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	07/26/2022

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 a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00384162 and IN00385211. Complaint IN00384162 - Substantiated. Federal/State deficiencies related to the allegations are cited at F-0692 & F-0842. Complaint IN00385211- Unsubstantiated due to lack of evidence. Survey dates: July 19, 20, 21, 22, 25 and 26, 2022 Facility number: 000099 Provider number: 155188 AIM number: 100291140 Census Bed Type: SNF/NF: 123 Total: 123 Census Payor Type: Medicare: 13 Medicaid: 92 Other: 18 Total: 123 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 2, 2022	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.**	
F 0558 SS=D Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive			

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

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	07/26/2022

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
	services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. Based on interview, observation, and record review, the facility failed to accommodate the need of providing a comfortable environment for Resident 95 and failed to provide a call light that Resident 64 was capable of using for 2 of 2 residents reviewed for accommodation of needs. Findings include: 1. The clinical record for Resident 95 was reviewed on 7/21/2022 at 4:20 p.m. The medical diagnoses included, but were not limited to, dementia, depression, and anxiety. A Quarterly Minimum Data Set Assessment, dated 6/27/2022, indicated that Resident 95 was cognitively impaired and needed assistance of staff for toileting, transferring, bed mobility. An observation on 7/21/2022 at 3:35 p.m. indicated Resident 95 laying on a metal bedframe in his room. An observation on 7/21/2022 at 4:01 p.m. indicated Resident 95 laying on a metal bedframe in his room. An interview with CNA 10 on 7/21/2022 at 4:05 p.m. indicated the mattress had been removed from the spare bed in Resident 95's room to be used a fall mat in another resident's room. He had been laying on the metal frame on and off all shift. An interview with LPN 11 on 7/21/2022 at 4:09	F 0558	1. Resident 95 and resident 64 were not harmed by the alleged deficient practice. The DON/designee has reviewed the room environment for comfort and reasonable accommodation for each resident. The metal bed frame has been removed from the room of resident 95 and the call light was replaced for resident 64, to touch pad call light. The care plan for resident's 95 and 64 have been reviewed and updated. 2. All residents have the potential to be affected by same alleged deficient practice. All rooms have been inspected to ensure that all bed frames have a mattress in place. An audit has been conducted on all dependent residents to ensure ability to use call light provided. 3. DON/Designee have educated all staff on the "Routine Resident Care" policy, with emphasis on "encouraging maximum function for each resident" and "providing an environment that contributes to a positive self-image, preserves dignity and promotes privacy". This is to ensure dependent residents are provided a call light	09/02/2022

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	07/26/2022

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
	p.m., indicated that she had seen the resident laying on the metal frame throughout the shift so far. She was not aware of what had happened to the mattress, but it was off when she came on shift. She indicated the resident was due for an Invega shot in a few days and this caused him to do "peculiar" things. LPN 11 indicate it is not safe for a resident to lay on the metal frame of the bed without a mattress and she would remove the bed to an empty unit off the locked unit. An observation on 7/22/2022 at 1:53 p.m. confirmed the spare bed was removed form Resident 95's room and placed on the empty unit. A skin assessment was completed for Resident 95 on 7/22/2022 without any new skin impairments note. 2.) During an observation and interview on 7/19/22 at 11:53 a.m., Resident 64 indicated he was unable to push his call light and yelled for help when he needed something from the staff. The resident was observed to have a push button call light wrapped around the bed next to him. The resident had bilateral hand contractures. The resident indicated he would appreciate if he could have a call light he could utilize. During an interview and observation on 7/21/22 at 11:42 a.m., the Unit Manager indicated he was unaware Resident 64 was unable to use his push button call light. Resident 64 reported he was not able to use the call light and attempted to use the push button call light and was unable to. The resident reported to the Unit Manager he yelled for help when he needed it. The Unit Manager indicated he would provide the resident with a push pad call light that he would be able to use. Review of the record of Resident 64 on 7/26/22 at		that they are capable of using and the maintenance of a comfortable environment. 4. DON/Designee will observe physically dependent residents for the ability to use the call light provided: 5 residents will be observed 5x wk x 4 wks, then 3 residents 3 x wk x 4 wks, then 3 residents 1 x wk x 4 wk. DON/DESIGNEE will observe to ensure comfortable environment is maintained in 5 rooms 5x wk x 4 wks, then 3 rooms 3 x wk x 4 wks, then 3 rooms 1 x wk x 4 wk. 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. Date of completion: 09/02/2022	

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	07/26/2022

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
	2:45 p.m., indicated the resident's diagnoses included, but were not limited to, major depression disorder, cerebral palsy, epilepsy, mild intellectual disability and anxiety. The care plan for Resident 64, dated 1/28/22, indicated the resident was at risk for falls gait / balance problems, history of falls, Impaired cognition, Incontinence, safety awareness and Weakness. The interventions included, but were not limited to, place call bell within reach and remind resident to call for assistance. The Quarterly Minimum Data Set (MDS) assessment for Resident 64, dated 6/2/22, indicated the resident had functional limitation in range of motion and impaired on both sides of his upper extremities. 3.1-3(v)(1)			
F 0561 SS=D Bldg. 00	483.10(f)(1)-(3)(8) Self-Determination §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.			

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	07/26/2022

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
	§483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. Based on interview and record review, the facility failed to ensure a resident was provided showers as preferenced for 1 of 1 residents reviewed for choices. (Resident 35) Findings include: The clinical record for Resident 35 was reviewed on 7/19/22 at 2:00 p.m. The diagnosis for Resident 35 included, but was not limited to, chronic obstructive pulmonary disease. An interview was conducted with Resident 35 on 07/19/22 at 1:46 p.m. She indicated she does not receive her showers. A shower schedule, and the bathing logs for Resident 35 were provided by the Executive Director on 7/21/22 at 2:00 p.m. It indicated Resident 35 was to receive showers on Tuesdays and Fridays on day shift. The bathing logs indicated the following days the resident received bathing and what type of bathing she received: 6/3/22 Friday - shower, 6/7/22 - Tuesday - bed bath,	F 0561	1. Resident 35 was not harmed by the alleged deficient practice. The DON/designee has reviewed the resident shower preferences and updated the care plan to reflect resident choice. 2. All residents have the potential to be affected by same alleged deficient practice. All residents, that are able to express a preference, have had their shower schedules updated to reflect their personal choice. Those residents not able to express their preferences have had their POA contacted to determine bathing preference. All bathing preferences have been updated in the resident medical record. 3. DON/Designee have educated all staff on the “Personal Bathing and Shower” policy, with emphasis on “resident	09/02/2022

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	07/26/2022

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
	6/10/22 - Friday - bed bath, 6/14/22 - Tuesday - bed bath, 6/17/22 - Friday - bed bath, 6/21/22 - Tuesday - bed bath, 6/24/22 - Friday - bed bath, 6/28/22 - Tuesday - bed bath, 7/1/22 - Friday - bed bath, 7/5/22 - Tuesday - bed bath, 7/8/22 = Friday - Bed bath, 7/12/22 - Tuesday - bed bath, 7/15/22 - Friday - bed bath, and 7/19/22 - Tuesday - bed bath The resident's plan of care did not indicate she refuses receiving her showers. An interview was conducted with Certified Nursing Assistant (CNA) 4 on 7/21/22 at 11:45 a.m. She indicated she had provided Resident 35 a bed bath, due to an appointment that day. An interview was conducted with Unit Manager 1 and Resident 35 on 7/21/22 at 2:27 p.m. She indicated she had not been receiving her showers. Unit Manager 1 indicated Resident 35 had been refusing her showers after her hip fracture. He did not know she did not want bed baths any longer. He would check with her to ensure she was receiving her showers. 3.1-3(v)(1)		preferences" for type of bathing preferred. This is to ensure residents are provided the bathing preference of their choice. 4. DON/Designee will observe residents shower completion based on resident preference for 5 residents 5x wk x 4 wks, then 3 residents 3 x wk x 4 wks, then 3 residents 1 x wk x 4 wk. 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. Date of completion: 09/02/2022	
F 0585 SS=D Bldg. 00	483.10(j)(1)-(4) Grievances §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such			

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	07/26/2022

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
	grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term			

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	07/26/2022

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
	Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in			

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	07/26/2022

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
	accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. Based on interview and record review, the facility failed to timely complete a grievance form and to maintain documentation of the resolution of a grievance for 1 of 1 reviewed for grievances (Resident 96). Findings include: The clinical record for Resident 96 was reviewed on 7/19/22 at 2:08 p.m. The Resident's diagnosis included, but were not limited to, weakness and anxiety disorder. An Admission MDS (Minimum Data Set) Assessment, completed 6/27/22, indicated he was cognitively intact. He was able to make himself understood and to understand what was being said to him and that he needed total assistance with transfers, and extensive assistance with bed mobility and toilet use. During an interview on 7/19/22 at 2:08 p.m., Resident 96 indicated that a couple of weeks ago he had informed SSD (Social Service Director) 19 of a concern he had about a staff member being argumentative and telling him that he was using the call light too often. The staff member he had	F 0585	F585 Corrective actions accomplished for those residents found to have been affected by the deficient practice: Resident 96 had a completed grievance that was reviewed by Executive Director and resident 96 has no further concerns at this time. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All resident have the potential to be affected by this deficient practice. The SSD was educated on Grievance Policy. What measures will be put in place and what systemic changes will be made to ensure the deficient practice does not recur: The Executive Director and/or designee has educated the SSD and all of the Grievance committee	09/02/2022

