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	04/30/2025

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 IN00457431. Complaint IN00457431 - Federal/State deficiencies related to the allegations are cited at F602. Survey date: April 30, 2025 Facility number: 000509 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 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed May 5, 2025.	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 Community 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. Greenwood Health and Living Community is respectfully requesting consideration for desk review.	
F 0602 SS=D Bldg. 00	483.12 Free from Misappropriation/Exploitation 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) Finding include:	F 0602	**F 602 Free from Misappropriation/Exploitation** **I. The corrective actions to be accomplished for those residents found to have been affected by the practice.**	05/29/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Dorian Mihay	HFA	05/28/2025

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	04/30/2025

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
	On 4/30/25 at 12:02 p.m., Resident B's clinical record was reviewed. The diagnoses included, but were not limited to, diabetes mellitus, right tibia (shin bone) fracture, cellulitis, and pain in right leg. The annual MDS (Minimum Data Set) assessment, dated 3/7/25, indicated Resident B was cognitively intact. The Physician Order Report, dated 4/30/25, indicated the following: - Oxycodone-acetaminophen (pain medication) 7.5-325 mg (milligrams), twice a day for pain, initiated 1/13/25. - Oxycodone-acetaminophen 7.5-325 mg, every 4 hours as needed for right leg pain, initiated 1/13/25. Resident B's Controlled Drug Record for Oxycodone-acetaminophen 7.5-325 mg had a tablet signed out on 4/11/25 at 10:00 a.m. by Licensed Practical Nurse (LPN) 1. Four tablets remained. During an interview on 4/30/25 at 1:08 p.m., the Director of Nursing (DON) indicated on 4/11/25, when LPN 1 started her day shift, she counted the medications which were in the lock box on the 200 medication cart. At 10:00 a.m., LPN 1 administered Resident B an Oxycodone-acetaminophen 7.5-325 mg ordered twice a day for pain. There were 4 tablets left on the medication card. At the end of her day shift (2:30 p.m.), LPN 1 went to count the medication in the 200 medication cart lock box, and Resident B's Oxycodone-acetaminophen 7.5-325 mg medication card was missing. During		The residents Percocet was replaced by the facility and the resident did not miss any doses of the medication. **II. The facility will identify other residents that may potentially be affected by the practice.** Other carts were counted and medications were verified without other discrepancies. **III. The facility will put into place the following systematic changes to ensure that the practice does not recur.** RNs, LPNs, and QMAs are being educated regarding medication storage and misappropriation of property. **IV. The facility will monitor the corrective action by implementing the following measures.** The DON, or designee, will review the sign in/out sheets and controlled drug sheets daily for 4 weeks, weekly x4 weeks, Monthly x3 months, and quarterly x3 months. The results of these reviews will be discussed at the monthly facility	

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	04/30/2025

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
	LPN 1's shift, she gave the 200 hall medication cart keys to the Unit Manager (UM). The UM placed another resident's medication in the lock box on the 200 hall medication cart. During an interview on 4/30/24 at 1:53 p.m., the UM indicated on 4/11/25, a resident was moving to the 200 hall. She got the 200 hall medication cart keys from LPN 1. With LPN 2, she placed three medication cards in the lock box. The UM did not indicate she and LPN 1 counted the lock box after the UM placed the medication in the 200 hall medication lock box. During an interview on 4/30/25 at 2:00 p.m., RN 1 indicated she worked evening shift on 4/11/25. At the beginning of her shift, RN 1 and LPN 1 counted the medication cards in the 200 medication lock box. LPN 1 was checking the Controlled Drug Records in the narcotic binder and RN 1 was counting the medication on the card. LPN 1 indicated Resident B had 4 Oxycodone-acetaminophen 7.5-325 mg tablets on the card. RN 1 indicated Resident B did not have a card with Oxycodone-acetaminophen 7.5-325 mg tablets. LPN 1 indicated Resident B had Oxycodone-acetaminophen 7.5-325 mg at 10:00 a.m., and should have had 4 left on her card. RN 1 indicated Resident B medication card was not in the cart. RN 1 reported to the DON Resident B's Oxycodone-acetaminophen 7.5-325 mg tablets were missing. On 4/30/25 at 2:54 p.m., the Administrator (ADM) provided the facility policy, "Abuse, Neglect, and Misappropriation Prohibition and Prevention Policy," with a revision date of 6/4/19, and indicated it was the policy currently being used by the facility. A review of the policy indicated, "...It is the policy of CarDon & Associates, Inc.		Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once 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: 5/29/25 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	04/30/2025

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
	and its member Communities to provide each resident with an environment that is free from...misappropriation 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. 3.1-28(a)			