| PRINTED: | 08/27/2021 |
|----------|------------|
| FORM API | PROVED     |

OMB NO. 0938-039

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

| STATEMENT OF DEFICIENCIES       X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER |  |  |        | ULTIPLE CO<br>JILDING | NSTRUCTION<br>00  | (X3) DATE SURVEY<br>COMPLETED |            |
|---|--|--|--------|-----------------------|---|-------------------------------|------------|
| AND FLAN  | or condenion   | 155188   | B. W   |                       |   | 08/05/                        |            |
|   |  |  |        | STREET A              | ADDRESS, CITY, STATE, ZIP COD   |                               |            |
| NAME OF P   | PROVIDER OR SUPPLIER   | ł  |        |                       | EEN MEADOWS DR  |                               |            |
| GREENF  | IELD HEALTHCAR   | E CENTER   |        | GREEN                 | FIELD, IN 46140   |                               |            |
| (X4) ID   |  | STATEMENT OF DEFICIENCIE                                 |        | ID                    | PROVIDER'S PLAN OF CORRECTION   |                               | (X5)       |
| PREFIX  |  | CY MUST BE PRECEDED BY FULL                              |        | PREFIX                | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | TE                            | COMPLETION |
| TAG<br>F 0000   | REGULATORY OR  | R LSC IDENTIFYING INFORMATION                            |        | TAG                   | DEFICIENCE  |                               | DATE       |
| 1 0000  |  |  |        |                       |   |                               |            |
| Bldg. 00  |  |  |        |                       |   |                               |            |
|   |  |  | F 0    | 000                   |   |                               |            |
|   |  | ne Investigation of Complaints<br>358363 and IN00358958. |        |                       |   |                               |            |
|   | Complaint IN00357<br>lack of evidence.                         | 754 - Unsubstantiated due to                             |        |                       |   |                               |            |
|   | Complaint IN00358<br>lack of evidence.                         | 3363 - Unsubstantiated due to                            |        |                       |   |                               |            |
|   | Complaint IN00358<br>Federal/state deficie                     | 8958 - Substantiated.<br>encies related to the           |        |                       |   |                               |            |
|   | allegations are cited  | l at F755 and F842.                                      |        |                       |   |                               |            |
|   | Survey dates: Augu   | st 4 and 5, 2021   |        |                       |   |                               |            |
|   | Facility number: 00  | 0099   |        |                       |   |                               |            |
|   | Provider number: 1   |  |        |                       |   |                               |            |
|   | AIM number: 1002   | 91140  |        |                       |   |                               |            |
|   | Census bed type:   |  |        |                       |   |                               |            |
|   | SNF/NF: 104  |  |        |                       |   |                               |            |
|   | Total: 104   |  |        |                       |   |                               |            |
|   | Census payor type:<br>Medicare: 6<br>Medicaid: 81<br>Other: 17 |  |        |                       |   |                               |            |
|   | Total: 104   |  |        |                       |   |                               |            |
|   | These deficiencies a accordance with 41                        | reflect State Findings cited in 0 IAC 16.2-3.1.          |        |                       |   |                               |            |
|   | Quality review com   | pleted on August 11, 2021                                |        |                       |   |                               |            |
| F 0755<br>SS=E  | 483.45(a)(b)(1)-(3<br>Pharmacy                                 | )  |        |                       |   |                               |            |
| LABORATOR   | Y DIRECTOR'S OR PRO  | VIDER/SUPPLIER REPRESENTATIVE'S S                        | GNATUR | Е                     | 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.

| · · ·                    |   | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER<br>155188  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <u>00</u><br>B. WING |  | COM<br>08/                    | (X3) DATE SURVEY<br>COMPLETED<br>08/05/2021 |  |
|--------------------------|---|--|--|--|-------------------------------|---|--|
|                          | PROVIDER OR SUPPLIE   |  | 200  | EET ADDRESS, CITY, STATE, ZIP<br>GREEN MEADOWS DR<br>EENFIELD, IN 46140  | COD                           |   |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIE)  | STATEMENT OF DEFICIENCIE<br>NCY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION  | ID<br>PREFIX<br>TAG  | CROSS-REFERENCED TO THE  | SHOULD BE                     | (X5)<br>COMPLETION<br>DATE                  |  |
| Bldg. 00                 | Srvcs/Procedures<br>§483.45 Pharmae<br>The facility must<br>emergency drugs<br>residents, or obta<br>described in §483<br>permit unlicensed<br>drugs if State law<br>general supervisi<br>§483.45(a) Proce<br>provide pharmac<br>procedures that a<br>acquiring, receivi<br>administering of a<br>meet the needs of<br>§483.45(b) Servio<br>must employ or of<br>licensed pharmac<br>§483.45(b)(1) Pro<br>aspects of the pro<br>in the facility.<br>§483.45(b)(2) Es<br>records of receip<br>controlled drugs i<br>an accurate reco<br>§483.45(b)(3) De<br>are in order and t<br>controlled drugs i<br>periodically recor<br>Based on interview<br>failed to ensure na<br>documented, as ad<br>with dosage and fr | s/Pharmacist/Records<br>cy Services<br>provide routine and<br>a and biologicals to its<br>ain them under an agreement<br>3.70(g). The facility may<br>d personnel to administer<br>or permits, but only under the<br>on of a licensed nurse.<br>edures. A facility must<br>eutical services (including<br>assure the accurate<br>ng, dispensing, and<br>all drugs and biologicals) to<br>of each resident.<br>the consultation. The facility<br>obtain the services of a<br>cist who-<br>bovides consultation on all<br>povision of pharmacy services<br>tablishes a system of<br>t and disposition of all<br>n sufficient detail to enable<br>nciliation; and<br>termines that drug records<br>that an account of all<br>s maintained and | F 0755   | F755 Pharmacy<br>Services/Procedures<br>st/Records<br>Corrective action for<br>resident(s) found to<br>affected by the defic | <sup>-</sup> the<br>have been | 08/22/202                                   |  |