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	07/26/2022

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
	reported to SSD 19 still worked at the facility, however, was no longer caring for him. During an interview on 7/22/22 at 2:13 p.m., SSD 7 indicated there were no grievance forms for Resident 96 prior to 7/19/22. During an interview on 7/26/22 at 10:01 a.m., SSD 19 indicated that a few weeks ago, Resident 96 had informed her of a concern with CNA (Certified Nursing Assistant) 21 telling him that he was pressing the call light too often, and that the care he received was not up to his standards. She had talked to the Executive Director and CNA 21 about the concern, and they had decided that CNA 21 would not care for him anymore. She was not sure if she had filled out a grievance form documenting the concern. During an interview on 7/26/22 at 1:23 p.m., SSD 19 indicated there had not been a grievance form completed for the concern. During an interview on 7/26/22 at 2:27 p.m., CNA 21 indicated that SSD 19 had a couple of weeks ago, SSD 19 had spoken with her about a concern that Resident 96 had voiced about the care she provided. SSD 19 and the Executive Director had instructed her to not provide care for him anymore. If she had to provide care, then they requested she take another staff person into the room with her. She had been doing that since their conversation. The conversation about the care concerns had occurred prior to July 19, 2022. On 7/26/22 at 2:05 p.m., SSD 19 provided the current Resident's Grievances Policies and Procedures which read "...1. Upon receipt of an oral, written, or anonymous grievance submitted by a resident, the Grievance Official/ Director of		per company policy. How the corrective actions will be monitored to ensure the deficient practice will not recur: The Executive Director and/or designee will audit all grievances monthly for 60 days and report findings in the monthly QAPI meeting. The results of the audit will be reviewed until 100% compliance is achieved. Date of completion: 9/2/2022	

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	07/26/2022

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
	Social Services will take immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated. 2. Investigation. The Grievance Committee/ Grievance Official shall complete an investigation of the resident's grievance. This may include a review of facility process, programs, and policies, as well as interviews with staff, residents, and visitors, as indicated, and any other review deemed necessary by the Grievance Committee...". 3.1-7(a)			
F 0645 SS=D Bldg. 00	483.20(k)(1)-(3) PASARR Screening for MD & ID §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental			

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	07/26/2022

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
	disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).			

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	07/26/2022

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
	(ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. Based on interview and record review, the facility failed to ensure a resident in a nursing facility received a PASRR (Pre Admission Screening and Annual Resident Review) Level I screening timely for 1 of 1 residents reviewed for 1 of 3 residents reviewed for PASRR. (Resident 93) Findings include: The clinical record for Resident 93 was reviewed on 7/20/22 at 10:36 a.m. Resident 93's diagnoses included, but not limited to, schizophrenia, psychosis, dementia with behavioral disturbances, anxiety, and major depressive disorder. Resident 93 was admitted to the facility on 6/9/22. The clinical record did not contain a Level I PASSR screen, but did contain a LOC (Level of Care) determination letter which indicated, Resident 93 was approved for a short-term nursing facility stay for 30 days with an end date of 7/9/22. An interview with SSD (Social Service Director) 19 was conducted on 07/21/22 at 2:37 p.m. She indicated, when a new resident is admitted to the facility, AC (Admission Coordinator) 60 was responsible for ensuring the PASSR Level I screen was completed. An interview with AC 60 was conducted on 7/25/22 at 10:48 a.m. She indicated, she was not part of the clinical team and she does not	F 0645	F645 **Corrective actions accomplished for those residents found to have been affected by the deficient practice: Resident 93's PASRR was completed** **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All new admissions have the potential to be affected by this deficient practice. Social services conducted facility wide audit to ensure PASRR screening was completed.** **What measures will be put in place and what systemic changes will be made to ensure the deficient practice does not recur:** **The Executive Director and/or designee has educated the PASRR team on ensuring all Level 1's are completed timely and accurately.** **How the corrective actions will be monitored to ensure the**	09/02/2022

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	07/26/2022

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
	complete the Level I screens but rather just admits the new resident to the contracted provider who provides the Level I screening process. An interview with Receptionist 9, who also works in the business office, was conducted on 7/25/22 at 10:55 a.m. She indicated, a Level I PASRR screening was to be done upon admission. She indicated, the facility has been receiving more short-term LOCs and the facility had not been very proactive with them. She stated, Resident 93's Level I screening has not been done as of yet. An Indiana PASSR policy was received on 7/21/22 at 10:01 a.m. from ED (Executive Director). The policy indicated, "All individuals who apply for admission to a Medicaid certified NF [sic, Nursing Facility} must be screened for a PASSR disability whether they have such a disability and, if so, whether they need specialized services to address their PASSR-related needs and offer all applicants the most appropriate setting for their needs...Level I Screen Requirements i.) A Level I screen is required in the following cases: (1) Before admission to a Medicaid-certified NF...". 3.1-16(d)(1)		**deficient practice will not recur:** **The Social Services Director and/or designee will audit all new admissions weekly for 60 days and report findings in the monthly QAPI meeting. The results of the audit will be reviewed until 100% compliance is achieved.** Date of completion: 9/2/2022	
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident.			

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	07/26/2022

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
	(C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on record review and interview, the facility failed to update and revise a plan of care related to a resident's aggressive behaviors and for a resident's use of a Broda (tilt-in-space positioning chair) chair for use as a fall intervention for 2 of 27 residents whose care plans were reviewed. (Residents 14 and 44) Findings include: 1. The clinical record for Resident 14 was reviewed on 7/20/22 at 1:50 p.m. Resident 14's diagnoses included, but not limited to, dementia with behavior disturbance, psychotic disorder with delusions, violent behavior, and major depressive disorder. An IDT (Interdisciplinary Team) note dated 7/13/2022 at 11:39 a.m. indicated, "Type of incident: AGGRESSIVE BEHAVIOR What was	F 0657	1. Residents 14 and 44 were not harmed by the alleged deficient practice. The DON/designee has updated the care plan for each resident to include the use of the broda chair for resident 44 as a fall intervention as well as resident 14 to include history of aggressive behaviors towards others. 2. All residents have the potential to be affected by same alleged deficient practice. The behavior care plans for each resident with a history of displaying aggressive behaviors towards others has been reviewed and updated to include resident specific interventions. The fall care	09/02/2022

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	07/26/2022

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
	happening at the time:: Resident was ambulating on the unit. Root cause of incident:: Dementia Intervention(s) put into place:: Psych[sic, psychiatric] follow up. Care plan updated?[sic]: in place Other essential information:: n/a[sic, not applicable] List all IDT members involved in follow up:: DON, ADON, SS DIRECTOR, NP[sic, Director of Nursing, Assistant Director of Nursing, Social Services Director, Nurse Practitioner]" A incident report was received on 7/22/22 at 9:15 a.m. from ED (Executive Director). It indicated, the incident occurred on 7/11/22 at 6:01 p.m. The incident involved Resident 14 and Resident 85. The brief description of the incident indicated, Resident 14 was attempting to enter Resident 85's room. Resident 85 became agitated after Resident 14 had made inappropriate comments to her. Then Resident 14 attempted to make contact with her closed fist to Resident 85 but did not make contact. Resident 85 then pushed Resident 14 out of her doorway. Staff intervened and separated the residents. The follow up reported on 7/19/22 indicated, both residents were seen by psychiatric services and had an evaluation. The follow up stated, "New intervention in place for both residents with successful results". Resident 14's care plan was received on 7/25/22 at 12:19 p.m. from RDCO (Regional Director of Clinical Operations). Resident 14's care plan initiated on 4/19/21 and revised on 7/14/22, contained a focus area for behavior problems which included, but not limited to, dementia with behaviors, history of violent behaviors, psychotic disorders with delusions such as: throwing walker, spits on staff, and intrusive wandering.		plans have been reviewed and updated for residents that have sustained a fall in the last 30 days to include resident specific interventions. 3. DON/Designee have educated all members of the clinical management team, including Unit Manager, MDS, Social Service and E.H.R. on the Plan of Care Overview policy, with emphasis on “updating the plan of care timely to reflect for accuracy for needed interventions or care” to provide an individualized plan of care for every resident. 4. DON/Designee will audit the fall and behavior care plans of every resident with an occurrence of a fall or aggressive behavior for an intervention that focuses on resident centered care. This audit will occur 5x wk x 4 wks, then 3 x wk x 4 wks, then 1 x wk x 4 wk. 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. Date of completion: 09/02/2022	

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	07/26/2022

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
	Resident 14's care plan did not contain a focus for resident to resident aggressive behaviors or interventions. A General Behavior Management policy was received on 7/22/22 at 9:15 a.m. from ED (Executive Director). The policy indicated, "Residents will be provided with a resident centered behavior management plan to safely manage the resident and others...Procedure: 1. Assess for problematic/dangerous behaviors...f. Problematic/dangerous behaviors may include but are not limited to:..fighting...arguing...posing a danger to self or others...7. Complete a Care Plan a. Update with changes and/or new behaviors...d. Include resident specific interventions..." 2. The clinical record for Resident 44 was reviewed on 7/19/22 at 12:04 p.m. Resident 44's diagnoses included, but not limited to, dementia with behavioral disturbance, anxiety disorder, and closed fracture of left femur neck with routine healing. A physical therapy (PT) evaluation was completed on 3/27/22. It indicated, Resident 44 was referred to PT due to decline in functional mobility. The evaluation did contain an evaluation for use of a Broda chair as a fall intervention. A physician's order placed on 4/20/22 indicated, to admit to (sic, Hospice Company's Name) hospice. A hospice visit note dated 4/20/22 indicated, Resident 44 had prior history of fall within 3 months, had a cognitive impairment and was at risk for falling. It further indicated, equipment/supplies ordered by hospice included,			

