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

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155412	A. BUILDING 00 B. WING	09/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREENWOOD HEALTH AND LIVING COMMUNITY	937 FRY RD 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 IN00415069. Complaint IN00415069 - Federal/State deficiencies related to the allegations are cited at F656. Survey dates: September 19 and 20, 2023 Facility number: 000509 Provider number: 155412 AIM number: 100266620 Census Bed Type: SNF/NF: 92 Total: 92 Census Payor Type: Medicare: 15 Medicaid: 67 Other: 10 Total: 92 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed September 22, 2023.	F 0000	The plan of correction is to serve as Greenwood Health and Living's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Greenwood Health and Living or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations. The facility respectfully requests desk review for this citation.	
F 0656 SS=E Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Daniel Kern	Administrator	09/29/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155412	A. BUILDING 00 B. WING	09/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREENWOOD HEALTH AND LIVING COMMUNITY	937 FRY RD 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
	psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155412	A. BUILDING 00 B. WING	09/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREENWOOD HEALTH AND LIVING COMMUNITY	937 FRY RD 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
	Based on observation, interview, and record review, the facility failed to implement the plan of care for 4 out of 5 residents reviewed for falls. Call lights were not within reach. (Resident B, Resident C, Resident D, Resident E) Finding includes: 1. On 9/19/23 at 9:07 a.m., observed Resident B sitting in his wheelchair, in his room, watching television. Resident B's call light was observed attached to Resident B's pillow, on the bed, approximately 4 feet from Resident B. At that time, Resident B indicated if he needed assistance he would use the call light, but he could not reach the call light. Resident B was not able to propel his wheelchair on his own nor transfer and get to the bathroom without assistance because his leg was amputated. The clinical record for Resident B was reviewed 9/20/23 at 12:37 p.m. The diagnoses included, but were not limited to, acquired absence of right leg below the knee and abnormality of gait and mobility. A Brief Interview for Mental Status, dated 9/19/23, indicated Resident B was mildly cognitively impaired. A care plan, dated 9/18/23 and current through 12/19/23, indicated Resident B was at risk for falls and fall related injuries related to an amputation. The interventions included, but were not limited to, keep the call light in reach at all times, cue or remind Resident B to utilize the call light to seek assistance as needed. 2. On 9/19/23 from 9:46 a.m. until 9:53 a.m.,	F 0656	**F 656 Develop/Implement Comprehensive Care Plan** **I. The corrective actions to be accomplished for those residents found to have been affected by the practice.** Residents B, C, D & E call lights are within reach. **II. The facility will identify other residents that may potentially be affected by the practice.** Other residents in the facility have been observed and call lights are within reach per plan of care. **III. The facility will put into place the following systematic changes to ensure that the practice does not recur.** Staff are being educated regarding implementation of the individual plan of care including placement of call lights in reach. **IV. The facility will monitor the corrective action by implementing the following measures.** The DON, or designee, will round the facility and observe residents to ensure their individual plan of care has be implemented including call lights in reach daily for 4 weeks, weekly for 12 weeks and then quarterly ongoing. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once	10/04/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155412	A. BUILDING 00 B. WING	09/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREENWOOD HEALTH AND LIVING COMMUNITY	937 FRY RD 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
	observed Resident C laying in her bed sleeping. Resident C's call light was wrapped around the foot board of the other bed in her room approximately 6 feet from Resident C. At that time, QMA 1 (Qualified Medication Aide) walked into Resident C's room and indicated Resident C was at high risk for a falls and should have had her call light within reach even though she was sleeping. The clinical record for Resident C was reviewed on 9/20/23 at 12:41 p.m. The diagnoses included, but were not limited to, repeated falls, anxiety disorder, and diabetic neuropathy. A Quarterly MDS (Minimum Data Set) assessment, dated 9/15/23, indicated Resident C was cognitively intact. Resident C required extensive assistance from 2 staff for bed mobility, transfers, and toileting. Resident C required extensive assistance from 1 staff for personal hygiene, A care plan, dated 1/10/23 and current through 10/21/23, indicated Resident C was at risk for falls and fall related injuries related to a history of repeated falls and weakness. The interventions included, but were not limited to, keep the call light in reach at all times and cue or remind Resident C to utilize the call light to seek assistance as needed. 3. On 9/19/23 at 9:57 a.m., observed Resident D sitting up in a recliner chair with a walker in front of her. Resident D's call light was laying on the floor, at the foot of her bed, approximately 4 feet behind Resident D. At that time, Resident D indicated if she needed any help, she would use her call light. Resident D was observed to feel the arm rest on her chair and indicated the call light should be right there. Resident D could not reach		compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. **V. Plan of Correction completion date.** Date of Compliance: October 4th, 2023 The Administrator will be responsible for ensuring the facility is in compliance by date of compliance listed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155412	A. BUILDING 00 B. WING	09/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREENWOOD HEALTH AND LIVING COMMUNITY	937 FRY RD 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

the call light.

The clinical record for Resident D was reviewed on 9/20/23 at 12:50 p.m. The diagnoses included, but were not limited to, diabetes, dementia, and delusional disorder.

A Quarterly MDS assessment, dated 6/28/23, indicated Resident D was severely cognitively impaired. Resident D required extensive assistance from 1 staff for bed mobility, transfers, and toilet use.

A care plan, dated 8/24/16 and current through 10/3/23, indicated Resident D was at risk for falls and fall related injuries related to weakness, debility, and dizziness. The interventions included, but were not limited to, keep the call light in reach and cue or remind Resident D to utilize the call light to seek assistance as needed.

4. On 9/19/23 at 9:59 a.m., observed Resident E sitting up in a chair. Resident E's call light was attached to her pillow on the opposite side of her bed, approximately 4 feet away from Resident E. At that time Resident E indicated she did not think she could reach her call light if she needed assistance. Resident E needed assistance to transfer. At that time, CNA 1 (Certified Nursing Aide) entered Resident E's room. CNA 1 indicated Resident E's call light should always be within reach when Resident E was in her room.

The clinical record for Resident E was reviewed on 9/20/23 at 1:00 p.m. The diagnoses included, but were not limited to, repeated falls, obesity, and vascular dementia.

A Quarterly MDS assessment, dated 6/18/23, indicated Resident E was mildly cognitively

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155412	A. BUILDING 00 B. WING	09/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREENWOOD HEALTH AND LIVING COMMUNITY	937 FRY RD 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
	impaired. Resident E required extensive assistance from 1 staff for bed mobility, transfers, dressing, toileting, and personal hygiene. A care plan, dated 1/2/23 and current through 9/23/23, indicated Resident E was at risk for falls and fall related injuries related to history of repeated falls and unsteady on feet. The interventions included, but were not limited to, keep call light in reach at all times and cue or remind resident to utilize call light to seek assistance as needed. During an interview on 9/19/23 at 2:05 p.m., the Unit Manager indicated Resident B's, ResIdent C's, Resident D's, and Resident E's call lights should have been within reach. On 9/20/23 at 1:20 p.m., the facility was unable to provide a policy regarding call lights. This Federal tag relates to Complaint IN00415069. 3.1-35(g)(2)			