|  | NT OF DEFICIENCIES   | X1) PROVIDER/SUPPLIER/CLIA       | (X2) MULTIPLE C |  | (X3) DATE SURVEY |
|--|----------------------|----------------------------------|-----------------|--|------------------|
| AND PLAN OF CORRECTION IDENTIFICATION NUMBER<br>155188 |                      | A. BUILDING <u>00</u><br>B. WING |                 | COMPLETED<br>08/05/2021  |                  |
|  | DROUDER OR CURRLE    |                                  | STREET          | ADDRESS, CITY, STATE, ZIP COD  |                  |
|  | PROVIDER OR SUPPLIE  |                                  |                 | REEN MEADOWS DR  |                  |
| GREEN  | FIELD HEALTHCA       | RECENTER                         | GREE            | NFIELD, IN 46140   |                  |
| (X4) ID  |                      | STATEMENT OF DEFICIENCIE         | ID              | PROVIDER'S PLAN OF CORRECTION  | (X5)             |
| PREFIX   |                      | NCY MUST BE PRECEDED BY FULL     | PREFIX          | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIAT<br>DEFICIENCY) |                  |
| TAG  |                      | R LSC IDENTIFYING INFORMATION    | TAG             |  | DATE             |
|  | administration. (R   | esident B, D, E and G)           |                 | practice:  |                  |
|  | Tin dia an in chadaa |                                  |                 | Residents D and G no longer  |                  |
|  | Findings include:    |                                  |                 | reside in the facility.  |                  |
|  | 10. The aliniaal rad | cord for Resident B was          |                 | Resident B was identified as be<br>part of the facilities deficient                    | eing             |
|  |                      | 1 at 12:57 p.m. The diagnoses    |                 | practice.  |                  |
|  |                      | not limited to, gout,            |                 | Resident E was identified as b   | oing             |
|  | osteoarthritis, and  |                                  |                 | part of the facilities deficient   | eng              |
|  | osteoartinitis, and  | anxiety disorder.                |                 | practice.  |                  |
|  | A physician order    | dated 1/28/21, indicated the     |                 | Corrective action taken for  |                  |
|  | following, "Klor     |                                  |                 | those residents having the   |                  |
|  | -                    | 1 tablet by mouth every 6 hours  |                 | potential to be affected by the  | •                |
|  | for Anxiety"         | T dolet by modul every b hours   |                 | same deficient practice:   | 5                |
|  | ior runnety          |                                  |                 | All residents whom are prescril  | hed              |
|  | A "controlled drug   | administration record" for       |                 | narcotics have the potential to  |                  |
|  | -                    | opin, dated 5/27/21 to 6/3/21,   |                 | affected by the deficient practic  |                  |
|  |                      | tation of the time the           |                 | An audit has been conducted of   |                  |
|  |                      | ministered on 5 of 30            |                 | residents whom receive narcot  |                  |
|  | administrations.     |                                  |                 | and a pain assessment was  |                  |
|  |                      |                                  |                 | completed to ensure those  |                  |
|  | A "controlled drug   | administration record" for       |                 | resident have not been affecte   | d by             |
|  | -                    | opin, dated 6/4/21 to 6/11/21,   |                 | the facilities deficient practice.   | _ ~ )            |
|  |                      | tation of the time the           |                 | Any identified concerns were   |                  |
|  | medication was ad    | ministered on 2 of 30            |                 | immediately addressed.   |                  |
|  | administrations.     |                                  |                 | Measures/ systemic changes   | ,                |
|  |                      |                                  |                 | put into place to ensure the   |                  |
|  | A "controlled drug   | administration record" for       |                 | deficient practice does not  |                  |
|  | Resident B's Klone   | opin, dated 6/26/21 to 7/4/21,   |                 | recur:   |                  |
|  | noted no documen     | tation of the time the           |                 | The Administrator/Director of  |                  |
|  |                      | ministered on 4 of 30            |                 | Nursing/Designee have comple   | eted             |
|  | administrations.     |                                  |                 | education with licensed nurses   | \$               |
|  |                      |                                  |                 | and qualified medication aides   |                  |
|  | -                    | administration record" for       |                 | using "Medication Administration   | on"              |
|  |                      | opin, dated 7/4/21 to 7/11/21,   |                 | policy to ensure documentation   | n of             |
|  |                      | tation of the time the           |                 | medications as administered, v   | with             |
|  |                      | ministered on 4 of 30            |                 | dosage and frequency per MD  |                  |
|  |                      | here was an additional dose of   |                 | order.   |                  |
|  |                      | 7/6/21 for a total of 5 doses    |                 | Corrective actions to be   |                  |
|  | administered, inste  | ead of 4 per physician order.    |                 | monitored to ensure the  |                  |
|  |                      |                                  |                 | deficient practice does not  |                  |

