STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155193	A. BUILDING 00 B. WING	06/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREENWOOD HEALTHCARE CENTER	377 WESTRIDGE BLVD GREENWOOD, IN 46142

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00411214. Complaint IN00411214 - No deficiencies related to the allegations are cited. Survey dates: June 26, 27, 28, 29, and 30, 2023 Facility number: 000101 Provider number: 155193 AIM number: 100291290 Census Bed Type: SNF/NF: 158 Total: 158 Census Payor Type: Medicaid: 123 Other: 35 Total: 158 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed July 7, 2023.	F 0000		
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, interview, and record review, the facility failed to ensure medications were not left at bedside without a self medication	F 0554	F 554 Resident Self-Admin Meds – Clinical Appropriateness	07/21/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Linda Turner | HFA, ED | 07/21/2023

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	administration assessment for 1 of 1 random observations.(Resident 79) Finding includes: During an interview on 6/27/23 at 11:30 a.m., with Resident 79, a medicine cup full of pills was observed to be sitting on the bedside table. The resident indicated the nurse dropped them off that morning and had not left any water nor had she split the potassium in half as required by the resident to swallow the pill. During an interview on 6/27/23 at 11:45 a.m., Licensed Practical Nurse (LPN) 1 indicated she should have stayed with Resident 79 to watch her take the morning medications. LPN 1 indicated Resident 79 was not assessed to self administer medications. Resident 79's clinical record was reviewed on 6/27/23 at 11:50 a.m. The diagnoses included, but were not limited to, Multiple Sclerosis (MS) and peripheral vascular disease. Current physician orders, dated June, 2023, indicated Resident 79's medications included, but were not limited to: - Abilify (for depression) 5 milligrams (mg) 1 tablet in the morning. - Ascorbic acid (for wound healing) 500 mg 1 tablet in the morning. - Bupropion (for depression) 150 mg 1 tablet in the morning. - Cymbalta (for depression) 30 mg 1 capsule in the morning. - Cymbalta 60 mg 1 capsule in the morning. - Lasix (for swelling) 40 mg 1 tablet in the morning. - Linzess (for constipation) 72 micrograms (mcg) 1 capsule in the morning.		It is the standard of this facility to recognize the right to self-administer medications if the interdisciplinary team has determined that this practice is clinically appropriate. -What corrective action be accomplished for those residents found to have been affected by the deficient practice? Resident 79 was not affected by this alleged deficient practice. Resident was immediately assessed with no adverse effects noted. Resident was reviewed for ability to self-administer medication. Medications were administered as ordered without adverse effects. Nursing staff involved were immediately educated on facilities policy “Medication Administration” with focus on proper medication pass procedures. -How will the facility identify residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected. All residents reviewed for self-administration abilities and orders updated if indicated. All licensed nursing staff to be educated on facilities policy “Medication Administration” with focus on proper medication pass procedures.	

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	- Multivitamin give 1 table in the morning. - Oxybutynin chloride (for bladder spasms) 5 mg 1 tablet in the morning. - Potassium chloride (for swelling) 20 milliequivalent (meq) 1 tablet in the morning. - Vitamin D3 give 2000 units in the morning. - Zinc sulfate oral capsule give 1 capsule in the morning. - Zyrtec (for allergies) 10 mg 1 tablet in the morning. - Cephalexin (for urinary tract infection) 250 mg 1 capsule in the morning. - Ferrex (iron) 150 capsule two times a day. - Senna-time (for constipation) 8.6-50 mg give 2 tablets by mouth two times a day. - Baclofen (for MS) 10 mg give 1 tablet three times a day. - Lyrica (for pain) 75 mg give 1 capsule three times a day. A review of the Medication Administration Record on 6/28/23 at 11:00 a.m., for Resident 79 indicated the above medications were administered as ordered on 6/27/23. During an interview on 6/27/23 at 12:18 a.m., the Infection Control Nurse indicated LPN 1 should have stayed to observe Resident 79 take her medications. . On 6/30/23 at 3:35 p.m., the Executive Director provided the facility's policy, "Medication Administration" undated, and indicated it was the policy currently being used by the facility. A review of the policy indicated, "... bb. Remain with resident until the medication is swallowed ... cc. Do not leave medication at bedside ..." 3.1-11(a)		-What measure will be put into place and what systemic changes will be made to ensure that the deficient practice will not recur? Unit Manager or designee will audit medication pass with a random sample of 10 residents weekly times 4 weeks, then 5 resident's med passes monthly for 6 months. -How will the corrective actions be monitored to ensure the alleged deficient practice will not recur? Unit Manager or designee will audit medication pass with a random sample of 10 residents weekly times 4 weeks, then 5 resident's med pass monthly for 6 months and quarterly thereafter until 100% compliance is achieved. The results of these audits will be reported to the facility Quality Assurance (QAPI) committee. -By what date the systemic changes for each deficiency will be completed? July 21,2023	

