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	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREENWOOD MEADOWS	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 (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 Complaint IN00428632 and IN00429267. Complaint IN00428632 - Federal/State deficiencies related to the allegations are cited at F600 and F610. Complaint IN00429267 - No deficiencies related to allegations are cited. Survey date: March 13, 2024 Facility number: 012564 Provider number: 155788 AIM number: 201018510 Census Bed Type: SNF/NF: 114 SNF: 19 Total: 133 Census Payor Type: Medicare: 10 Medicaid: 73 Other: 50 Total: 133 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed March 14, 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 December on or after April 6, 2024	
F 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from			

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.

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	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREENWOOD MEADOWS	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 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION 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 involuntary seclusion; Based on interview and record review, the facility failed to protect a resident's right to be free from verbal abuse by a staff member for 1 of 3 residents reviewed for abuse. (Resident B, CNA 1) Finding includes: During an interview on 3/13/24 at 8:46 a.m., the Administrator indicated, on 2/29/24 at approximately 3:30 a.m. LPN 1 called the DON to report CNA 1 for using foul language when CNA 1 was providing care to Resident B. LPN 1 entered Resident B's room and stopped CNA 1 from providing care. LPN 1 asked CNA 1 to leave Resident B's room and wait for LPN 1 at the nurse's station. LPN 1 finished providing care to Resident B then LPN 1 called the DON. The DON told LPN 1 that CNA 1 had to leave the facility. When LPN 1 told CNA 1 that CNA 1 needed to leave the facility, CNA 1 did not leave. CNA 1 went to other staff and called LPN 1 names. LPN 1 called the police. The Administrator believed CNA 1 left the facility as the police arrived. CNA 1 quit working for the facility when CNA 1 would not respond to the Administrator's phone calls during this investigation.	F 0600	**F600- Free from abuse and neglect** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** - Resident B was monitored and showed no psychosocial distress. - CNA 1 was suspended at the time of the occurrence and is no longer employed. **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 have the potential to be affected by this deficient practice. - All staff will be educated on abuse policy by ED/Designee	04/05/2024

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	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREENWOOD MEADOWS	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 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 3/13/24 at 10:00 a.m., the Administrator provided a witness statement, dated 2/29/24, the statement indicated LPN 1 overheard CNA 1 using foul language when CNA 1 was speaking to Resident B. LPN 1 entered Resident B's room and stopped CNA 1 from providing care. CNA 1 exited Resident B's room. CNA 1 was instructed to clock out and leave the building. CNA 1 became agitated and verbally aggressive toward staff. LPN 1 notified the DON and called the police for assistance. CNA 1 exited the facility. The clinical record for Resident B was reviewed on 3/13/24 at 10:02 a.m. The diagnoses included, but were not limited to, diabetes, hip fracture, and anxiety. An Admission MDS (Minimum Data Set) assessment, dated 1/13/24, indicated Resident B was severely cognitively impaired. A progress note, dated 2/29/24 at 3:45 a.m., indicated concern with care noted related to communication. The physician and family were notified. The Administrator and DON were notified. Staff were to observe Resident B and report any changes to the physician. During an interview on 3/13/24 at 12:45 p.m., LPN 1 indicated on 2/29/24 at approximately 3:00 a.m., LPN 1 was sitting at the nurse's station and overheard CNA 1 tell Resident B to get his dirty "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 got to Resident B's doorway, CNA 1 told Resident B to get his dirty "f****** hands" off of CNA 1 two more times. LPN 1 asked CNA 1 to stop providing care and exit Resident B's room. Once CNA 1 was out of Resident B's room, LPN 1 asked		on or before 4/5/24. - Abuse questions were completed with all interviewable residents on unit showing no concerns with abuse. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** All staff educated on abuse policy ED/Designee on or before 4/5/24 ED and/or designee will audit all abuse reportables to ensure compliance. ED to attend resident council with permission to encourage residents to voice concerns immediately **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** ·The Abuse QAPI Tool (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 developed to ensure compliance	