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	07/26/2022

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
	but not limited to, bedrails, geri-chair, and Broda chair, which was awaiting authorization. It did not contain an evaluation for use of a Broda chair as a fall intervention. An interview with SSD (Social Services Director) 9 was conducted on 7/25/22 at 2:29 p.m. ED (Executive Director) was also present during the interview. SSD indicated, Resident 44 was declining in his health. She further indicated, she received an email from Resident 44's hospice provided which indicated Resident 44 was ordered the Broda chair for comfort and multiple falls. An interview with CNA(Certified Nursing Assistant) 61 was conducted on 7/26/22 at 11:29 a.m. She indicated she worked on the unit where Resident 44 resides quite often and was very familiar with Resident 44. She indicated, when Resident 44's Broda chair was in the reclined position she observed him sitting up in the chair as well as trying to stand up. An interview with Resident 44's hospice LPN (licensed practical nurse) was conducted on 7/26/22 at 12:00 p.m. She indicated, for Resident 44, any attempt to get out of any chair would be considered dangerous for him. She stated, she has seen Resident 44 on many occasions since he had been admitted to their service and had witnessed his Broda chair in the upright and reclined positions. Resident 44's hospice plan of care dated 4/20/22 did not indicate Resident 44's Broda chair was an intervention for frequent falls. Resident 44's facility's care plan for risk for falls related to gait/balance problems, history of falls, impaired cognition, incontinence, safety			

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	07/26/2022

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
	awareness, and weakness was initiated on 3/4/22 and last revised on 3/4/22, did not contain the Broda chair as an intervention nor had the care plan indicated the Broda chair as a potential for an increased risk for falls related to Resident 44 being able to sit up in the reclined Broda chair. A Fall Prevention and Management policy was received on 7/22/22 at 10:27 a.m. from ED. It indicated, "Care Plan...Post Fall Intervention: Attempt to put an intervention in place that could prevent further falls...Attempt to identify why the resident fell and put an immediate intervention in place." A Plan of Care policy was received on 7/22/22 at 9:16 a.m. from ED. The policy indicated, "The facility will:..review care plans quarterly and/or with significant changes in care. 3.1-35(d)(2)(B)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview and record review the facility failed to provide nail care and assist a resident with showers for 2 of 3 residents reviewed for activities of daily living (Resident 2 and Resident G). Findings include: 1.) During an observation and interview on 7/19/22 at 12:02 p.m., Resident 2's fingernails were long and with black substance inside the nails and	F 0677	1. Residents 2 and G were not harmed by the alleged deficient practice. Resident 2 has been provided nail care and the resident's nails remain clean and trimmed. Resident G received a shower and a routine shower schedule has been maintained based on the resident choice.	09/02/2022

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	07/26/2022

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
	around the cuticles on both hands. Resident 2 indicated the CNA's were suppose to provide him with nail care. The resident indicated it had not been provided for awhile and his fingernails really needed to cut and cleaned "bad". During and observation and interview with Resident 2 on 7/20/22 at 2:20 p.m., indicated his nails still had not been cut. The resident had a left hand contracture and he was able to pull his fingers away from his palm with his right hand, there were no open area's. The resident's fingernails were long with black substance underneath the nails and around the cuticles. During an observation and interview on 7/21/22 at 11:37 a.m., the Unit Manager verified Resident 2's fingernails on both hands were long and dirty. The Unit Manager indicated the CNA's were responsible to provide the resident with nail care and he would ensure this would be completed for the resident today. Review of the record of Resident 2 on 7/25/22 at 12:35 p.m., indicated the resident's diagnoses included, but were not limited to, ankylosing spondlitis of the spine, diabetes mellitus, contracture of the left hand. The plan of care for Resident 2, dated 10/7/2020, indicated the resident had self care deficit related to weakness, debility, arthritis and pain. The interventions included, but were not limited to, (5/28/21) nail care with each shower. The Quarterly Minimum Data (MDS) assessment for Resident 2, dated 7/12/22, indicated the resident was cognitively intact for daily decision making. The resident was consistent and reasonable. The resident required extensive		2. All residents have the potential to be affected by same alleged deficient practice. The shower schedule for each resident has been updated according to resident preferences. Nail care has been provided and maintained in accordance with resident specified shower schedule. The ADL care plans have been reviewed and updated, for each resident, to reflect resident choice. 3. DON/Designee has educated all members of the nursing staff on the Nail and Hair Hygiene Policy with emphasis on “routine nail and hair hygiene as part of the bath or shower” with a focus on resident preference. 4. DON/Designee will observe that a shower/bath has been provided to the resident with nail care included. The observation will occur 5x wk x 4 wks, then 3 x wk x 4 wks, then 1 x wk x 4 wk. 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. Date of completion: 9/2/22	

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	07/26/2022

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
	assistance of two people for personal hygiene. The resident had limited range of motion on both sides of his upper extremities. 2.) During an observation and interview with Resident G on 7/19/22 at 12:16 p.m., indicated she was admitted to the facility in May 2022 and had only one shower since she had been admitted. The resident indicated a therapist assisted her with washing up in the sink the other day. The resident indicated when she was at home she took a shower every other day. The resident's hair was observed to be dirty and greasy. The resident stated " I wish I could have a shower". During observation on 7/20/22 at 2:15 p.m., Resident 52 was playing bingo with several other resident's the residents hair was greasy and dirty. During an observation and interview on 7/21/22 at 11:48 a.m., indicated she had not received a shower still and had not had one since May 2022. The resident indicated look at my hair "it is horrible" and she hated being seen by other people with dirty greasy hair. The resident indicated she hated laying in bed nasty and dirty and stated "I have terrible body odor". During an observation and interview on 7/21/22 at 11:54 a.m., the Unit Manager felt Resident G's hair, the resident reported to the Unit Manager she felt dirty and had not had a shower since May 2022. The Unit Manager indicated he would ensure the resident received a shower. The UM felt her hair and indicated well if it is terrible to her then I will get it remedied, I thought she was getting showers I have shower sheets for her. No staff have talked to me about my weight loss I asked for chocolate ensures and my favorite nurse brought me a couple. Nor do I get any type of			

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	07/26/2022

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
	supplements provided, puddings, ice cream, nothing. During an interview with CNA 5 on 7/21/22 at 11:45 a.m., indicated the staff did fill out shower sheets, but resident showers were not being completed. During an observation on 7/21/22 at 11:59 a.m., Restorative Aide 18 came into Resident G's room and indicated she was going to assist the resident with a shower. Resident G became tearful and thanked Restorative Aide 18 for her helping her get a shower as she had not had one since May 2022 when she first came to the facility. Review of the record of the resident G on 7/26/22 at 3:42 p.m., indicated the resident's diagnoses included, but were not limited to, anxiety, major depression disorder, osteoarthritis, and heart disease. The Admission MDS assessment for Resident G, dated 5/26/22, indicated the resident was cognitively intact. Daily decision making was consistent and reasonable. The resident required one person to physically assist with bathing. The plan of care (no date) for Resident G, indicated the resident had self care deficit and required extensive assistance with activities of daily living. The interventions included, but were not limited to, one staff to assist with bathing two times a week. The nail and hair hygiene policy provided by MDS Coordinator 23, on 7/25/22 at 11:10 a.m., indicated the facility would promote resident centered care by attending to the physical, emotional, social and spiritual needs and honor			

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	07/26/2022

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
	resident lifestyle preferences while in the care of the facility. The facility would provide routine care for the resident for hygienic purposes and for the psychosocial well-being of the resident included, but were not limited to, routine care of nail hygiene of trimming, cleaning and filing fingernails. The facility would provide bathing to accommodate the resident resident's preference. 3.1-38(a)(3)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on interview, observation, and record review, the facility failed to schedule a specialist appointment per physician's order for Resident H and failed to monitor Resident 46's blood sugars while the resident was utilizing a diabetic medication for 2 of 6 residents reviewed for compliance with physician orders and medication management. Findings include: 1. The clinical record for Resident H was reviewed on 7/22/2022 at 2:44 p.m. The medical diagnoses included, but were not limited to, down syndrome and chronic kidney disease.	F 0684	1. Residents H and 46 were not harmed by the alleged deficient practice. The specialist appointment for resident H has been scheduled, as ordered per the physician. Resident 46 is receiving blood sugar monitoring routinely, as ordered per the physician. The care plans for each resident has been reviewed and updated to reflect current physician orders. 2. All residents have the potential to be affected by same alleged deficient practice. The physician orders for each resident	09/02/2022

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	07/26/2022

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
	A Quarterly Minimum Data Set Assessment, dated 5/16/2022, indicate that Resident H had short- and long-term memory problems, needed assistance with all activities of daily living, including extensive assistance of one staff for eating. A physician's order, dated 5/12/2022, indicated to refer Resident H to nephrology for progressive chronic kidney disease. A physician's progress note, dated 5/16/2022, indicated need for Resident H to be referred to nephrology. A physician's progress note, dated 7/20/2022, indicated it was discussed with staff the importance to schedule referral to nephrology. A physician's order, dated 7/21/2022, indicated to refer Resident H to nephrology for progressive chronic kidney disease. An interview with UM 1 (Unit Manager) on 7/21/2022 at 1:43 p.m., indicate he did not believe Resident H was followed by nephrology, but only urology. An interview with UM 1 (Unit Manager) on 7/22/2022 at 11:43 a.m., indicate he was not sure why the nephrology appointment had not been scheduled for Resident H. When reviewing the orders, he indicated he must have missed it, but he had obtained a new order on 7/21/2022 and started the process of setting up the nephrology appointment. A policy entitled, "Physician Orders", was provided by the Director of nursing on 7/22/2022 at 11:00 a.m. The policy indicated, " ...It is the		have been reviewed and all referrals for specialist appointments have been scheduled as ordered. The physician orders for each resident with a diagnosis of Diabetes Mellitus have been reviewed for blood sugar monitoring orders as appropriate. All orders for blood sugar monitoring have been implemented as ordered. The diagnosis care plans have been reviewed and updated, for each resident, to reflect the use of a specialist as ordered. The Diabetes care plans have been reviewed and updated to reflect blood sugar monitoring as ordered. 3. DON/Designee has educated all licensed nurses on the Physician Order Policy with emphasis on “Execution of order”. 4. DON/Designee will audit physician orders in daily clinical meeting, Monday thru Friday, for any new referrals to a specialist and ensure appointments are scheduled as ordered this will be an on-going practice. DON/Designee will audit physician orders in daily clinical meeting, Monday thru Friday, on all new residents with a diagnosis of Diabetes Mellitus for blood sugar monitoring, this will be an on-going practice. DON/Designee will report on audits monthly to the	