|                        | NT OF DEFICIENCIES  | X1) PROVIDER/SUPPLIER/CLIA              | (X2) MULTIPLE CONSTRUCTION |  | (X3) DATE SURVEY |                  |
|------------------------|---------------------|---|----------------------------|--|------------------|------------------|
| AND PLAN OF CORRECTION |                     | IDENTIFICATION NUMBER 155188            | A. BUILDING<br>B. WING     | 00   | _                | PLETED<br>5/2021 |
| NAME OF                | PROVIDER OR SUPPLIE | ER                                      |                            | ET ADDRESS, CITY, STATE, ZIP (   | COD              |                  |
|                        | FIELD HEALTHCA      |   |                            | GREEN MEADOWS DR<br>ENFIELD, IN 46140                                  |                  |                  |
| (X4) ID                | SUMMARY             | Y STATEMENT OF DEFICIENCIE              | ID                         | PROVIDER'S PLAN OF COI   | RECTION          | (X5)             |
| PREFIX                 | (EACH DEFICIE       | NCY MUST BE PRECEDED BY FULL            | PREFIX                     | (EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE                   | HOULD BE         | COMPLETIC        |
| TAG                    |                     | OR LSC IDENTIFYING INFORMATION          | TAG                        | DEFICIENCY)  |                  | DATE             |
|                        |                     | g administration record" for            |                            | recur:   | . <u> </u>       |                  |
|                        |                     | opin, dated 7/11/21 to 7/19/21,         |                            | The Director of Nursin   |                  |                  |
|                        |                     | tation of the time the                  |                            | will audit resident's rec  |                  |                  |
|                        | administrations.    | lministered on 3 of 30                  |                            | are prescribed narcoti   |                  |                  |
|                        | administrations.    |   |                            | accurate documentation medications as admin                            |                  |                  |
|                        | There were no cor   | ntrolled drug administration            |                            | including dosage and   |                  |                  |
|                        |                     | at B's Klonopin to account for          |                            | per MD order. The au   |                  |                  |
|                        |                     | 7/19/21 to $7/26/21$ .                  |                            | as follows: 5 residents  |                  |                  |
|                        |                     | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, |                            | x4 weeks, then 3 resid   | •                |                  |
|                        | A physician order.  | , dated 7/29/21, indicated the          |                            | week x 4 weeks, then   |                  |                  |
|                        |                     | nopin tablet 1 mgGive 1.5 mg            |                            | per week, 4 weeks for  |                  |                  |
|                        | -                   | e a day for Anxiety AND Give 1          |                            | than 3 months and co   |                  |                  |
|                        | mg by mouth one     | time a day for Anxiety AND              |                            | maintained. Any identi   |                  |                  |
|                        | Give 1 mg by mou    | th one time a day for Anxiety           |                            | concerns will be addre   | essed.           |                  |
|                        | AND Give 1.5 mg     | , by mouth one time a dayfor            |                            | The Director of Nursin   | g will           |                  |
|                        | Anxiety"            |   |                            | present the results of   | the audits       |                  |
|                        |                     |   |                            | monthly to QAPI comr   |                  |                  |
|                        |                     | g administration record" for            |                            | less than 3 months. A  | • •              |                  |
|                        |                     | opin, dated 7/26/21 to 8/1/21,          |                            | that are identified will   |                  |                  |
|                        |                     | tation of the time the                  |                            | Action plan initiated. T   |                  |                  |
|                        | administrations.    | lministered on 2 of 28                  |                            | committee will determ<br>100% compliance is a<br>ongoing monitoring is | chieved or if    |                  |
|                        | A "controlled drug  | g administration record" for            |                            |  | required.        |                  |
|                        |                     | opin, dated 8/2/21 to 8/4/21,           |                            |  |                  |                  |
|                        |                     | tation of the time the                  |                            |  |                  | 1                |
|                        | medication was ad   | lministered on 2 of 10                  |                            |  |                  |                  |
|                        | administrations. T  | here were only partial doses of 1       |                            |  |                  |                  |
|                        |                     | ocumented as administered               |                            |  |                  |                  |
|                        |                     | mg dose, per the physician              |                            |  |                  |                  |
|                        | orders, on 8/3/21 a | and 8/4/21.                             |                            |  |                  |                  |
|                        | 1b. A physician or  | rder, dated 4/28/21, indicated the      |                            |  |                  |                  |
|                        |                     | codone30 mgGive 1 tablet by             |                            |  |                  | 1                |
|                        |                     | ars for chronic pain"                   |                            |  |                  |                  |
|                        | A "controlled drug  | g administration record" for            |                            |  |                  |                  |
|                        | Resident B's oxyc   | odone, dated 6/26/21 to 7/1/21,         |                            |  |                  | 1                |
|                        | noted no documen    | tation of the time the                  |                            |  |                  |                  |

| STATEMENT OF DEFICIENCIES       X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER         155188         NAME OF PROVIDER OR SUPPLIER |                                       | IDENTIFICATION NUMBER  | (X2) MULTIPLE CO<br>A. BUILDING<br>B. WING      | DNSTRUCTION 00   | (X3) DATE SURVEY<br>COMPLETED<br>08/05/2021 |  |
|---|---------------------------------------|--|---|--|---|--|
|   |                                       | 200 GF   | ADDRESS, CITY, STATE, ZIP CO<br>REEN MEADOWS DR | D  |   |  |
| GREEN   | FIELD HEALTHCA                        | RECENTER   | GREEN   | NFIELD, IN 46140   |   |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIE                         | Y STATEMENT OF DEFICIENCIE<br>NCY MUST BE PRECEDED BY FULL<br>DR LSC IDENTIFYING INFORMATION                               | ID<br>PREFIX<br>TAG                             | PROVIDER'S PLAN OF CORRI<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE AP<br>DEFICIENCY) | OULD BE COMPLETIC                           |  |
|   |                                       | lministered on 7 of 30   |   |  |   |  |
|   | Resident B's oxyc<br>noted no documen | g administration record" for<br>odone, dated $7/1/21$ to $7/5/21$ ,<br>attain of the time the<br>liministered on 2 of 20   |   |  |   |  |
|   | Resident B's oxyc<br>noted no documen | g administration record" for<br>odone, dated $7/5/21$ to $7/8/21$ ,<br>atation of the time the<br>liministered on 2 of 20  |   |  |   |  |
|   | Resident B's oxyc<br>noted no documen | g administration record" for<br>odone, dated $7/8/21$ to $7/13/21$ ,<br>attaion of the time the<br>liministered on 5 of 30 |   |  |   |  |
|   | Resident B's oxyc                     | g administration record" for<br>odone, dated 7/18/21 to 7/23/21,<br>on of oxycodone 30 milligrams<br>23/21 at 6:00 a.m.    |   |  |   |  |
|   | following, "oxyo                      | , dated 8/2/21, indicated the<br>codone30 mgGive 1 tablet by<br>ars for chronic pain"                                      |   |  |   |  |
|   | Resident B's oxyc<br>noted no documen | g administration record" for<br>odone, dated $8/2/21$ to $8/5/21$ ,<br>tation of the time the<br>Iministered on 6 of 24    |   |  |   |  |
|   | (MDS) Nurse 4, o<br>she was unable to | lucted with Minimum Data Set<br>n 8/5/21 at 4:21 p.m., indicated<br>locate the missing<br>ord for Resident B's Klonopin    |   |  |   |  |

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID 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 COMPLETED 00 B. WING 08/05/2021 155188 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 200 GREEN MEADOWS DR GREENFIELD HEALTHCARE CENTER GREENFIELD, IN 46140 (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 DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE from 7/19/21 to 7/26/21. 2. The clinical record for Resident D was reviewed on 8/5/21 at 1:00 p.m. The diagnoses included, but were not limited to, weakness, anxiety disorder, and major depressive disorder. Resident D was admitted to the facility on 7/14/21 and discharged on 7/22/21. A physician order, dated 7/15/21, indicated the following, "...Methadone...10 mg...Give 8 tablet by mouth one time a day for pain .... " There were no controlled drug administration records present in Resident D's chart in regards to the physician order for Methadone. An interview conducted with MDS Nurse 4, on 8/5/21 at 4:58 p.m., indicated there were no controlled administration records that could be located for Resident D's Methadone during her stay at the facility. 3. The clinical record for Resident E was reviewed on 8/5/21 at 1:29 p.m. The diagnoses included, but were not limited to, chronic pain syndrome, arthritis, and neuropathy. A physician order, dated 7/18/21, indicated the use of a Fentanyl patch, 75 micrograms, to be applied transdermally every 48 hours for pain. A physician order, dated 2/2/21, indicated the use of Lyrica 100 milligrams twice daily for seizures. A "controlled drug administration record" for Resident E's Lyrica, dated 6/23/21 to 7/7/21, noted no documentation of the time the medication was administered on 4 of 30 administrations. Event ID: 002511 Facility ID: 000099 Page 6 of 17 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