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	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREENWOOD MEADOWS	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 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	CNA 1 to wait in the nurse's station for LPN 1 to return. LPN 1 entered Resident B's room to finish providing care to Resident B. When LPN 1 was finished providing care to Resident B, LPN 1 walked away from the nurse's station to get another staff member to witness LPN 1's conversation with CNA 1. When LPN 1 returned to the nurse's station and told CNA 1 she needed to leave the facility. CNA 1 became upset and refused to leave. CNA 1 walked to two other halls to speak with other staff. LPN 1 repeatedly asked CNA 1 to leave the facility and finally LPN 1 had to call the police. CNA 1 left the facility before the police spoke with her. On 3/13/24 at 8:51 a.m., the DON provided a copy of a facility policy, dated 2/2010, titled Abuse Prohibition, Reporting, and Investigation, and indicated this was the current policy used by the facility. A review of the policy indicated it was the policy of the facility to provide each resident with an environment free from abuse. This citation relates to IN00428632. 3.1-27(b)			
F 0610 SS=D Bldg. 00	483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of 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.			

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	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREENWOOD MEADOWS	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 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION 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 failed to follow the abuse policy and ensure an alleged perpetrator of abuse was immediately removed from the facility for 1 of 3 allegations of abuse reviewed. (CNA 1) Finding included: During an interview on 3/13/24 at 8:46 a.m., the Administrator indicated, on 2/29/24 at approximately 3:30 a.m., LPN 1 called the DON to report CNA 1 for using foul language when CNA 1 was providing care to Resident B. LPN 1 entered Resident B's room and stopped CNA 1 from providing care. LPN 1 asked CNA 1 to leave Resident B's room and wait for LPN 1 at the nurse's station. LPN 1 finished providing care to Resident B then LPN 1 called the DON. The DON told LPN 1 that CNA 1 had to leave the facility. When LPN 1 told CNA 1 that CNA 1 needed to leave the facility, CNA 1 did not leave. CNA 1 went to other staff and called LPN 1 names. LPN 1 called the police. The Administrator believed CNA 1 left the facility as the police arrived. During an interview on 3/13/24 at 12:45 p.m., LPN 1 indicated on 2/29/24 at approximately 3:00 a.m. LPN 1 was sitting at the nurse's station and overheard CNA 1 tell Resident B to get his dirty "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	F 0610	Greenwood Meadows requests additional evidentiary information be considered to reduce severity or delete F610 from the 2567. The current statement of deficiencies on the 2567 omits facility information and therefore misrepresents the care and services administered by the provider to its residents. **F610- Investigate/Prevent/Correct Alleged Violation** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** - Resident B was monitored and showed no psychosocial distress - Skin assessment completed on resident B with no new areas identified. - C.N.A. 1 was suspended	04/05/2024

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	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREENWOOD MEADOWS	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 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	got to Resident B's doorway, CNA 1 told Resident B to get his dirty "f******" hands off of CNA 1 two more times. LPN 1 asked CNA 1 to stop providing care and exit Resident B's room. Once CNA 1 was out of Resident B's room, LPN 1 asked CNA 1 to wait in the nurse's station for LPN 1 to return. LPN 1 entered Resident B's room to finish providing care to Resident B. When LPN 1 was finished providing care to Resident B, LPN 1 walked away from the nurse's station to get another staff member to witness LPN 1's conversation with CNA 1. When LPN 1 returned to the nurse's station and told CNA 1 she needed to leave the facility. CNA 1 became upset and refused to leave. CNA 1 walked to two other halls to speak with other staff. LPN 1 repeatedly asked CNA 1 to leave the facility and finally LPN 1 had to call the police. CNA 1 left the facility before the police spoke with her. CNA 1 was under constant supervision by staff after she was told to leave and walked out of the nurse's station. On 3/13/24 at 8:51 a.m., the DON provided a copy of a facility policy, dated 2/2010, titled Abuse Prohibition, Reporting, and Investigation, and indicated this was the current policy used by the facility. A review of the policy indicated any staff member implicated in the alleged abuse will be removed from the facility at once. This citation relates to Complaint IN00428632. 3.1-28(d)		at the time of the occurrence and is no longer employed. **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 have the potential to be affected by this deficient practice. - All staff educated on abuse policy ED/Designee on or before 4/5/24 - Abuse questions were completed with all interviewable residents on the unit showing no concerns with abuse. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** All staff educated on abuse policy by ED/Designee on or before 4/5/24. ED/Designee to be notified immediately of an allegation of abuse and ensure the staff involved is removed immediately. ED/Designee to review 100% of all abuse reportables to ensure staff were removed from facility at once. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** ·The Abuse Assessment QAPI	

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	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREENWOOD MEADOWS	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 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			Tool (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 developed to ensure compliance	