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	07/26/2022

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
	policy of the facility to provide resident centered care that meets the psychosocial, physical and emotion al meets and concerns of the residents ...The nurse that takes the physician order will be responsible for executing the order ..."2. The clinical record for Resident 46 was reviewed on 7/21/22 at 2:00 p.m. The diagnosis for Resident 46 included, but was not limited to, type 2 diabetes mellitus. A physician order dated 5/18/22 indicated Resident 46's blood sugars were to be obtained in the mornings and at bedtime. The medical provider was to be notified if blood sugars were less than 60 or greater than 350. The order was discontinued on 7/14/22. A physician order dated 5/18/22 indicated Resident 46 was to receive 10 units of lantus insulin in the mornings. The order was discontinued on 7/14/22. A physician order dated 5/18/22 indicated Resident 46 was to receive 5 units of lantus insulin at bedtime. The order was discontinued on 7/14/22. A physician order dated 4/15/22 indicated Resident 46 was to receive 500 milligrams of metformin every morning and at bedtime. This order was discontinued on 7/14/22. A hospital summary report indicated Resident 46 was sent to the hospital on 7/13/22 and was admitted. The resident then was discharged on 7/14/22. A physician order dated 7/15/22 indicated Resident 46 was to receive 10 units of lantus insulin once a day.		interdisciplinary team for 6 months during QAPI Meeting. The IDT will determine if the audits are necessary to continue after 6 months with 100% compliance achieved. Date of completion: 9/2/2022	

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	07/26/2022

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
	A physician order dated 7/15/22 indicated Resident 46 was to receive 5 units of lantus insulin at bedtime. A physician order dated 7/15/22 indicated Resident 46 was to receive 500 milligrams of metformin two times a day. The resident's clinical record did not include physician orders to obtain blood sugar readings nor clarification if the medical provider wanted to discontinue the orders after the resident returned from hospitalization. An interview was conducted with the Director of Nursing on 7/21/22 at 2:10 p.m. The physician order to obtain blood sugar readings to monitor Resident 46's blood sugars was missed. 3.1-37(a)			
F 0689 SS=G Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview, observations, and record review, the facility failed to provide adequate supervision for Resident 44 while in a Broda (tilt-in-space positioning chair) chair resulting in a fall with a major injury of multiple broken ribs, failed to provide a fall intervention of a colored	F 0689	1. Residents 44, 48, 118, 119 and 520 were not harmed by the alleged deficient practice. Resident 44 is kept in common areas while using the Broda chair to provide supervision and safety	09/02/2022

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	07/26/2022

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
	call light for Resident 48 , failed to provide supervision for Resident 118 and 119 during smoking activities, and failed to update an elopement risk assessment for Resident 520 for 5 out of 6 residents reviewed for accidents and hazards. Findings include: 1. The clinical record for Resident 44 was reviewed on 7/19/22 at 12:04 p.m. Resident 44's diagnoses included, but not limited to, dementia with behavioral disturbance, anxiety disorder, and closed fracture of left femur neck with routine healing. An incident report regarding Resident 44 was received on 7/21/22 at 3:21 p.m. from ED (Executive Director). It indicated, on 7/3/22 at 1:01 p.m. "During morning rounds, resident was found in dining room lying of left side." The immediate action taken indicated, a pain assessment was completed, the Medical Doctor, Executive Director, Director of Nursing and family was notified, and a new order to send Resident 44 out to the local emergency department for further evaluation and treatment. The type of injury was "left eye laceration, fx [sic, fracture] along the posterior aspect of the right 7th-10th ribs and additional fx [sic] of the right 8th and 9th ribs. The preventive measures taken were to complete pain assessment, notify necessary persons, send the resident out to emergency room and upon return to: complete a skin assessment, have social services follow up for 3 days to ensure no psychosocial distress, physical therapy to evaluate, and the care plan to be reviewed and updated as appropriate. The follow up dated, 7/8/22, indicated, Resident 44 returned to the facility with no new orders from the hospital, to		monitoring. Resident 48 has had the colored call light implemented to aide in fall prevention. Residents 118 and 119 have had their smoking assessments updated to reflect current resident need for supervision during smoking activity. Resident 520 has an updated elopement risk assessment completed to reflect current condition. All care plans have been reviewed and updated to reflect a resident centered plan of care. 2. All residents have the potential to be affected by same alleged deficient practice. The fall care plans for each resident have been reviewed to ensure all current interventions implemented. All call lights have been audited to ensure each resident has the appropriate call light in place and the resident centered plan of care reflects call light type implemented. Each resident, that is defined as a smoker, has had an updated smoking assessment completed, with their care plan updated to reflect supervision status. Any resident that has been identified as an elopement risk has had their elopement risk assessment updated and care plan reviewed to reflect current resident centered plan of care. 3. DON/Designee has	

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	07/26/2022

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
	continue on hospice services for pain management and comfort care, social services to follow for 72 hours for possible psychosocial distress and noted the care plan had been updated. A nursing note dated 7/2/2022 at 6:10 a.m. indicated, "This writer[sic] notified by CNA[sic, Certified Nursing Assistant) that resident was on the floor in dining room and bleeding. This writer [sic] to dining room and noted resident to be on the floor and next to his wheelchair. Laying slightly on his left side, there was a large amount of blood noted underneath resident's head. This writer assessed and noted it to be coming from a laceration next to residents left eye. Pressure put on wound immediately. No other immediate concerns noted at this time. Resident conts [sic, continues] to talk and interact with staff per his usual. 911 called. 911 transported res [sic, resident] to [sic, name of local hospital] ER[sic, emergency room] for eval[sic, evaluation] et[sic, and] tx[sic, treatment], they were made aware he was a hospice pt[sic, hospice]". The emergency room notes were received on 7/25/22 at 2:55 p.m. from MDS (minimum data set coordinator) 62 and dated 7/2/22 at 7:01 a.m.. It indicated, Resident 44 presented to the emergency room after an unwitnessed fall at the facility. The report given to nursing staff was that the patient was found down in the dining room and felt that the patient tried to get up from his chair then fell. The chest/abdomen/pelvis CT (computed tomography) scan revealed fractures along the posterior aspect of the right 7th through 10th ribs and additional lateral fractures of the right 8th and 9th ribs. An interview with CNA 61 was conducted on		educated all members of the IDT team and all licensed nurses on the Fall Prevention and Management Policy with emphasis on “care plan and post fall intervention”. DON/Designee has educated all members of the IDT team and all licensed nurses on the Smoking Policy with an emphasis on “assessment, observation and designation of independent or supervised smoker”. DON/Designee has educated the IDT team and all licensed nurses regarding the Elopement Prevention Policy with an emphasis on “initiating individualized interventions to address elopement risk factors”. 4. DON/Designee will observe fall intervention implementation for each fall occurrence 5 x wk x 4 wks, then 3 x wk x 4 wks, then 1 x wk x 4 wk. DON/Designee will audit all smoking assessments, for resident with a smoking preference identified, for accurate representation of each smoker 3x wk x 4 wks, then 2x wk x 4 wks then 1 x wk x 4 wks. DON/Designee will identify any new and current residents at risk for elopement, in daily clinical meeting x 12 weeks, and complete an updated elopement risk assessment with identification. DON/Designee will report on audits monthly to the interdisciplinary team for 3 months	

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	07/26/2022

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
	7/26/22 at 11:29 a.m. She indicated, she had just come in for her day shift on 7/2/22. The night shift staff were right by the units locked entry door. She stated, one staff person was about to take the trash out and another staff member was checking on the residents at that end of the hallway. She indicated, she walked down the hall and that's when she saw Resident 44 on the floor in the dining room next to his Broda chair and he was bleeding from his head. She asked him if he was "ok" and he replied "oh, my head". She stated the Broda chair was in the tilted back position when he was found on the floor. She indicated, she hadn't heard any loud noises as she walked down the hall. She stated, she worked on the unit where Resident 44 resides quite often and was very familiar with Resident 44. She indicated, when Resident 44's Broda chair was in the reclined position she observed him sitting up in the chair as well as trying to stand up. Resident 44 also had falls with and/or without injury on the following dates: -4/4/22 at 1:37 p.m. while ambulating -5/11/22 at 4:53 p.m. from bed -5/18/22 at 2:15 p.m. from bed -6/3/22 at 9:50 p.m. from bed An interview with SSD (Social Services Director) 9 was conducted on 7/25/22 at 2:29 p.m. ED (Executive Director) was also present during the interview. SSD indicated, Resident 44 was declining in his health. She further indicated, she received an email from Resident 44's hospice provided which indicated Resident 44 was ordered the Broda chair for comfort and multiple falls. An interview with Resident 44's hospice LPN (licensed practical nurse) was conducted on 7/26/22 at 12:00 p.m. She indicated, she had been		during QAPI Meeting. The IDT will determine if the audits are necessary to continue after 6 months with 100% compliance achieved. Date of completion: 9/2/2022	

