PRINTED: 05/30/2025 FORM APPROVED OMB NO. 0938-039

CENTERS FOR	MEDICARE & MEDIC	AID SERVICES			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 00		COMPLETED		
155412		B. WING		04/30/2025		
		1	<del></del>		* *****	
NAME OF P	ROVIDER OR SUPPLIER	8		ADDRESS, CITY, STATE, ZIP COD		
			937 FR			
GREENV	VOOD HEALTH AN	ID LIVING COMMUNITY	GREEN	NWOOD, IN 46142		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRE		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
F 0000						
Bldg. 00						
	This visit was for the Investigation of Complaint		F 0000	The plan of correction is to se	rve	
	IN00457431.	00457431.		as Greenwood Health and Liv		
				credible allegation of compliar	_	
	Complaint IN00457431 - Federal/State deficiencies					
	related to the allegations are cited at F602.			Submission of this plan of		
				correction does not constitute	an	
	Survey date: April 3	30, 2025		admission by Greenwood Hea		
	Survey duterriprin	50, 2020		and Living Community or its		
	Facility number: 00	0509		management company that th	_	
	Provider number: 155412 AIM number: 100266620  Census Bed Type: SNF/NF: 101 Total: 101  Census Payor Type: Medicare: 7 Medicaid: 68 Other: 26 Total: 101			allegations contained in the su		
				report is a true and accurate	n voy	
				portrayal of the provision of nu	ırsina	
				care and other services in this	-	
				facility. Nor does this submissi		
				constitute an agreement or		
				admission of the survey		
				allegations. Greenwood Healt	th I	
				and Living Community is	.11	
				respectfully requesting		
				consideration for desk review.		
				consideration for desk review.		
	10tal. 101					
	This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1.					
	accordance with 41	0 11 (C 10.2-3.1.				
	Quality review completed May 5, 2025.					
	Quanty review completed May 3, 2023.					
F 0602	483.12					
SS=D	Free from Misappropriation/Exploitation					
Bldg. 00	1 100 Hom Micapp	горпалот, Ехртопалот				
g. 50	Based on interview and record review, the facility failed to protect the resident's rights to be free from misappropriation of property for 1 of 1 allegation of misappropriation of property. (Resident B)		F 0602	F 602 Free from	05/29/2025	
			1, 0007	Misappropriation/Exploitatio		
				appropriation Exploitatio	"	
				I. The corrective actions to be accomplished for those residents found to have been		
	Finding include:			affected by the practice.		
				ansold by the plactice.		

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

TITLE (X6) DATE

Dorian Mihay HFA 05/28/2025

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 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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 04/30/2025 155412 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 937 FRY RD GREENWOOD HEALTH AND LIVING COMMUNITY 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 PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE On 4/30/25 at 12:02 p.m., Resident B's clinical The residents Percocet was record was reviewed. The diagnoses included, but replaced by the facility and the were not limited to, diabetes mellitus, right tibia resident did not miss any doses of (shin bone) fracture, cellulitis, and pain in right the medication. leg. II. The facility will identify The annual MDS (Minimum Data Set) assessment, other residents that may dated 3/7/25, indicated Resident B was cognitively potentially be affected by the intact. practice. The Physician Order Report, dated 4/30/25, Other carts were counted and indicated the following: medications were verified without other discrepancies. - Oxycodone-acetaminophen (pain medication) 7.5-325 mg (milligrams), twice a day for pain, III. The facility will put into initiated 1/13/25. place the following systematic changes to ensure that the - Oxycodone-acetaminophen 7.5-325 mg, every 4 practice does not recur. hours as needed for right leg pain, initiated 1/13/25. RNs, LPNs, and QMAs are being educated regarding medication Resident B's Controlled Drug Record for storage and misappropriation of Oxycodone-acetaminophen 7.5-325 mg had a property. tablet signed out on 4/11/25 at 10:00 a.m. by Licensed Practical Nurse (LPN) 1. Four tablets remained. IV. The facility will monitor the corrective action by During an interview on 4/30/25 at 1:08 p.m., the implementing the following Director of Nursing (DON) indicated on 4/11/25, measures. when LPN 1 started her day shift, she counted the medications which were in the lock box on the 200 The DON, or designee, will review medication cart. At 10:00 a.m., LPN 1 administered the sign in/out sheets and Resident B an Oxycodone-acetaminophen 7.5-325 controlled drug sheets daily for 4 mg ordered twice a day for pain. There were 4 weeks, weekly x4 weeks, Monthly tablets left on the medication card. At the end of x3 months, and quarterly x3 her day shift (2:30 p.m.), LPN 1 went to count the months. medication in the 200 medication cart lock box, and Resident B's Oxycodone-acetaminophen The results of these reviews will be 7.5-325 mg medication card was missing. During discussed at the monthly facility

