STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155188	A. BUILDING 00 B. WING	02/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREENFIELD HEALTHCARE CENTER	200 GREEN MEADOWS DR GREENFIELD, IN 46140

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00401246. Complaint IN00401246 - Substantiated. Federal/state deficiency related to the allegations is cited at F600. Survey dates: February 9, 10 and 13, 2023 Facility number: 000099 Provider number: 155188 AIM number: 100291140 Census Bed Type: SNF/NF: 129 Total: 129 Census Payor Type: Medicare: 8 Medicaid: 99 Other: 22 Total: 129 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed February 15, 2023	F 0000		
F 0600 SS=G 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 abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment,			

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.

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	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 physical abuse perpetrated by another resident, resulting in a fall and subsequent hip fracture, requiring a hospitalization, for 1 of 5 residents reviewed for abuse. (Residents S and T) Findings include: The Executive Director (ED) provided a copy of a state reportable incident report on, 2-10-23 at 10:45 a.m., dated 2-7-23, which indicated on 2-7-23 at 3:01 p.m., Resident T entered the room of Resident S "while holding a folding chair and attempted to hit [name of Resident S]. [Name of Resident S] grabbed the chair and was pulled out of his seat, resulting in a fall ...Staff immediately intervened and [name of Resident T] was placed on 1:1 [one to one] supervision ...New order for x-ray for [name of Resident S]." It indicated the ED, Director of Nursing, Medical Doctor, local police department and family were notified and Resident T was sent out to an area geriatric-psychiatric facility for further evaluation and treatment, with Social Services to follow-up with both residents for a minimum of 72 hours and care plans to be revised as needed. In an interview with the ED on 2-10-23 at 9:15 a.m., he indicated both residents resided on the secured advanced dementia unit. He indicated	F 0600	**F600** **Free from Abuse and Neglect** Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. **The facility cordially requests paper compliance regarding alleged deficient practices.** Resident S was allegedly affected by the stated deficient practice. Resident S was immediately protected at the time of the incident. Resident S received immediate assessment and transfer to the hospital for evaluation and treatment. All residents have the potential to be affected by same alleged deficient practice. All alert and oriented resident have been interviewed regarding any concerns for abuse. All residents that are not able to be interviewed	03/04/2023

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	Resident T struck Resident S with a folding chair. "From the interviews, it doesn't sound like they were fighting, just near one another and he had picked the chair up and bumped him and [name of Resident S] fell backwards and ended up breaking his hip." The ED indicated Resident S was still hospitalized and expected to return to the facility soon. The ED indicated Resident T was sent out to a geriatric psychiatric facility the same evening and may not be returning to the facility as his family was considering relocating him to another facility. In an interview with CNA 5 on 2-10-23 at 10:33 a.m., she indicated she was working on the afternoon of 2-7-23 on the secured advanced dementia care unit with both Resident S and T, and was familiar with both residents. She recalled hearing loud voices coming from Resident S's room. When she entered the room, she observed Resident T "jabbing" a folding chair at Resident S, whom she found lying on the floor, adjacent to his bed with his head near the foot of the bed. She indicated Resident S was grabbing at the chair "to keep from getting hit and yelling, 'Help me, stop hitting me', while I tried to get the chair away from Resident T." She recalled she was able to get the chair away from Resident T, while she was yelling to get the attention of the other staff on the unit. She recalled CNA 6 was down the hall in the nurse's station. She indicated CNA 6 arrived to assist her within 1-2 minutes. She indicated once she got the chair away from Resident T, she was able to redirect him out of the room. She indicated while Resident S was lying on the floor, it was obvious to her his leg did not look right and she wondered if it was broken, plus he seemed to be in a great deal of pain. She indicated she sent CNA 6 to get help from the other secured memory care unit. QMA 7, arrived soon after to help and check		have received a head to toe physical assessment to observe for any physical signs or symptoms of abuse. There were no new findings with these audits/interviews. DON/Designee has educated all staff members on the Abuse, Neglect and Misappropriation Policy. DON/Designee will interview 5 alert and oriented residents and complete a head to toe assessment on 3 residents that are not alert and oriented weekly x 12 weeks. DON/Designee will report on audits monthly to the interdisciplinary team for 3 months during QAPI Meeting. The IDT will determine if the audits are necessary to continue after 6 months with 100% compliance achieved. Facility requesting IDR due to completing/reporting investigation per abuse policy. There was no indication resident S had been aggressive towards other residents prior to incident. Date of completion: 3/4/23	