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F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on interview and record review, the facility failed to ensure Minimum Data Set (MDS) assessments accurately reflected resident status for 3 of 3 residents reviewed for accuracy of assessments. Level 2 PASRR (Preadmission Screening and Resident Review) and discharge status were coded incorrectly. (Resident 25, Resident 38, Resident 166) Findings include: 1. On 6/30/23 at 11:40 a.m., Resident 25's clinical record was reviewed. The diagnoses included, but were not limited to, bipolar disorder and major depressive disorder. The Level 2 PASRR, dated 7/19/21 indicated, "You meet PASRR criteria based on your diagnoses, current symptoms, and treatment needs including recent medication management". The Annual MDS assessment, dated 9/23/22, indicated, "Has the resident been evaluated by level 2 PASRR and determined to have a serious mental illness and/or mental retardation or related condition...no". 2. On 6/30/23 at 11:50 a.m., Resident 38's clinical record was reviewed. The diagnoses included, but were not limited to, schizoaffective disorders and dementia. The Level 2 PASRR, dated 10/26/21 indicated, "You meet PASRR criteria based on your diagnosis of Schizoaffective, psychotic/delusional	F 0641	F641 Accuracy of assessments It is the standard of this facility to complete assessments that accurately reflect the resident's status. -What corrective action be accomplished for those residents found to have been affected by the deficient practice? Immediately after the survey team identified the concern about inaccurate MDS assessments, it was corrected. -How will the facility identify residents having the potential to be affected by the same deficient practice? All residents with a Level II have had MDS assessments audited to ensure correct coding of Level II Preadmission Screening. All discharges for last three months have had MDS assessments audited to ensure correct discharge destination was captured. No other residents were affected by this alleged deficient practice. -What measure will be put into place and what systemic changes	07/21/2023

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	disorder current and past symptoms and need for mental health treatment to manage symptoms". The Annual MDS assessment, dated 10/22/22, indicated, "Has the resident been evaluated by level 2 PASSR and determined to have a serious mental illness and/or mental retardation or related condition...no". During an interview on 6/30/23 at 3:50 p.m., the MDS Coordinator indicated the MDS assessments for Resident 38 and Resident 25 were coded incorrectly. 3. On 6/30/23 at 2:40 p.m., Resident 166's clinical record was reviewed. The diagnoses included but were not limited to, anemia, cardiomyopathy, and rhabdomyolysis. A Discharge MDS assessment, dated 5/3/23, indicated the resident was discharged to an acute hospital. A review of the resident's progress notes indicated the following: - On 4/27/23 at 2:55 p.m., she would be discharged from the facility to a motel. - On 5/3/23 at 3:34 p.m., she was discharged from the facility with all of her belongings. During an interview on 6/30/23 at 3:50 p.m., the MDS Coordinator indicated the resident's MDS assessment was coded inaccurately as she was discharged to the motel. 3.1-31(d)		will be made to ensure that the deficient practice will not recur? MDS Coordinator & Social Service Directors were inserviced on 7/18/23 on Section A of the RAI manual, coding of Level II Preadmission Screening as well as coding accurate discharge destination by the Regional MDS consultant. -How will the corrective actions be monitored to ensure the alleged deficient practice will not recur? Social Service Director or designee will audit Level II Preadmission Screen coding on MDS with a random sample of 5 residents monthly for 3 months and quarterly thereafter until 100% compliance is achieved. The MDS Coordinator will audit discharge designation with a random sample of 5 residents monthly for 3 months and quarterly thereafter until 100% compliance achieved. The results of these audits will be reported to the facility Quality Assurance (QAPI) committee. -By what date the systemic changes for each deficiency will be completed? July 21,2023	
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans			