08/27/2021

PRINTED:

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION          |  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER<br>155188  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <u>00</u><br>B. WING                       |  | (X3) DATE SURVEY<br>COMPLETED<br>08/05/2021 |                   |  |
|--|--|--|--|--|---|-------------------|--|
| NAME OF PROVIDER OR SUPPLIER<br>GREENFIELD HEALTHCARE CENTER |  | 200 GR   | STREET ADDRESS, CITY, STATE, ZIP COD<br>200 GREEN MEADOWS DR<br>GREENFIELD, IN 46140 |  |   |                   |  |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY<br>(EACH DEFICIE   | Y STATEMENT OF DEFICIENCIE<br>NCY MUST BE PRECEDED BY FULL<br>DR LSC IDENTIFYING INFORMATION   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOULI<br>CROSS-REFERENCED TO THE APPRC<br>DEFICIENCY) | ) BE  | (X5)<br>COMPLETIC |  |
|  | A "controlled drug<br>Resident E's Lyric<br>no documentation<br>administered on 1<br>wasn't an administ<br>for the morning do<br>A "controlled drug<br>Resident E's Fenta<br>7/8/21, noted no d<br>of the Fentanyl pa<br>4a. The clinical re-<br>reviewed on 8/5/2<br>included, but were<br>degeneration, wea<br>disorder.<br>A physician order,<br>of Klonopin 0.25 m<br>anxiety.<br>A physician order,<br>use of Klonopin 0.<br>anxiety.<br>The "controlled dr<br>Resident G's Klon<br>date(s)/time(s) wh<br>signed off, as adm<br>6/20/21- afternoor<br>7/9/21- night time<br>7/17/21- afternoor<br>7/25/21- night time | g administration record" for<br>a, dated 7/9/21 to 7/27/21, noted<br>of the time the medication was<br>of 30 administrations. There<br>tration signed off for the 7/21/21<br>ose.<br>g administration record" for<br>myl patches, dated 6/28/21 to<br>ocumentation of administration<br>tch for 7/6/21.<br>cord for Resident G was<br>1 at 1:12 p.m. The diagnoses<br>e not limited to, cervical disc<br>kness, chronic pain, and anxiety<br>, dated 6/2/21, indicated the use<br>milligrams three times daily for<br>, dated 6/30/21, indicated the<br>.5 milligrams three times daily for<br>ug administration record" for<br>opin noted the following<br>ere the medication was not<br>inistered:<br>n dose,<br>dose, &<br>e dose.<br>der, dated 5/14/21, indicated the<br>5 milligram extended release |  |  |   | DATE              |  |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER<br>155188  | (X2) MULTIPLE CONSTRUCTION A. BUILDING D B. WING |   | (X3) DATE SURVEY<br>COMPLETED<br>08/05/2021 |
|---|--|--|--|---|---|
| NAME OF   | PROVIDER OR SUPPLIE  | ER   |  | ADDRESS, CITY, STATE, ZIP C<br>REEN MEADOWS DR                                | COD   |
| GREEN   | FIELD HEALTHCA   | RE CENTER  |  | NFIELD, IN 46140  |   |
| (X4) ID<br>PREFIX                                   |  | Y STATEMENT OF DEFICIENCIE<br>NCY MUST BE PRECEDED BY FULL   | ID<br>PREFIX                                     | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE | SHOULD BE COMPLETIC                         |
| TAG   | REGULATORY C   | OR LSC IDENTIFYING INFORMATION   | TAG  | DEFICIENCY)   | DATE  |
|   | Resident G's exter<br>following date(s)/was not signed off   |  |  |   |   |
|   | 6/2/21- morning d<br>6/6/21- night time  |  |  |   |   |
|   | 6/7/21- night time   | dose,  |  |   |   |
|   | 6/8/21- night time   |  |  |   |   |
|   | 6/11/21- night tim<br>6/12/21- night tim   |  |  |   |   |
|   |  | ning and night time dose, &  |  |   |   |
|   | 7/10/21- night tim   |  |  |   |   |
|   | signed off, as adm   | ttended release Morphine was<br>inistered, of 3 doses within a 24<br>d of 2 doses as ordered.  |  |   |   |
|   |  | der, dated 5/14/21, indicated the milligrams twice daily.  |  |   |   |
|   | The "controlled dr   | rug administration record" for   |  |   |   |
|   |  | ca noted the following   |  |   |   |
|   | date(s)/time(s) wh<br>signed off, as adm   | ere the medication was not inistered:  |  |   |   |
|   | 7/6/21- night time<br>7/26/21- morning   |  |  |   |   |
|   |  | yrica was signed off for 3<br>ithin a 24 hour period instead of<br>l.  |  |   |   |
|   | 8/5/21 at 4:58 p.m<br>card goes along w<br>administration rec<br>review to ensure the<br>available for conti | Aucted with MDS Nurse 4, on<br>, indicated the empty medication<br>ith the controlled drug<br>ord into a filing system for<br>he resident has the medication<br>nued use. Narcotic count sheets<br>ted and consistent with |  |   |   |