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	Resident S out. She indicated QMA 7 was able to get his vital signs and between the three of them, were able to get him back to bed. Around this time, LPN 8, the ED and the Social Worker arrived. She indicated initially, they said they weren't going to send him out, but would let the doctor know and probably get orders for in-house x-rays. Resident S was able to tell them he had been sitting in his room in a dining room chair and said he was just sitting there when the other resident came into his room, picked up the folding chair that was folded up and leaning against the wall and started hitting him with it. CNA 5 recalled not long after that, LPN 8 said she had talked to the telehealth physician and had orders to keep him here and get x-rays. CNA 5 indicated Residents S and T were ambulatory. She described Resident S as a resident who occasionally wandered, but tended to stay in his room. CNA 5 described Resident T as having a history of wandering and can be pretty confused at times. She shared, "I heard that not long ago, he had given a CNA a black eye. I don't know that he's ever been rough with other residents, but he definitely has been that way with the employees." In an interview with CNA 9 on 2-13-23 at 10:55 a.m., she indicated she was familiar with Resident S and T as she had worked on the secured dementia care unit for over 5 years. She described Resident S as having some cognition issues, "but seems higher functioning than some of the advanced dementia care unit residents, but does have some confusion at times and is easily redirectable if having confusion issues." She indicated he did not wander on the unit as he tended to stay in his room a lot. She could not recall any incidents of aggression with this resident. She recalled Resident T had a history of wandering at least daily or more often "and this			

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	seemed to increase in the afternoons or evenings. He seemed to be searching for his wife or a way to get out of the unit." She indicated he had recently had Covid-19 and seemed to go downhill and seemed weaker after that. CNA 9 Indicated Resident T would be agitated at times and this seemed to correlated to his confusion and wandering. CNA 9 indicated she was not aware of any incidents of aggression aimed at staff or other residents. "Normally, he seemed to be easily redirected. This incident was a shock to me, I was very surprised when I heard about it, because I was not aware [name of Resident T] had ever been physically aggressive to anyone." 1. The clinical record of Resident S was reviewed on 2-10-23 at 11:06 a.m. His diagnoses included, but were not limited to unspecified dementia with anxiety and diabetes. He was sent to an area hospital on 2-7-23 for further evaluation and treatment. He was admitted to that hospital on 2-7-23 for a fractured hip. He remained in the hospital as of the exit date of the survey on 2-13-23. 2. The clinical record of Resident T was reviewed on 2-10-23 at 11:32 a.m. His diagnoses included, but were not limited to, unspecified dementia with severe behavioral disturbances, anxiety and depression. Progress notes, dated 1-6-23, related to aggression towards staff, on that date. Upon notification to the psych services Nurse Practitioner, the resident was started on Depakote 125 milligrams three times daily, specific to the behaviors of aggression towards staff. In an interview with the ED on 2-13-23 at 12:32 p.m., he indicated Resident T had been physically aggressive towards one of the aides and had			

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	given her a black eye several weeks prior to the interaction with Resident S. Progress notes, dated 2-7-23 at 1:35 a.m., indicated Resident T was found lying on the floor of his room, between his bed and dresser at approximately 12:50 a.m. An assessment at this time revealed no injuries and no complaints of pain. Telehealth medical coverage was notified of the fall with no orders received. A follow up call was made by the telehealth medical coverage approximately one hour later. Notes indicated Resident T had no decline in mental status, but "may be weaker than at baseline." Orders received at this time included to have the nurse practitioner to see the resident later in the day and to obtain lab work and a urinalysis. The urinalysis was obtained and the results indicated it was within normal limits. Resident T was care planned for the following behavior and care-related issues: -residing on a secured dementia unit, related to his diagnosis of dementia with behaviors of exit seeking, aggression, wandering and elopement risk. This care plan was developed on 10-18-22. Interventions to accomplish this included, but were not limited to, evaluate need for secured dementia unit; if needed, obtain order for such from physician, with appropriate diagnosis and include any exhibited behaviors, with consent of resident and/or representative; notify the medical provider and representative of any behavioral changes; offer snacks to redirect and redirect when appropriate with diversionary activities. -impaired cognitive function related to dementia with behaviors on 10-18-22 and updated on 1-26-23. Interventions for this issue included, but were not limited to, "Observe/document/report to medical provider any changes in: decision making			

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	ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status." -having a behavior problem related to being combative with care, physical aggression, preferring to attempting to assist other residents with needs, such as locomotion or feeding, exit seeking, looking for his spouse, getting into others' personal space, pounding on table with his fists, swinging his cane and being combative or aggressive with staff. This care plan was developed on 10-18-22 and updated on 1-6-23 and 1-26-23. Interventions for this care plan included, but are not limited to approach and speak in a calm manner, consultation with behavioral health professionals, communicate with resident and/or representatives regarding behaviors and treatment, encourage active support from family and/or representatives, encourage participation activities of choice, monitor behavioral episodes and attempts to determine underlying cause and to intervene as necessary to protect the rights and safety of others. An intervention, dated 1-6-23, indicated a medication adjustment was conducted on 1-6-23. This Federal tag relates to Complaint IN00401246. 3.1-27(a)(1)			