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	07/26/2022

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
	seeing for Resident 44 about once a week every week and some weeks twice since he has been on hospice service. She indicated, he was usually in his Broda chair either in an upright or reclined position. She indicated, Resident 44 was attempting to get up out of his Broda chair a lot during this visit and any attempt to get out of any chair would be considered dangerous for him. Neither Resident 44's hospice care plan, nor the facility's care plan addressed the need for increased monitoring and/or supervision for a resident with multiple falls. The facility failed to provide adequate supervision to prevent accidents. 2. The clinical record for Resident 48 was reviewed on 7/26/2022 at 11 a.m. The medical diagnoses included, but were not limited to, unspecified dementia and muscle weakness. A Quarterly Minimum Data Set Assessment, dated 5/25/2022, indicated that Resident 48 was cognitively impaired and needed assistance of staff for transferring and walking tasks. Resident had a history of falling during this review period. A fall care plan, last revised on 7/22/2022, indicated for Resident 48 to have a color code call light for a reminder to use a call light. An observation on 7/26/2022 at 10:36 a.m., indicated Resident 48 laying in bed with her call light clipped to the bottom sheet and covered with her top sheet, white blanket, and then a fleece blanket. The call light was a standard white button call light. CNA 30 assisted resident to stand with walker with stand by assistance. An interview with CNA 30 on 7/26/2022 at 10:39 a.m. indicated she wasn't familiar with Resident 48			

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	07/26/2022

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
	and she wasn't aware of Resident 48 needing a special call light. She indicated the resident "takes care of herself during the day". A policy entitled, "Fall Prevention and Management", was provided by the Executive Director on 7/22/2022 at 10:27 a.m. The policy indicated, that " ...a fall investigation should begin ...", the intradisciplinary team should review all information for the falls the next Daily Clinical meetings, and " ...A progress not of the discussion should be placed in the resident's chart ..."3. The clinical record for Resident 118 was reviewed on 7/19/22 at 3:00 p.m. The diagnosis for Resident 118 included, but was not limited to, dementia. The resident was admitted on 6/28/22. An Admission MDS (Minimum Data Set) assessment, dated 7/8/22, indicated Resident 118 was cognitively impaired. A smoking assessment dated 6/29/22 indicated Resident 118 needed supervision for smoking safety. 4. The clinical record for Resident 119 was reviewed on 7/19/22 at 3:15 p.m. The diagnosis for Resident 119 included, but was not limited to, chronic obstructive pulmonary disease. The resident was admitted on 6/28/22. An Admissions MDS (Minimum Data Set) assessment, dated 7/8/22, indicated Resident 119 was moderately cognitive impaired. A smoking assessment dated 6/29/22 indicated Resident 118 needed supervision for smoking safety. An observation was made of Resident 118 and			

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	07/26/2022

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
	Resident 119's room on 7/19/22 at 3:00 p.m. Resident 118's bed was observed with a red lighter lying on the bed. Resident 119 indicated at that time, that her and her roommate (Resident 118) hold their own tobacco products and go outside and smoke. She indicated she was going back outside to smoke. Resident 118 was currently outside smoking. An observation was made of Resident 118 and Resident 119 in the courtyard on 7/19/22 at 3:11 p.m. The residents were observed outside sitting in chairs inside a two sided wall up against a door smoking. There were no staff present in the courtyard supervising the smoking activity. An interview was conducted with the Nurse Consultant on 7/19/22 at 3:19 p.m. She indicated Residents' 118 and 119 needed to be reassessed for smoking. The smoking assessments were conducted on admission. A smoking procedure and policy was provided by the Executive Director on 7/21/22 at 10:01 a.m. It indicated "...Definition:...Supervised Smoker: A resident is unable to demonstrate safe smoking habits including smoking materials management, lighting, controlling cigarette ash and extinguishing smoking materials and requires staff supervision when smoking. Policy: It is the policy of this facility to promote resident centered care by providing a safe smoking area for residents/patients that request to smoke and are capable of safe smoking behaviors either independently or with supervision unless facility is a designated non-smoking facility...8. Facility staff will: a. Secure smoking materials in a locked area when not in use by the resident/patient for supervised smokers..." 5. The clinical record for Resident 520 was			

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	07/26/2022

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
	reviewed on 7/20/22 at 11:03 a.m. The Resident's diagnosis included, but was not limited to, Alzheimer's disease. She was admitted to the facility on 7/13/22. An Admission Initial Evaluation, dated 7/13/22, indicated she was able to ambulate independently, without the use of a wheelchair or an assistive device. She had not displayed pacing with no course of action or direction, attempts to exit door, or wandering without a sense of purpose. A Behavior Note, dated 7/14/2022 at 5:45 p.m., read ". Resident has been pacing the floor all day. Resident has tried getting outside multiple times and setting off alarms. Resident has been oriented to safety issues and to let staff know when she wants to go outside. Resident forgets this almost immediately." A SBAR (Situation, Background, Assessment and Recommendation) Communication Form, dated 7/14/22, indicated she was experiencing behavioral changes, described as pacing and intrusively entering other resident's rooms. On 7/20/22 at 1:00 p.m., Resident 520 was observed standing in the hallway by the community outdoor sitting area exit door. A staff member was walking through the courtyard and entered the door. She spoke briefly with Resident 520 and let her out into the sitting area. There were no staff members present in the sitting area. During an interview on 7/21/22 at 9:06 a.m., LPN (Licensed Practical Nurse) 20 indicated that Resident 520 was fairly new to the facility. She was a "wanderer". She would wander around the facility and would get "lost" on the other unit. The staff would bring her back to her room. She			

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	07/26/2022

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
	was pleasantly confused. She did go outside to sit at times. During an interview on 7/21/22 at 9:00 a.m., Resident 520 indicated she had been at the facility for about 4 weeks. She was unsure of why she was there. She would go home when her family came to get her. During an interview on 7/22/22 at 11:37 a.m., SSD (Social Service Director) 7 indicated Resident 520 should have been reassessed for elopement risk after her change in behavior and that social services had not been made aware of her continued or intrusive wandering. She did not have a care plan for wandering or elopement risk. On 7/21/22 at 3:22 p.m., the Executive Director provided the Elopement Prevention Policy, last reviewed 4/20/17, which read "... 1. Identify resident/[sic] patient who are at risk for elopement. a. All new admissions that are at risk for elopement will have interventions put into place immediately until further assessment is complete...b. Any resident/[sic] patient admitted who is cognitively impaired and can self-ambulate is considered an elopement risk until determined otherwise. c. Any resident/[sic] patient that has a change in condition that places them at risk for elopement..." 3.1-45(a)(2)			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a			

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	07/26/2022

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
	resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on observation, interview and record review the facility failed to notify the physician of a significant weight loss, failed to follow up on a resident with significant weight loss, failed to obtain weekly weights, failed to document supplement consumption and failed to monitor a resident's hydration status for 3 of 3 residents reviewed for nutrition/hydration status (Resident G, Resident C and Resident H). Findings include: 1.) During an in interview with Resident G on 7/19/22 at 12:22 p.m., the resident indicated she had lost weight since her admission to the facility in May 2022. The resident's normally weight was 125 pounds but she down to 100 since came to the facility. The resident indicated she did not receive snacks at the facility like she did at home. The resident indicated she was on a puree diet and at home she would eat cottage cheese and soup between meals.	F 0692	1. Residents G, C and H were not harmed by the alleged deficient practice. Resident's G and C are being monitored with weekly weights, physician and responsible party notifications have been complete for each resident. Supplement monitoring is in place for resident's G and C. Resident H has fluids maintained at bedside. The care plan for each resident has been reviewed and updated. 2. All residents have the potential to be affected by same alleged deficient practice. Each resident has been weighed and any weight losses have been calculated per facility policy. The physician and responsible parties have been notified with any significant weight losses noted.	09/02/2022

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	07/26/2022

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
	During an observation and interview with Resident G on 7/21/22 at 11:48 a.m., indicated she had no clothes to wear because she had lost so much weight since coming to the facility. The resident indicated the facility had not talked with her about her weight loss or offered any type of supplement, pudding or ice cream. The resident was thin in appearance. During an interview with the Registered Dietician and the Director Of Nursing on 7/25/22 at 11:27 a.m., indicated the facility protocol when a resident had a significant weight loss was to notify the physician, monitor weekly weights, implement interventions such as nutritional supplements and Registered Dietician and the Interdisciplinary Team (IDT) would monitor the resident's weight. Review of the record of the resident G on 7/26/22 at 3:42 p.m., indicated the resident's diagnoses included, but were not limited to, anxiety, major depression disorder, osteoarthritis, and heart disease. The weights for Resident G were as follows: 5/19/22 - 115 pounds, 5/26/22 - 114.4 pounds, 6/9/22 - 101.6 and 7/8/22 - 104.9. This indicated a 11.65% weight loss in 22 days. The IDT at risk meeting for Resident G, dated 6/16/2022 1:34 p.m., indicated the resident triggering for weight loss. Weights: (6/9) 101.6 lbs, (5/26) 114.4 lbs, (5/19) 115 lbs; indicating significant weight loss of 11% x 14 days. Possible that weights are inaccurate considering large weight loss in short period of time. Recommend re-weight to confirm weight change. Body Mass Index (BMI): 18, underweight. Skin: no pressure areas noted. Estimated nutrition needs using most		Supplements and diet changes have been implemented as ordered per the physician and consumption is being monitored. Water is being passed to each resident unless a physician order is in place which do not contradict this practice. Water is passed every shift and is kept in an accessible location for each resident. All appropriate care plans have been implemented, reviewed and updated per facility policy to reflect a resident centered plan of care. 3. DON/Designee has educated all members of the nursing staff, the Interdisciplinary Team and the Registered Dietician on the Hydration Needs Assessment Policy with emphasis on “fresh water being kept at bedside” and “fresh water being provided each shift”. DON/Designee has educated all members of the Interdisciplinary Team and the Registered Dietician have been educated on the Resident Height and Weight Policy with an emphasis on “unstable residents will be weighed weekly”, “weight loss concerns will be discussed in weekly clinical meeting”. 4. DON/Designee will audit all resident weights that are clinically indicated for weekly weights 1 x wk x 12 wks in clinical meeting	