| ·                          |  |   |                     |  | X3) DATE SURVEY<br>COMPLETED<br>08/05/2021 |                            |
|----------------------------|--|---|---------------------|--|--|----------------------------|
| NAME OF                    | PROVIDER OR SUPPLIE  | BR  |                     | ADDRESS, CITY, STATE, ZIP COD<br>EEN MEADOWS DR  |  |                            |
| GREEN                      | FIELD HEALTHCA   | RE CENTER   | GREEN               | IFIELD, IN 46140   |  |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIE  | Y STATEMENT OF DEFICIENCIE<br>NCY MUST BE PRECEDED BY FULL<br>DR LSC IDENTIFYING INFORMATION  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOUL)<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | ) BE                                       | (X5)<br>COMPLETION<br>DATE |
|                            | physician orders.  |   |                     |  |  |                            |
|                            | Security", revised<br>Nurse 4 on 8/5/21<br>the following, "I<br>Count and Inventor<br>controlled drugs, of<br>cards must be reco<br>and signed for cor<br>A policy titled "M<br>revised 12/14/17,<br>on 8/5/21 at 11:00<br>following, "Proc<br>Administer medic<br>providerf. Obser<br>each medication<br>doseee. Narcotic<br>givenff. Medicat<br>the time frame of<br>after time ordered.<br>Documentation of<br>medication admin | edication Controlled Drugs and<br>7/15/18, was provided by MDS<br>at 5:00 p.m. The policy indicated<br>ProcedureIV. The Narcotic<br>oryc. The inventory of the<br>count sheets and number of<br>orded on the narcotic records<br>rectness of count"<br>edication Administration",<br>was provided by MDS Nurse 4<br>a.m. The policy indicated the<br>redureI. General Proceduresa.<br>ation only as prescribed by the<br>tve the "five rights" in giving<br>ii. the right timeiv. the right<br>es will be signed out when<br>tions will be administered within<br>one hour before up to one hour<br>Documentationa.<br>"medication will be current for<br>istrationb. Documentation of<br>ollow accepted standards of |                     |  |  |                            |
|                            | This Federal tag ro  | elates to Complaint IN00358958.   |                     |  |  |                            |
| F 0842<br>SS=E<br>Bldg. 00 | §483.20(f)(5) Re<br>(i) A facility may<br>is resident-identi<br>(ii) The facility m<br>resident-identifia<br>accordance with<br>agent agrees not   | s - Identifiable Information<br>sident-identifiable information.<br>not release information that<br>fiable to the public.<br>ay release information that is<br>ble to an agent only in<br>a contract under which the<br>t to use or disclose the<br>pt to the extent the facility   |                     |  |  |                            |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER<br>155188  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <u>00</u><br>B. WING |  | COMPI   | (X3) DATE SURVEY<br>COMPLETED<br>08/05/2021 |  |
|---|--|--|--|--|---------|---|--|
| NAME OF   | PROVIDER OR SUPPLIE  | ER   |  | ADDRESS, CITY, STATE, ZIP CC<br>REEN MEADOWS DR  | D       |   |  |
| GREEN   | FIELD HEALTHCA   | RE CENTER  |  | NFIELD, IN 46140   |         |   |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIE  | Y STATEMENT OF DEFICIENCIE<br>NCY MUST BE PRECEDED BY FULL<br>DR LSC IDENTIFYING INFORMATION   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORR<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE AF<br>DEFICIENCY) | DULD BE | (X5)<br>COMPLETIO<br>DATE                   |  |
|   | professional star<br>facility must main<br>each resident tha<br>(i) Complete;<br>(ii) Accurately do<br>(iii) Readily acce<br>(iv) Systematical<br>§483.70(i)(2) The<br>confidential all in<br>resident's record<br>regardless of the<br>the records, exce<br>(i) To the individu<br>representative w<br>law;<br>(ii) Required by L<br>(iii) For treatmen<br>operations, as pe<br>compliance with<br>(iv) For public he<br>abuse, neglect, o<br>oversight activitie<br>proceedings, law<br>organ donation p<br>or to coroners, m<br>directors, and to<br>health or safety a<br>compliance with<br>§483.70(i)(3) The<br>medical record in<br>destruction, or un<br>§483.70(i)(4) Me<br>retained for- | accordance with accepted<br>indards and practices, the<br>intain medical records on<br>at are-<br>incumented;<br>ssible; and<br>ly organized<br>e facility must keep<br>formation contained in the<br>s,<br>form or storage method of<br>ept when release is-<br>ual, or their resident<br>here permitted by applicable<br>-aW;<br>t, payment, or health care<br>ermitted by and in<br>45 CFR 164.506;<br>alth activities, reporting of<br>or domestic violence, health<br>es, judicial and administrative<br>or enforcement purposes,<br>burposes, research purposes,<br>nedical examiners, funeral<br>avert a serious threat to<br>as permitted by and in<br>45 CFR 164.512.<br>e facility must safeguard<br>formation against loss, |  |  |         |   |  |

|  | TEMENT OF DEFICIENCIES       X1) PROVIDER/SUPPLIER/CLIA         PLAN OF CORRECTION       IDENTIFICATION NUMBER         155188  |  | (X2) MULTIPLE<br>A. BUILDING<br>B. WING | <u></u>   |   | (X3) DATE SURVEY<br>COMPLETED<br>08/05/2021 |  |
|--|--|--|---|---|---|---|--|
| NAME OF PROVIDER OR SUPPLIER<br>GREENFIELD HEALTHCARE CENTER |  |  | 200 0                                   | ET ADDRESS, CITY, STATE, ZIP CO<br>GREEN MEADOWS DR   | D   |   |  |
| GREEN  |  | RECENTER   | GRE                                     | ENFIELD, IN 46140   |   | -   |  |
| (X4) ID<br>PREFIX  | (EACH DEFICIE)   | STATEMENT OF DEFICIENCIE<br>NCY MUST BE PRECEDED BY FULL   | ID<br>PREFIX                            | PROVIDER'S PLAN OF CORRI<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE AP<br>DEFICIENCY)  | DULD BE   | (X5)<br>COMPLETION                          |  |
| TAG  | <ul> <li>(ii) Five years frowhen there is nowhen the nowhead and nowhead and nowhead and nowhead the normalization of the normalization of</li></ul> | f any preadmission<br>sident review evaluations and<br>onducted by the State;<br>urse's, and other licensed<br>ogress notes; and<br>adiology and other diagnostic<br>as required under §483.50.<br>v and record review, the facility<br>cumentation included times of<br>stration of narcotic medication<br>count sheets to provide<br>liation of narcotics for 4 of 4<br>for medication administration.<br>and G)<br>cord for Resident B was<br>at 12:57 p.m. The diagnoses<br>not limited to, gout,<br>anxiety disorder.<br>dated 1/28/21, indicated the | F 0842                                  | F842 RESIDENT RECO<br>Corrective action for the<br>resident(s) found to hav<br>affected by the deficient<br>Residents D and G no la<br>reside in the facility.<br>Resident B was identified<br>part of the facilities defice<br>practice.<br>Resident E was identified<br>part of the facilities defice<br>practice.<br>Corrective action taken<br>those residents having<br>potential to be affected<br>same deficient practice<br>All residents whom are<br>narcotics have the poten<br>affected by the deficient<br>An audit has been cond<br>residents whom receive | e been<br>t practice:<br>onger<br>ed as being<br>cient<br>d as being<br>cient<br>for<br>the<br>by the<br>e:<br>prescribed<br>ntial to be<br>t practice.<br>ucted of all | 08/22/202                                   |  |

