheard CNA 1 tell Resident B to get his dirty - Skin assessment "f\*\*\*\*\*" hands off of CNA 1. LPN 1 walked to

Resident B's doorway, which was approximately

10 feet from the nurse's station. By the time LPN 1

FEZ211

completed on resident B with no

- C.N.A. 1 was suspended

new areas identified.

T .		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED		
		155788	B. WING			03/13/2024		
				CTREET /	ADDRESS CITY STATE TIL COD			
NAME OF I	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD			
ODEENW	VOOD MEADOWO				STATE ROAD 135			
GREENV	VOOD MEADOWS			GREENWOOD, IN 46142				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S DI AN OF CODDECTION	(	X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMP	LETION	
TAG				TAG	DEFICIENCY)	D/	ATE	
	got to Resident B's	doorway, CNA 1 told Resident			at the time of the occurrence	ınd		
	B to get his dirty "f	******" hands off of CNA 1			is no longer employed.			
		N 1 asked CNA 1 to stop			How will you identify other			
		exit Resident B's room. Once			residents having the potential	al		
		Resident B's room, LPN 1 asked			to be affected by the same			
	CNA 1 to wait in th	ne nurse's station for LPN 1 to			deficient practice and what			
	return. LPN 1 enter	ed Resident B's room to finish			corrective action will be take	n?		
	providing care to Re	esident B. When LPN 1 was			- All residents have the			
	finished providing of	care to Resident B, LPN 1			potential to be affected by this			
	walked away from t	the nurse's station to get			deficient practice.			
	another staff memb	er to witness LPN 1's			- All staff educated on			
	conversation with C	CNA 1. When LPN 1 returned			abuse policy ED/Designee on	or		
	to the nurse's station and told CNA 1 she needed				before 4/5/24			
	to leave the facility. CNA 1 became upset and				- Abuse questions were			
	refused to leave. CNA 1 walked to two other halls				completed with all interviewab	le		
	to speak with other staff. LPN 1 repeatedly asked				residents on the unit showing	no		
	CNA 1 to leave the	facility and finally LPN 1 had			concerns with abuse.			
	to call the police. C	NA 1 left the facility before the			What measures will be put ir	to		
	police spoke with h	er. CNA 1 was under constant			place or what systemic			
	supervision by staff after she was told to leave				changes you will make to			
	and walked out of the nurse's station.				ensure that the deficient			
					practice does not recur?			
	On 3/13/24 at 8:51	a.m., the DON provided a copy			All staff educated on abu	ıse		
		dated 2/2010, titled Abuse			policy by ED/Designee on or			
	Prohibition, Report	ing, and Investigation, and			before 4/5/24.			
		he current policy used by the			ED/Designee to be notifi			
	1	f the policy indicated any staff			immediately of an allegation o	f		
		in the alleged abuse will be			abuse and ensure the staff			
	removed from the fa	acility at once.			involved is removed immediat	ely.		
					ED/Designee to review			
	This citation relates	to Complaint IN00428632.			100% of all abuse reportables	to		
					ensure staff were removed fro	m		
	3.1-28(d)				facility at once.			
					How the corrective action (s)			
					will be monitored to ensure t	he		
					deficient practice will not			
					recur, i.e., what quality			
					assurance program will be p	ut		
					into place?			
					·The Abuse Assessment QA	.PI		

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

PRINTED: 05/17/2024 FORM APPROVED OMB NO. 0938-039

GREENWOOD MEADOWS  1200 N STATE ROAD 135  GREENWOOD, IN 46142	
(X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  TAG  TOOI (F600/F610) will be utilized by ED/designee 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 100% is not achieved, an action plan will be	

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: FEZ211 Facility ID: 012564 If continuation sheet Page 7 of 7