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	07/26/2022

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
	recent weight of 46 kg: Energy: 1400-1600 kcal/day (30-35 kcal/kg bw), Protein: 46-55 g/day (1.0-1.2 g/kg bw), Fluid: 1 ml/kcal. Diet: Regular diet, dysphagia pureed texture, thin liquids. Po intake: typically varies between 26-100% of meals. Resident is typically independent with meals. Resident is on a 1200 ml fluid restriction, will add Proheal 30 ml BID (twice a day) to help meet estimated needs. Will monitor weekly weights. During an interview with the Registered Dietician and the Unit Manager on 7/26/22 at 1:40 p.m., indicated there was no documentation the physician was notified of Resident G's significant weight loss, there were no weekly weights completed and IDT did not follow and monitor the resident's significant weight loss and they were unsure why IDT did not follow and monitor the significant weight loss. The Registered dietician indicated the resident was not at a healthy a healthy BMI and she would like to see the resident gain some weight. 2. The clinical record for Resident C. was reviewed on 7/21/22 at 10:00 a.m. The diagnosis for Resident C included, but was not limited to, Alzheimer's disease. A care plan dated 7/20/22 indicated, "[Resident C] is at risk for nutritional decline related to: diagnosis of Alzheimer's, impaired dentition, on altered texture diet, requires total feeding assistance and sig [significant] weight loss....Interventions...Monitor & evaluate weight/weight changes..." The weights for Resident C were recorded on the following days: 7/22/2022 - 113 pounds, 7/8/2022 - 118.8 pounds,		for stability of weights, physician/responsible party notifications and dietary changes. DON/Designee will observe fresh water placement at bedside of 15 residents 5 x wk x 4 wks, then 10 residents 3 x wk x 4 wks, then 5 residents 1 x wk x 4 wks. DON/Designee will audit the consumption of nutritional supplements on residents ordered to receive nutritional supplements 5 x wk x 4 wks, then 3 x wk x 4 wks, then 1 x wk x 4 wks. 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. Date of completion: 9/2/2022	

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	07/26/2022

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
	6/9/2022 - 127.2 pounds, 5/11/2022 - 129.4 pounds, 4/3/2022 - 129.2 pounds, and 3/1/2022 - 131.4 pounds An "IDT (Interdisciplinary Team) At Risk Meeting" indicated, "Resident [C] is being followed for weight loss. Weights: (7/8) 118.8 lbs, (6/9) 127.2 lbs, (4/3) 129.2 lbs, (1/1) 135.6 lbs; indicating significant weight loss of 6.6% x 30 days. BMI: 21.7,...Resident is totally dependent for meals, nursing staff reporting she is typically eating 76-100% of meals. Re-weight requested to confirm weight change. Ensure added 2 x [times]/day until re-weight is completed. Family notified. Will monitor weekly weights." A physician order dated 7/12/22 indicated staff was to provide ensure supplements to Resident C twice a day and record percentage consumed. A physician order dated 7/14/22 indicated staff was to obtain weekly weights once every 7 days for 4 weeks for Resident C. The July 2022 Medication/Treatment Administration Record for Resident C indicated ensure supplements were administered as ordered, but no consumptions were recorded. The resident was not re-weighed on 7/14/22 nor 7 days later; on 7/21/22. An interview was conducted with the Unit Manager 1 on 7/22/22 at 11:59 a.m. He indicated the recording of the consumptions of the ensure supplements and weights were missed for Resident C. 3. The clinical record for Resident H was reviewed on 7/22/2022 at 2:44 p.m. The medical diagnoses included, but were not limited to, down syndrome			

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	07/26/2022

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
	and chronic kidney disease. A Quarterly Minimum Data Set Assessment, dated 5/16/2022, indicate that Resident H had short- and long-term memory problems, needed assistance with all activities of daily living, including extensive assistance of one staff for eating. A care plan, dated 5/13/2022, indicated for Resident H to have additional fluids during med passes and during social gatherings as well as to notify the physician of signs and symptoms of dehydration. A restorative nursing care plan, dated 7/1/2021, indicated Resident H received a nursing restorative program of cueing, set up, and hand-over-hand assistance for eating/swallowing 7 times a week. An observation on 7/20/2022 at 10:45 a.m. indicated Resident H was in her room at this time with no fluids at the bedside. An observation on 7/22/2022 at 2:19 p.m., indicated Resident H was in her wheelchair in room and did not have fluids at the beside. A hydration assessment, dated 7/7/2022 and signed on 7/20/2022, indicated Resident H was at risk for dehydration. A dietary assessment, dated 5/2/2022, indicated that Resident H estimated fluid needs of 1600-1900 milliliters of fluid a day. Fluid intake documentation for Resident H indicated she received 480-1560 milliliters of fluids a day with the average from 7/7/2022 to 7/22/2022 being 496 milliliters of fluid a day.			

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	07/26/2022

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
	The BUN test measures the amount of urea nitrogen in blood. Urea nitrogen is a waste product that the kidneys remove from blood. A normal range for this level is 6 to 20 mg/dL (milligrams per deciliter). A creatinine test is a measure of how well the kidneys are performing their job of filtering waste from blood. A normal range for this level is 0.7 to 1.3 mg/dL. The glomerular filtration rate (GFR) calculation shows how well the kidneys are filtering. A normal range for this level is 60 or higher mL/min (milliliter/minute). A metabolic panel for Resident H, dated 7/19/2022, indicated a BUN level of 33 mg/dL, a creatinine level of 1.9 mg/dL, and a GFR calculation of 27.2 mL/min. A previous metabolic panel for Resident H, dated 5/16/2022, indicated a BUN of 37 mg/dL, creatinine level of 1.8 mg/dL, and GFR calculation of 29.1 mL/min. An interview with UM 1 (Unit Manager) on 7/22/2022 at 11:43 a.m., indicated that staff do not monitor Resident H's fluid intake. That the dietician would be the only one to review her fluid intake. A policy entitled, "Hydration Needs Assessment", was provided by the Executive Director on 7/22/2022 at 10:27 a.m. The policy indicated " ...Assess and measure oral intake ...Documentation may include but not limited to ...Notification of physician, dietary professional, staff and family ..."			

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	07/26/2022

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
	A policy entitled, "Resident Height and Weight", was provided by the Regional Director of Clinical Operations on 7/25/2022 at 12:14 p.m. The policy indicated, " ...Weights will be obtained ...as ordered by the physician ...Unstable residents will be reviewed by the IDT [Intradisciplinary Team] team to determine weekly or other ..." Reweight parameters per this policy could be obtained within 24 hours and include validation from the nurse for accuracy then notification of IDT team/doctor/family if indicated. This Federal tag relates to Complaint IN00384162. 3.1-46(a)(1) 3.1-46(b)			
F 0694 SS=D Bldg. 00	483.25(h) Parenteral/IV Fluids § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. Based on observation, interview, and record review, the facility failed to monitor a intravenous (IV) peripheral site for 1 of 2 residents reviewed for infection control. (Resident 90) Findings include: The clinical record for Resident 90 was reviewed on 7/20/22 at 10:00 a.m. The diagnosis for Resident 90 included, but was not limited to, covid-19. A physician order dated 7/15/22 indicated	F 0694	1. Resident 90 was not harmed by the alleged deficient practice. Resident 90 no longer has the peripheral I.V. site place. 2. All residents with an intravenous access site have the potential to be affected by the same alleged deficient practice. An audit of all residents with an intravenous access site has occurred to verify physician orders	09/02/2022

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	07/26/2022

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
	Resident 90 was to receive 0.9 percent of normal saline of fluids intravenously at 60 milliliters an hour for hydration until 7/18/22. A care plan dated 7/18/22 indicated "[Resident 90] is at risk for dehydration, or potential fluid deficit, Received IV [intravenous] fluids 7/16, 7/17 for hydration..." The clinical record did not indicate the monitoring of the resident's IV site. An observation was made of Resident 90 on 7/20/22 at 9:30 a.m. The resident's left arm was observed to have a peripheral intravenous site. The transparent bandage and tape was pulled away from her arm on one side and the insertion site was visible and uncovered. The tape was dated, 7/15/22. An observation was made of Resident 90 on 7/22/22 at 2:25 p.m. The resident's left arm was observed with a peripheral intravenous site. The dressing was pulled away on one side and not securely covering the insertion site. The date on the tape was 7/15/22. An observation was made of Resident 90 with the Director of Nursing on 7/22/22 at 2:31 p.m. After observing the resident's peripheral intravenous site dressing not intact, he indicated the peripheral intravenous site should be assessed daily. A peripheral venous access policy was provided by the Regional Director of Clinical Operations on 7/25/22 at 11:22 a.m. It indicated "...Purpose. To provide general guidance on routine standardized cannula insertion site inspection, site care and application of a sterile dressing to reduce or		are in place to observe the site for signs and symptoms of infection and dressing change orders are in place and that the dressing is being changed per facility policy. 3. DON/Designee has educated all licensed members of the nursing staff on the Peripheral Venous Access Policy with an emphasis on “site inspection and care”. 4. DON/Designee will audit all residents with an intravenous access site to verify dressing change completion and site inspection and care documentation per facility policy 5 x wk x 4 wks, then 3 x wk x 4 wks, then 1 x wk x 4 wks. 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. Date of completion: 9/2/2022	