| STATEME | NT OF DEFICIENCIES  | X1) PROVIDER/SUPPLIER/CLIA      | (X2) MU                          | LTIPLE CO                        | ONSTRUCTION   | (X3) DATE    | SURVEY     |
|---------|---------------------|---------------------------------|----------------------------------|----------------------------------|---|--------------|------------|
|         |                     | IDENTIFICATION NUMBER           |                                  |                                  |   | COMPLETED    |            |
|         |                     | 155188                          | A. BUILDING <u>00</u><br>B. WING |                                  |   | - 08/05/2021 |            |
|         |                     |                                 | <u> </u>                         | STREET                           | ADDRESS, CITY, STATE, ZIP COD   |              |            |
| NAME OF | PROVIDER OR SUPPLIE | R                               |                                  |                                  | REEN MEADOWS DR   |              |            |
| GREEN   | FIELD HEALTHCA      | RE CENTER                       |                                  |                                  | NFIELD, IN 46140  |              |            |
| X4) ID  | SUMMARY             | STATEMENT OF DEFICIENCIE        |                                  | ID                               | PROVIDER'S PLAN OF CORRECTION   |              | (X5)       |
| PREFIX  | (EACH DEFICIE       | NCY MUST BE PRECEDED BY FULL    | Р                                | REFIX                            | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | ATE          | COMPLETION |
| TAG     | REGULATORY C        | R LSC IDENTIFYING INFORMATION   |                                  | TAG                              | DEFICIENCY)   |              | DATE       |
|         | A "controlled drug  | administration record" for      |                                  |                                  | to ensure those resident have   | e not        |            |
|         | Resident B's Klone  | opin, dated 5/27/21 to 6/3/21,  |                                  |                                  | affected by the facilities defici   | ent          |            |
|         | noted no documen    | tation of the time the          |                                  |                                  | practice. Any identified conce  | rns          |            |
|         | medication was ad   | ministered on 5 of 30           |                                  |                                  | were immediately addressed.   |              |            |
|         | administrations.    |                                 |                                  |                                  | Measures/ systemic change   | s            |            |
|         |                     |                                 |                                  |                                  | put into place to ensure the  |              |            |
|         | A "controlled drug  | administration record" for      |                                  |                                  | deficient practice does not   |              |            |
|         | Resident B's Klone  |                                 |                                  | recur:                           |   |              |            |
|         | noted no documen    |                                 |                                  | The Administrator/Director of    |   |              |            |
|         | medication was ad   |                                 |                                  | Nursing/Designee have comp       | leted   |              |            |
|         | administrations.    |                                 |                                  | education with licensed nurse    |   |              |            |
|         |                     |                                 |                                  |                                  | and qualified medication aide   | s            |            |
|         | A "controlled drug  | administration record" for      |                                  |                                  | using "Medication Administration  |              |            |
|         |                     | opin, dated 6/26/21 to 7/4/21,  |                                  |                                  | policy to ensure accurate   |              |            |
|         |                     | tation of the time the          |                                  |                                  | documentation of medications  | sat          |            |
|         |                     | ministered on 4 of 30           |                                  |                                  | time of administration on EMA   |              |            |
|         | administrations.    |                                 |                                  |                                  | and Narcotic count sheets fo  |              |            |
|         |                     |                                 |                                  |                                  | reconciliation by 8/22/21.  | •            |            |
|         | A "controlled drug  | administration record" for      |                                  |                                  | Corrective actions to be  |              |            |
|         |                     | opin, dated 7/4/21 to 7/11/21,  |                                  |                                  | monitored to ensure the   |              |            |
|         |                     | tation of the time the          |                                  |                                  | deficient practice does not   |              |            |
|         |                     | ministered on 4 of 30           |                                  |                                  | recur:  |              |            |
|         |                     | here was an additional dose of  |                                  |                                  | The Director of Nursing/Desig   | noo          |            |
|         |                     | 1.7/6/21 for a total of 5 doses |                                  |                                  | will audit resident's records w   |              |            |
|         |                     | ead of 4 per physician order.   |                                  |                                  | are prescribed narcotics to er  |              |            |
|         | uummittereu, mitte  | and of a per physician oracle   |                                  |                                  | accurate documentation of   | isure        |            |
|         | A "controlled drug  | administration record" for      |                                  |                                  | medications as administered   |              |            |
|         | Resident B's Klone  |                                 |                                  | including time of administration | n on  |              |            |
|         |                     | tation of the time the          |                                  |                                  | EMAR and Narcotic Count sh  |              |            |
|         |                     | ministered on 3 of 30           |                                  |                                  | for reconciliation. The audit w   |              |            |
|         | administrations.    |                                 |                                  |                                  | occur as follows: 5 residents   |              |            |
|         | aummistrations.     |                                 |                                  |                                  | week x4 weeks, then 3 reside  |              |            |
|         | There were no con   | trolled drug administration     |                                  |                                  | per week x 4 weeks, then 1  | 110          |            |
|         |                     | t B's Klonopin to account for   |                                  |                                  | resident per week, 4 weeks for  | or no        |            |
|         |                     | 7/19/21 to 7/26/21.             |                                  |                                  | less than 3 months and  |              |            |
|         | ale unie period of  | //1//21 10 //20/21.             |                                  |                                  |   | V            |            |
|         | A physician and-    | dated 7/20/21 indicated the     |                                  |                                  | compliance is maintained. An  | у            |            |
|         |                     | dated 7/29/21, indicated the    |                                  |                                  | identified concerns will be   |              |            |
|         | -                   | nopin tablet 1 mgGive 1.5 mg    |                                  |                                  | addressed.  |              |            |
|         |                     | e a day for Anxiety AND Give 1  |                                  |                                  | The Director of Nursing will  | .,           |            |
|         | mg by mouth one     | time a day for Anxiety AND      |                                  |                                  | present the results of the aud  | IIS          |            |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 002511 Facility ID: 000099