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	§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with			

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	the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on interview and record review, the facility failed to ensure a care plan was in place for a resident who was diagnosed with a urinary tract infection for 2 of 2 residents reviewed for urinary tract infections. (Resident 34, Resident 151) Findings include: 1. Resident 34's clinical record was reviewed on 6/30/23 at 11:00 a.m. The diagnosis included, but was not limited to, adult failure to thrive. Current physician orders, dated June 2023, indicated Resident 34 was taking amoxicillin-pot clavulanate (an antibiotic) tablet 875-125 milligrams 1 tablet by mouth every 12 hours for Extended Spectrum Beta-Lactamase (ESBL) in the urine. The start date was 6/23/23. The Infection Surveillance Criteria Report, dated 6/29/23, indicated Resident 34 was diagnosed with a urinary tract infection (UTI). A lab report, dated 6/22/23, indicated Resident 34 had greater than 100,000 escherichia coli ESBL which indicated the resident had a UTI. A review of the care plans on 6/30/23 at 12:00 p.m., for Resident 34 lacked documentation of a current care plan for a urinary tract infection. 2. During an observation on 6/28/23 at 2:32 p.m., Resident 151 was observed to be resting in his bed with a urinary catheter drainage bag hanging from the	F 0656	F656 Develop/Implement Comprehensive Care Plans It is the standard of this facility to develop and implement a comprehensive person-centered care plan for each resident. -What corrective action be accomplished for those residents found to have been affected by the deficient practice? Resident's 34 & 151 care plans were reviewed and updated accordingly. -How will the facility identify residents having the potential to be affected by the same deficient practice? All residents with antibiotic orders have the potential to be affected. All residents with antibiotics ordered were reviewed and care plans were updated if indicated. MDS Coordinator, Unit Managers, DON and ADON educated on facilities policy "Plan of care Overview" with focus on episodic care plans.	07/21/2023

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	bed frame. During an observation on 6/30/23 at 10:13 a.m., Resident 151 was observed to be resting in his bed with a urinary catheter drainage bag hanging from the bed frame. On 6/29/23 at 10:09 a.m., Resident 151's clinical record was reviewed. The diagnoses included, but were not limited to, cerebral infarction (stroke), respiratory failure, and neuromuscular dysfunction (lacks bladder control) of the bladder. The Physician orders, dated June 6/30/23, indicated Resident 151 was ordered Bactrim DS (antibiotic) 800-160 milligrams (mg) twice a day for 7 days for urinary tract infection (UTI) (start date 6/26/23). The Infection Surveillance Criteria, dated 6/27/23, indicated Resident 151 had a UTI with an indwelling catheter. Resident 151's care plan lacked a care plan for UTI. During an interview on 6/29/23 at 11:27 a.m., Licensed Practical Nurse (LPN) indicated Resident 151 had an UTI. During an interview on 6/30/23 at 2:25 p.m., the Director of Nursing (DON) indicated when a resident had a UTI, there should be a UTI care plan. The care plans lacked a UTI care plan. On 6/30/23 at 3:30 p.m., the Executive Director provided the facility policy, "Plan of Care Overview," undated and indicated this was the policy currently being used by the facility. A review of the policy indicated...."It is the policy of		-What measure will be put into place and what systemic changes will be made to ensure that the deficient practice will not recur? New physician orders will be reviewed during morning clinical meeting with care plans reviewed and updated as warranted at that time. Staff will be educated on facilities policy “Plan of care overview” with focus on episodic care plans. -How will the corrective actions be monitored to ensure the alleged deficient practice will not recur? MDS Coordinator or designee will audit 5 care plans weekly times 4 weeks, then 3 monthly for 6 months to ensure that care plan reflect resident’s current diagnoses. The DON/Unit Manager/Designee will present the results of these audits monthly to the QAPI committee for no less than 6 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required. -By what date the systemic changes for each deficiency will be completed?	

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	this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents..." 3.1-35(a)		July 21,2023	