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AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED		
		155412			04/30/	/2025	
			<u> </u>	CTDEET /	ADDRESS CITY STATE ZID COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹		1	ADDRESS, CITY, STATE, ZIP COD		
CDEENIV	NOOD HEALTH AN			937 FR			
GREENV	VOOD REALIH AN	ID LIVING COMMUNITY		GREEN	IWOOD, IN 46142		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
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	LPN 1's shift, she g	gave the 200 hall medication cart			Quality Assurance Committee		
	-	anager (UM). The UM placed		meeting monthly for 3 months and			
	another resident's n	nedication in the lock box on			then quarterly thereafter once		
	the 200 hall medica	ation cart.		compliance is at 100%.			
					Frequency and duration of reviews		
	_	v on 4/30/24 at 1:53 p.m., the			will be increased as needed, if		
		11/25, a resident was moving			compliance is below 100%.		
		got the 200 hall medication cart					
		With LPN 2, she placed three					
		the lock box. The UM did not			V. Plan of Correction		
		N 1 counted the lock box after			completion date.		
	_	medication in the 200 hall					
	medication lock box	X.			Date of Compliance: 5/29/25		
					The Administrator will be		
	-	v on 4/30/25 at 2:00 p.m., RN 1			responsible for ensuring the fa	acility	
		ed evening shift on 4/11/25. At			is in compliance by date of		
	the beginning of her shift, RN 1 and LPN 1				compliance listed.		
		tion cards in the 200					
	medication lock box. LPN 1 was checking the						
		ecords in the narcotic binder					
		ating the medication on the					
		ted Resident B had 4					
	-	inophen 7.5-325 mg tablets on					
		cated Resident B did not have a					
		ne-acetaminophen 7.5-325 mg					
		cated Resident B had					
		inophen 7.5-325 mg at 10:00					
		we had 4 left on her card. RN 1 B medication card was not in					
		rted to the DON Resident B's					
		inophen 7.5-325 mg tablets					
	were missing.	mophen 7.5-525 mg tablets					
	were missing.						
	On 4/30/25 at 2:54	p.m., the Administrator (ADM)					
		y policy, "Abuse, Neglect, and					
		rohibition and Prevention					
		sion date of 6/4/19, and					
	-	policy currently being used					
	by the facility. A review of the policy indicated,						
		f CarDon & Associates, Inc.	1				

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155412	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 04/30/2025		
NAME OF PROVIDER OR SUPPLIER GREENWOOD HEALTH AND LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP COD  937 FRY RD  GREENWOOD, IN 46142				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX			PREFIX (EACH CORRECTIVE ACTION SHOULD		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	BE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	and its member Communities to provide each resident with an environment that is free frommisappropriation of their property"  On 4/30/25 at 2:54 p.m., the Administrator (ADM) provided the facility policy, "Drug Storage," undated, and indicated it was the policy currently being used by the facility. A review of the policy indicated, "10. All Class II drugs must be stored under double lock at all time"  This citation relates to the Complaint IN00457431.						

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