If continuation sheet Page 12 of 17

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER<br>155188   | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <u>00</u><br>B. WING |   | (X3) DATE SURVEY<br>COMPLETED<br>08/05/2021               |                           |
|---|--|---|--|---|---|---------------------------|
|   | PROVIDER OR SUPPLIE  |   | 200 G  | TADDRESS, CITY, STATE, ZIP CO<br>REEN MEADOWS DR<br>ENFIELD, IN 46140   | D   |                           |
|   |  | RECENTER  |  |   |   | 1                         |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIE  | Y STATEMENT OF DEFICIENCIE<br>NCY MUST BE PRECEDED BY FULL<br>DR LSC IDENTIFYING INFORMATION  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORR<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE AF<br>DEFICIENCY)  | ECTION<br>DULD BE<br>PPROPRIATE                           | (X5)<br>COMPLETIC<br>DATE |
|   | AND Give 1.5 mg<br>Anxiety"<br>A "controlled drug<br>Resident B's Klon<br>noted no documen | th one time a day for Anxiety<br>g by mouth one time a dayfor<br>g administration record" for<br>opin, dated 7/26/21 to 8/1/21,<br>tation of the time the<br>lministered on 2 of 28 |  | monthly to QAPI commi<br>less than 3 months. Any<br>that are identified will ha<br>Action plan initiated. Th<br>committee will determin<br>100% compliance is acl<br>ongoing monitoring is re | y patterns<br>ave an<br>e QAPI<br>le when<br>hieved or if |                           |
|   | Resident B's Klon<br>noted no documen  | g administration record" for<br>opin, dated 8/2/21 to 8/4/21,<br>tation of the time the<br>Iministered on 2 of 10   |  |   |   |                           |
|   | following, "oxyo   | rder, dated 4/28/21, indicated the codone30 mgGive 1 tablet by urs for chronic pain"  |  |   |   |                           |
|   | Resident B's oxyc<br>noted no documen  | g administration record" for<br>odone, dated 6/26/21 to 7/1/21,<br>tation of the time the<br>Iministered on 7 of 30   |  |   |   |                           |
|   | Resident B's oxyc<br>noted no documen  | g administration record" for<br>odone, dated 7/1/21 to 7/5/21,<br>itation of the time the<br>iministered on 2 of 20   |  |   |   |                           |
|   | Resident B's oxyc<br>noted no documen  | g administration record" for<br>odone, dated $7/5/21$ to $7/8/21$ ,<br>tation of the time the<br>dministered on 2 of 20   |  |   |   |                           |
|   |  | g administration record" for odone, dated 7/8/21 to 7/13/21,  |  |   |   |                           |

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID 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 COMPLETED 00 B. WING 08/05/2021 155188 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 200 GREEN MEADOWS DR GREENFIELD HEALTHCARE CENTER GREENFIELD, IN 46140 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE noted no documentation of the time the medication was administered on 5 of 30 administrations. A physician order, dated 8/2/21, indicated the following, "...oxycodone...30 mg...Give 1 tablet by mouth every 3 hours for chronic pain...." A "controlled drug administration record" for Resident B's oxycodone, dated 8/2/21 to 8/5/21, noted no documentation of the time the medication was administered on 6 of 24 administrations. An interview conducted with Minimum Data Set (MDS) Nurse 4, on 8/5/21 at 4:21 p.m., indicated she was unable to locate the missing administration record for Resident B's Klonopin from 7/19/21 to 7/26/21. 2. The clinical record for Resident D was reviewed on 8/5/21 at 1:00 p.m. The diagnoses included, but were not limited to, weakness, anxiety disorder, and major depressive disorder. Resident D was admitted to the facility on 7/14/21 and discharged on 7/22/21. A physician order, dated 7/15/21, indicated the following, "...Methadone...10 mg...Give 8 tablet by mouth one time a day for pain .... " There were no controlled drug administration records present in Resident D's chart in regards to the physician order for Methadone. An interview conducted with MDS Nurse 4, on 8/5/21 at 4:58 p.m., indicated there were no controlled administration records that could be located for Resident D's Methadone during her stay at the facility. Event ID: 002511 Facility ID: 000099 Page 14 of 17 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

08/27/2021

PRINTED:

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID 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 COMPLETED 00 B. WING 08/05/2021 155188 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 200 GREEN MEADOWS DR GREENFIELD HEALTHCARE CENTER GREENFIELD, IN 46140 (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 DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE 3. The clinical record for Resident E was reviewed on 8/5/21 at 1:29 p.m. The diagnoses included, but were not limited to, chronic pain syndrome, arthritis, and neuropathy. A physician order, dated 7/18/21, indicated the use of a Fentanyl patch, 75 micrograms, to be applied transdermally every 48 hours for pain. A physician order, dated 2/2/21, indicated the use of Lyrica 100 milligrams twice daily for seizures. A "controlled drug administration record" for Resident E's Lyrica, dated 6/23/21 to 7/7/21, noted no documentation of the time the medication was administered on 4 of 30 administrations. A "controlled drug administration record" for Resident E's Lyrica, dated 7/9/21 to 7/27/21, noted no documentation of the time the medication was administered on 1 of 30 administrations. 4a. The clinical record for Resident G was reviewed on 8/5/21 at 1:12 p.m. The diagnoses included, but were not limited to, cervical disc degeneration, weakness, chronic pain, and anxiety disorder. A physician order, dated 6/2/21, indicated the use of Klonopin 0.25 milligrams three times daily for anxiety. A physician order, dated 6/30/21, indicated the use of Klonopin 0.5 milligrams three times daily for anxiety. The "controlled drug administration record" for Resident G's Klonopin noted the following date(s)/time(s) where the medication was not Event ID: 002511 Facility ID: 000099 Page 15 of 17 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