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	07/26/2022

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
	prevent the complications of cannula related sepsis. General ...1. A sterile, transparent dressing will be used to cover IV peripheral sites...5. Documentation in the patient's chart must include assessment of cannula site..." 3.1-47(a)(2)			
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on interview and record review, the facility failed to perform pre and post dialysis assessments for 1 of 1 resident reviewed for dialysis (Resident 3). Findings include: The clinical record for Resident 3 was reviewed on 7/20/22 at 11:00 a.m. The Resident's diagnosis included, but were not limited to, end stage renal disease and heart failure. A care plan, initiated 4/7/22, indicated he was receiving dialysis therapy. The goal was for him to be free of complications from hemo-dialysis. The interventions included, but were not limited to, monitor vitals and report abnormal findings to medical provider, nephologist (kidney physician), dialysis center, and resident representative, initiated 4/7/22, and that he had a Permacath (dialysis catheter) in his chest, initiated 6/24/22.	F 0698	1. Resident 3 was not harmed by the alleged deficient practice. An audit of resident 3 occurred and the pre and post dialysis assessment has been implemented per facility policy. 2. All residents receiving dialysis services have the potential to be affected by the same alleged deficient practice. An audit of all residents receiving dialysis services has occurred to verify completion of a pre and post dialysis assessment per facility policy. 3. DON/Designee has educated all licensed members of the nursing staff on the Hemodialysis Care and Monitoring policy with an emphasis on “pre-dialysis assessment prior to	09/02/2022

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	07/26/2022

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
	An Admission MDS (Minimum Data Set) Assessment, completed 4/13/22, indicated he had moderate cognitive impairment and received dialysis treatments. During an interview on 7/22/22 at 3:10 p.m., LPN (Licensed Practical Nurse) 20 indicated Resident 3 received dialysis on Tuesday, Thursday, and Saturday each week. The clinical record contained a Pre-Dialysis Evaluation that was completed on 7/5/22 and one completed on 7/16/22. The clinical record contained a Post Dialysis Evaluations which was completed on 7/16/22. During an interview on 7/26/22 at 1:37 p.m., The Director of Nursing indicated that routine pre and post dialysis assessments should be completed each time a resident received dialysis. The facility had not been routinely completing them for Resident 3. On 7/22/22 at 11:25 a.m., the Regional Director of Clinical Operations provided the Hemodialysis Care and Monitoring Policy, last revised on 6/24/21, which read "...VIII. Pre-Dialysis a. Evaluation completed within four (4) hours of transportation to dialysis to include but not limited to: i. Accurate weight ii. Blood Pressure, Pulse, Respirations and Temperature...IX. Post-Dialysis...b. Nurse to complete the post-dialysis evaluation upon return from dialysis center to include but not limited to...iv. Blood pressure, pulse, respirations, and temperature upon return to the facility v. Visual inspection of site for bleeding, swelling, or other abnormalities vi. Any abnormal or unusual occurrence resident reports while at dialysis center..."		transportation to dialysis" and "complete post dialysis assessment upon return from dialysis center". 4. DON/Designee will audit all residents receiving dialysis services for completion of a pre and post dialysis assessment on each dialysis day 3 x wk x 8 wks, then 1 x wk x 4 wks. DON/Designee will report on audits monthly to the interdisciplinary team for 6 months during QAPI Meeting. The IDT will determine if the audits are necessary to continue after 6 months with 100% compliance achieved. Date of completion: 09/02/2022	

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	07/26/2022

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
	3.1-37(a)			
F 0744 SS=E Bldg. 00	483.40(b)(3) Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on observation, interview, and record review, the facility failed to ensure activities were provided to cognitive impaired residents for 5 of 5 residents reviewed for activities. (Resident C, 14, 44, 57, and 84) Findings include: 1. The clinical record for Resident C. was reviewed on 7/21/22 at 10:00 a.m. The diagnosis for Resident C included, but was not limited to, Alzheimer's disease. A MDS (Minimum Data Set) assessment, dated 5/4/22, indicated Resident C was cognitively impaired. A care plan dated 12/31/21 indicated "[Resident C] has impaired cognitive function/dementia or impaired thought processes r/t [related to] dx [diagnosis] of Alzheimers...Interventions...Engage in simple, structured activities that avoid overly demanding tasks. Offer to play bingo, arts and crafts, watch TV Land..." An observation was made of Resident C on 7/19/22 at 2:00 p.m. The resident was in bed. There was no activity observed.	F 0744	F744 **Corrective actions accomplished for those residents found to have been affected by the deficient practice:** **1. Residents C, 14, 44, 57, and 84 activity care plans updated with resident specifics related to cognitive impairment. An additional activities assistant has been hired to assist with activities on the dementia units.** **2. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents with cognitive impairment have the potential to be affected by this deficient practice The Administrator/Activity Director/Designee held an in-service to provide education and expectations to facility staff as it relates to the "Activity**	09/02/2022

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	07/26/2022

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
	An observation was made of Resident C on 7/20/22 at 3:00 p.m. The resident was in bed and there were no activities observed at that time. An observation was made of Resident C on 7/21/22 at 11:03 a.m. The resident was observed lying in bed with her eyes opened. The lights were off and blinds were closed. An observation was made of Resident C in her bed on 7/21/22 at 11:40 a.m. The resident was observed with her eyes open lying in bed. The room at that time was dark. An observation was made of Resident C on 7/21/22 at 12:06 p.m. The resident was observed dressed and in her wheelchair. She was sitting at the nurse's station. There was no observation of activities at that time. An observation was made of Resident C in bed on 7/22/22 at 2:10 p.m. The resident was lying in bed with eyes opened. There was no activities observed. An observation was made of Resident C in bed on 7/25/22 at 9:38 a.m. The resident was in bed with eyes opened. The television in the room was on, but the sound was turned down. The resident was not observed engaged with the television on. Interviews were conducted with Certified Nursing Assistants' (CNA) 2 and 3 on 7/22/22 at 2:10 p.m. They indicated they have not seen Resident C in an activity. An interview was conducted with Activities Director on 7/25/22 at 9:48 a.m. She indicated Resident C does not come down for activities.		**Program Policy" and providing self-initiated and group activities for dependent residents.** **3. Corrective actions to be monitored to ensure the deficient practice will not recur:** **The Administrator/Activity Director/Designee will audit 5 residents per week x 4 weeks, then 3 residents per week x 4 weeks, then 1 resident per week x 4 weeks to ensure self-initiated and group activities for dependent residents are being provided per their preference. This will continue for no less than 3 months and compliance is maintained. Any identified concerns will be immediately addressed.** **The Activity Director will present the results of these audits monthly to the QAPI committee for no less than 3 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.**	

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	07/26/2022

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
	2. The clinical record for Resident 14 was reviewed on 7/20/22 at 1:50 p.m. Resident 14's diagnoses included, but not limited to, dementia with behavior disturbance, psychotic disorder with delusions, violent behavior, and major depressive disorder. An observation was made on 7/19/22 at 11:32 a.m. of the R2 unit. Four residents were sitting around the dining room tables and there weren't any activities occurring. Resident 14 sitting at the dining table with her back to the television which and staring at the other residents. An observation was made on 7/20/22 at 10:22 a.m. of the R2 unit. Resident 14 was in her in room and in bed. Other residents were sitting around the dining tables and the television was on, but no other activities were occurring. An observation was made on 7/21/22 at 10:22 a.m. of the R2 unit. Resident 14 was in her room. In the dining room, the television was on, but no other activities were occurring. Resident 14's care plan dated 4/19/21 and revised on 10/01/21 indicated: a focus that she will maintain involvement in cognitive stimulation, social activities as desired through review date and the interventions included, but not limited to, needed assistance/escort activity functions dated; she was dependent on staff for activities, cognitive stimulation, social interaction and an intervention included, but not limited to, to attend/participate in activities of choice three times weekly; also, Resident 14 prefers activities which do not involve overly demanding cognitive tasks. She likes to engage in simple, structured activities such as stretching, movies, music, sing-alongs, coloring, drawing, sorting and		Date of completion: 9/2/2022	

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	07/26/2022

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
	stacking. She should be invited to scheduled activities. 3. The clinical record for Resident 44 was reviewed on 7/19/22 at 12:04 p.m. Resident 44's diagnoses included, but not limited to, dementia with behavioral disturbance, anxiety disorder, and closed fracture of left femur neck with routine healing. An observation was made on 7/19/22 at 11:32 a.m. of the R2 unit. Resident 44 was sitting in the dining room in his Broda chair in the reclined position. No activities were being conducted at that time. An observation was made on 7/20/22 at 2:34 p.m. of the R2 unit. Resident 44 was in his Broda chair which was in the reclined position. He was at one of the dining tables with his eyes closed and his mouth hanging open. There weren't any activities occurring at that time. An observation was made on 7/21/22 at 10:23 a.m. of the R2 unit. Resident 44 was seated in his Broda chair at one of the dining tables. He was facing the window, but the blinds were closed. The television was on in the dining area, but Resident 44 was positioned in such a way as he was unable to see the television. No other activities were occurring at that time. An observation of the R2 unit was made on 7/22/22 at 10:38 a.m. Resident 44 was sitting in his Broda chair at one of the dining tables. The television was on but he was not actively watching it. No other activities were occurring at that time. Resident 44's care plan initiated on 3/4/22			

