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	06/26/2024

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

(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 Complaints IN00435677, IN00427026, IN00426858, IN00426147, IN00425521 and IN00423037. Complaint IN00435677 - No deficiencies related to the allegations are cited. Complaint IN00427026 - No deficiencies related to the allegations are cited. Complaint IN00426858 - No deficiencies related to the allegations are cited. Complaint IN00426147 - No deficiencies related to the allegations are cited. Complaint IN00425521 - No deficiencies related to the allegations are cited. Complaint IN00423037 - Federal/State deficiencies related to the allegations are cited at F-755. Survey dates: June 24, 25, & 26, 2024 Facility number: 000099 Provider number: 155188 AIM number: 100291140 Census Bed Type: SNF/NF: 122 Total: 122 Census Payor Type: Medicare: 9 Medicaid: 92 Other: 21 Total: 122	F 0000	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.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Andrew Clark	Executive Director	07/11/2024

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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	This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on June 27, 2024.			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all			

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	controlled drugs is maintained and periodically reconciled. Based on interview and record review the facility failed to provide medications as ordered by the physician for 1 of 3 residents reviewed for medication administration. (Resident C) Finding include: During an interview with Resident C's family, on 6/24/24 at 12:35 p.m., indicated the resident did not receive all his medications as ordered by the physician when admitted to the facility on 11/23/23. The resident was discharged on 11/24/23. The clinical record of Resident C was reviewed on 6/25/24 at 12:40 p.m. The diagnoses included, but were not limited to, diabetes, severe protein calorie malnutrition, convulsions, sepsis, major depressive disorder, stiff man syndrome, hypotension, and pulmonary nodule. Review of the physician orders for Resident C, dated 11/23/24, indicated the resident was ordered and did not receive the following medications: tamsulosin 0.4 milligrams (mg) every morning (urinary retention medication), mirtazapine 15 mg at bedtime for depression, amoxicillin 500 mg; two capsules in the morning and at bedtime for an infection, midodrine 10 mg three times a day for hypotension, pantoprazole sodium 40 mg in the morning and at bedtime for digestive aid, and gabapentin 800 mg at bedtime for polyneuropathy. During an interview with the Regional Director of Clinical Operations, on 6/26/24 at 2:20 p.m., verified Resident C did not receive the medications as ordered by the physician and these medications were available in the	F 0755	F755 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: There were no residents harmed by the alleged practice. Resident C no longer resides in the facility. Facility completed education with direct care employees on medication administration and the emergency pharmacy service and emergency kit policy. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All new admissions that are prescribed medications have the potential to be affected. Facility will complete an audit on all new admission medication orders from the previous 14 days to ensure compliance and notify the physician, family/resident of any discrepancies. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: Education on medication administration and the emergency pharmacy service and emergency kit drug policy was completed with nursing staff with an emphasis on administering, documenting and obtaining medications from the	07/11/2024

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	Emergency Drug Kit (EDK) located in the facility. The floor nurse who admitted Resident C was responsible to obtain these medications out of the EDK and administer them to Resident C. The Emergency Pharmacy Service and Emergency kit policy provided by the Executive Director, on 6/26/24 at 3:19 p.m., indicated emergency pharmacy service was available 24 hours a day. Emergency needs for medication are met by using the facility's approved emergency medication supply. The provider pharmacy supplies emergency medication included, but were not limited to, emergency drugs and antibiotics. The nurse records the medication use from the emergency kit on the use form and seals the kit with a color- coded seal to indicate the need for replacement. This citation relates to Complaint IN00423037. 3.1-25(a)		EDK. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The DON/Designee will conduct audits of all new admissions medication orders to validate medications were given, timely 5 times a week for 4 weeks, then 3 times a week for 2 weeks, 2 times a week for 2 weeks then weekly for 4 weeks. Any discrepancies will be corrected immediately and education will be provided. The results of the audit observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of six months and then randomly thereafter for further recommendation. Date of Completion: 7/11/24	