08/27/2021

PRINTED:

|                        | R MEDICARE & MEDIC   |                                  |      |         |  |     | OMB NO. 0938-0   |  |
|------------------------|--|----------------------------------|------|---------|--|-----|------------------|--|
|                        | TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION |                                  |      |         |  | . , | (X3) DATE SURVEY |  |
| AND PLAN OF CORRECTION |  | IDENTIFICATION NUMBER            |      | UILDING | 00   |     | MPLETED          |  |
|                        |  | 155188                           | B. W | 'ING    |  | 08/ | /05/2021         |  |
| NAME OF                | PROVIDER OR SUPPLIEF   | -                                |      |         | ADDRESS, CITY, STATE, ZIP (                          | COD |                  |  |
|                        |  |                                  |      |         | EEN MEADOWS DR                                       |     |                  |  |
| GREEN                  | FIELD HEALTHCAR  | ECENTER                          |      | GREEN   | IFIELD, IN 46140                                     |     |                  |  |
| X4) ID                 | SUMMARY  | STATEMENT OF DEFICIENCIE         |      | ID      | PROVIDER'S PLAN OF CO                                |     | (X5)             |  |
| PREFIX                 |  | CY MUST BE PRECEDED BY FULL      |      | PREFIX  | (EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE |     | COMPLET          |  |
| TAG                    | REGULATORY OR LSC IDENTIFYING INFORMATION                                      |                                  |      | TAG     | DEFICIENCY)  |     | DATE             |  |
|                        | signed off, as admin   | nistered:                        |      |         |  |     |                  |  |
|                        | 6/20/21- afternoon   | dose.                            |      |         |  |     |                  |  |
|                        | 7/9/21- night time d   |                                  |      |         |  |     |                  |  |
|                        | 7/17/21- afternoon   |                                  |      |         |  |     |                  |  |
|                        | 7/25/21- night time  | dose.                            |      |         |  |     |                  |  |
|                        | 4b. A physician orde   | er, dated 5/14/21, indicated the |      |         |  |     |                  |  |
|                        |  | milligram extended release       |      |         |  |     |                  |  |
|                        | tablet every 12 hour   | -                                |      |         |  |     |                  |  |
|                        | The "controlled dru  | g administration record" for     |      |         |  |     |                  |  |
|                        |  | led release Morphine noted the   |      |         |  |     |                  |  |
|                        |  | me(s) where the medication       |      |         |  |     |                  |  |
|                        | was not signed off,  |                                  |      |         |  |     |                  |  |
|                        | 6/2/21- morning do   | se,                              |      |         |  |     |                  |  |
|                        | 6/6/21- night time d   |                                  |      |         |  |     |                  |  |
|                        | 6/7/21- night time of  | lose,                            |      |         |  |     |                  |  |
|                        | 6/8/21- night time d   | lose,                            |      |         |  |     |                  |  |
|                        | 6/11/21- night time  | dose,                            |      |         |  |     |                  |  |
|                        | 6/12/21- night time  |                                  |      |         |  |     |                  |  |
|                        |  | ing and night time dose, &       |      |         |  |     |                  |  |
|                        | 7/10/21- night time  | dose,                            |      |         |  |     |                  |  |
|                        | 4c. A physician ord  | er, dated 5/14/21, indicated the |      |         |  |     |                  |  |
|                        | use of Lyrica 225 n  | nilligrams twice daily.          |      |         |  |     |                  |  |
|                        | The "controlled dru  | g administration record" for     |      |         |  |     |                  |  |
|                        | Resident G's Lyrica  | noted the following              |      |         |  |     |                  |  |
|                        | date(s)/time(s) whe  | re the medication was not        |      |         |  |     |                  |  |
|                        | signed off, as admin   | nistered:                        |      |         |  |     |                  |  |
|                        | 7/6/21- night time d   | lose &                           |      |         |  |     |                  |  |
|                        | 7/26/21- morning d   |                                  |      |         |  |     |                  |  |
|                        | An interview condu   | icted with MDS Nurse 4, on       |      |         |  |     |                  |  |
|                        |  | indicated the empty medication   |      |         |  |     |                  |  |
|                        |  | h the controlled drug            |      |         |  |     |                  |  |
|                        | administration reco  | rd into a filing system for      | 1    |         |  |     |                  |  |

| NTERS FOR MEDICARE & MEDICAID SERVICES         STATEMENT OF DEFICIENCIES         X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION         IDENTIFICATION NUMBER |  | A. BUILDING   | construction 00  | CON  | OMB NO. 0938-039<br>(X3) DATE SURVEY<br>COMPLETED |                    |  |  |
|--|--|---|--|--|---|--------------------|--|--|
|  |  | 155188  | B. WING  |  | - 08/   | 05/2021            |  |  |
| NAME OF PROVIDER OR SUPPLIER GREENFIELD HEALTHCARE CENTER  |  |   | STREET ADDRESS, CITY, STATE, ZIP COD<br>200 GREEN MEADOWS DR<br>GREENFIELD, IN 46140 |  |   |                    |  |  |
| X4) ID<br>PREFIX   |  | STATEMENT OF DEFICIENCIE<br>NCY MUST BE PRECEDED BY FULL  | ID<br>PREFIX   | PROVIDER'S PLAN OF CORRI<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE AP<br>DEFICIENCY) | ULD BE  | (X5)<br>COMPLETION |  |  |
| TAG  | review to ensure the<br>available for contine<br>should be completed<br>physician orders.<br>A policy titled "Mod<br>Security", revised "<br>Nurse 4 on 8/5/21<br>the following, "P<br>Count and Inventor<br>controlled drugs, c<br>cards must be record<br>and signed for corre<br>A policy titled "Mod<br>revised 12/14/17, w<br>on 8/5/21 at 11:00<br>following, "Proce<br>Administer medicat<br>providerf. Obser-<br>each medicationif<br>doseee. Narcotic<br>givenff. Medicat<br>the time frame of c<br>after time ordered.<br>Documentation of<br>medications will for<br>nursing practice | R LSC IDENTIFYING INFORMATION<br>the resident has the medication<br>nued use. Narcotic count sheets<br>ed and consistent with<br>edication Controlled Drugs and<br>7/15/18, was provided by MDS<br>at 5:00 p.m. The policy indicated<br>rocedureIV. The Narcotic<br>ryc. The inventory of the<br>ount sheets and number of<br>rded on the narcotic records<br>rectness of count"<br>edication Administration",<br>vas provided by MDS Nurse 4<br>a.m. The policy indicated the<br>edureI. General Proceduresa.<br>tion only as prescribed by the<br>ve the "five rights" in giving<br>i. the right timeiv. the right<br>s will be signed out when<br>ions will be administered within<br>one hour before up to one hour<br>Documentationa.<br>medication will be current for<br>strationb. Documentation of<br>ollow accepted standards of<br>" | TAG  |  |   | DATE               |  |  |

OO2511 Facility ID: 000099

If continuation sheet Page 17 of 17