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	07/26/2022

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
	indicated, he was at risk for falls related to gait, balance, and history of falls. One of his interventions was to encourage diversional activities through-out the day to assist with a healthy sleep cycle. 4. The clinical record for Resident 57 was reviewed on 7/22/22 at 11:18 a.m. Resident 57's diagnoses included, but not limited to, dementia with behavioral disturbance and anxiety disorder. Resident 57 also resides on the R2 unit. An observation made on 7/20/22 at 2:32 p.m. found Resident 57 asleep on the couch in in the dining room. There were 6 other residents just sitting around the tables not actively watching the television. An observation made on 7/21/22 at 10:25 a.m. found Resident 57 sitting on couch in the dining room. The television was on, but she wasn't watching it. Six other residents were also sitting in dining area, but not actively watching the television. An observation made on 7/22/22 at 10:10 a.m. found Resident 57 on the couch in the dining room with her eyes closed. Resident 57's care plan initiated on 5/24/21 and revised on 7/19/22 indicated, she will have fewer episodes of behaviors and one of her interventions was to offer diversional activities for redirection. She also was to show engagement in activities of interest and one intervention was to invite resident to scheduled activities. A Confidential interview was conducted. They indicated, the residents on the R2 unit need more			

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	07/26/2022

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
	activities. They stated none of the activities that were scheduled for that day had occurred. A copy of the R2 activity calendar was received on 7/22/21. The activity calendar indicated the following activities were scheduled: 7/19/22: 9 a.m.--moving to the music 11 a.m.--balloon tennis 1 p.m.--soothing sounds and puzzles 3 p.m.--easy listening 7/20/22: 9 a.m.--moving to the music 11 a.m.--easy listening 1 p.m.--afternoon crafts 3 p.m.--snacks and short movie 7/21/22: 10 a.m.--moving to the music 11 a.m.--balloon toss 1 p.m.--movie and popcorn 3 p.m.--easy listening 7/22/22: 9 a.m.--moving to the music 11 a.m.--music and remembering 1 p.m.--reading out loud 3 p.m.--easy listening 5. The clinical record for Resident 84 was reviewed on 7/26/22 at 2:57 p.m. Resident 84's diagnoses included, but not limited to, psychotic disorder with delusions and anxiety disorder. An interview with Resident 84 was conducted on 7/20/22 at 9:35 a.m. She indicated, she would like for the facility to have more activities for the residents and would like to go outside more when the smoking residents are not outside as she does			

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	07/26/2022

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
	not want to inhale the second hand smoke. Resident 84 resides on the R1 unit. An observation was made on 7/20/22 at 9:59 a.m. There weren't any planned activities occurring at that time. An observation was made on 7/20/22 at 10:30 a.m. on the R1 unit. CNA (certified nursing assistant) 65 had brought out some pool noodles and played balloon baseball with some residents. CNA 65 was heard saying, "If I don't get my charting done, you're my witnesses because I have to do an activity with you". A Confidential interview was conducted on 7/22/22. They indicated, one of the facility's activity personnel had quit and so the scheduled activities do not always happen. They stated, "they are bored to death sometimes. Yes, they need someone to play games and read stories". An interview with Activities Director was conducted on 7/26/22 at 2:44 p.m. She indicated, they had lost an activity aide and so sometimes an activity person is not able to come down to the units to ensure the activity happens. She indicated, when that happens, the nursing assistants should help to conduct the activities. She stated, she has been trying to get the the R1 and R2 units every other day but sometimes she is only able to do an ice cream social with them in a day. 3.1-37			
F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility			

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	07/26/2022

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
	must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on interview and observation, the facility failed to promote safe medication storage by keeping medication carts locked when unattended, failed to keep medication carts free of loose medication, failed to store narcotics under double lock, failed to label insulin after opening and failed to discard insulin after the expiration date for 4 of 4 medication carts reviewed and 1 of 2 medication storage rooms reviewed. Findings include: An observation on 7/20/2022 at 11:30 a.m. indicated the dementia care unit 2 medication cart	F 0761	1. No Resident was harmed by the alleged deficient practice. 2. All residents have the potential to be affected by the same alleged deficient practice. An audit of all medication carts has occurred to ensure the carts are free of loose medications, all medications are properly dated, all medications are disposed of upon expiration, medication carts are locked when not in use and narcotics are maintained under double lock, per facility policy.	09/02/2022

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	07/26/2022

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
	was found outside of the nurse's station unlocked and unattended. QMA 35 indicated she had stepped away to chart and forgot to lock it. An observation on 7/20/2022 at 2:37 p.m. indicated the dementia care unit 2 medication cart was left unlocked in the hallway when QMA 35 went into the room to administer medications. An observation on 7/20/2022 at 1:55 p.m. indicated long term care unit medication cart 2 was found unlocked and unattended. LPN 36 indicated she was giving an as needed pain medication and forgot to lock the chart. An observation on 7/21/2022 at 2:01 p.m. indicated that long term care unit medication cart 3 was found at the beginning of the hall unlocked and unattended. RN 12 indicated she was taking a physician call and forgot to lock the cart before she stepped away. An observation on 7/21/2022 at 2:16 p.m. indicated that long term care unit medication cart 1 was unlocked at the beginning of the hall. LPN 14 indicated she was called away to finish report after counting and had not locked the cart. An observation on 7/21/2022 at 2:21 p.m. of long-term care unit medication cart 3 indicated that Lantus for Resident 46 had an open date of 6/12/2022 and Humalog for Resident 58 had an open date of 6/1/2022. 17 unidentified loose pills were found in the cart by RN 12. An observation on 7/21/2022 at 2:28 p.m. of long-term care unit medication cart 1 indicated LPN 14 had found 11 loose pills throughout the cart and an additional half orange oblong pill loose in the locked narcotic drawer. LPN 14 was		3. DON/Designee has educated all Licensed Nurses and Qualified Medication Aides on the Medication Administration Policy and the Medication Controlled Drugs Policy with an emphasis on “do not leave medication cart unlocked”, “medication carts will be clean and organized”, “label the date opened for medications that expire” and “narcotics should be kept in a separate locked compartment”. 4. DON/Designee will observe each med cart is locked when not in use, that the med carts remain free of loose medications, insulins are labeled with date open, that the med carts are free of expired medications and that narcotics are locked under double lock, per facility policy 5 x wk x 4 wks, then 3 x wk x 4 wks, then 1 x wk x 4 wks. 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. Date of completion: 09/02/2022	

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	07/26/2022

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
	unable to identify this pill and no similar pills in the drawer. An observation on 7/21/2022 at 3:33 p.m. of long-term care unit medication cart 2 indicated LPN 13 had found 5 loose pills in the medication cart. An observation on 7/21/2022 at 3:35 p.m. indicated LPN 13 had found 7 loose pills on the floor around the long-term care unit nurses' station. An observation on 7/21/2022 at 3:36 p.m. indicated LPN 13 had discovered 2 cups of undated applesauce in the refrigerator inside of the medication storage room. LPN 3 stated she could not verify when these were placed and when they should be discarded. An observation on 7/21/2022 at 4:22 p.m. indicated that the medication room on the dementia care unit 2 was also the staff break room, chart room, and where the staff stored snacks for residents. This room did not lock. Inside of this room was the medication refrigerator with a single lock on the outside. The refrigerator contained Lorazepam Intensol for Resident 44 and Resident 41. LPN 11 had found 7 loose pills in the medication cart. Resident 41 had glargine insulin that was opened without a date. An interview with LPN 11 on 7/21/2022 at 4:32 p.m. indicated she knew that Lorazepam should be kept under two locks, but the previous DON had moved it back to the unit awhile back because she raised a concern about signing the narcotic count sheet, but she did not have keys to even access it in the off-unit medication storage room. An interview with the Director of Nursing on			

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	07/26/2022

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
	7/21/2022 at 5:15 p.m. indicated that narcotics should be kept under a two-lock system and that he would have the Lorazepam removed to the off-unit medication room. A policy entitled, "Storage of Medications", was provided by UM 1 (Unit Manager) on 7/22/2022 at 2:00 p.m. The policy indicated, " ...Medications storage areas are to be kept clean, well-lit, and free of clutter...When the original seal of the manufacture's container or vial is initially broken, the container or vial will be dated ...The expiration date of the vial or container will be 30 days from opening ..." 3.1-25(j)(6) 3.1-25(n) 3.1-25(o)			
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized			

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	07/26/2022

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
	§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments;			

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	07/26/2022

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
	(iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. Based on interview and record review the facility failed to have complete and accurate documentation of a resident's meal intake for 1 of 2 residents reviewed for food quality (Resident B). Finding include: During an interview with Resident B on 7/20/22 at 11:00 a.m., the resident indicated she did not like the facility food. "The food was lousy bland and tough". The resident indicated she had not lost any weight. Review of the record of Resident B on 7/20/22 at 1:47 p.m., indicated the resident's diagnoses included, but were not limited to, hemiplegia, diabetes mellitus, hypertensive heart disease, dysphagia and major depression. Review of Resident B's meal consumption documentation from 6/6/22 to 7/21/22 indicated there was no documentation of meal consumption for 70 times in 30 days. During an interview with the Unit Manager on 7/26/22 at 12:12 p.m., indicated the CNA's were responsible to document Resident B's meal consumption when they pick up the resident's tray. The facility had a problem with the CNA's not completing documentation.	F 0842	1. Resident B was not harmed by the alleged deficient practice. An audit of resident B meal consumption records occurred and records have been found to be current. 2. All residents have the potential to be affected by the same alleged deficient practice. An audit of all residents meal consumption records has occurred to verify completion of the recording of meal consumption in the medical record per facility policy. 3. DON/Designee has educated all members of the nursing staff on the Routine Resident Care policy with an emphasis on “documentation of meal consumption”. 4. DON/Designee will audit the meal consumption records for completion for 15 residents 3 x wk x 8 wks, then 1 x wk x 4 wks. DON/Designee will report on audits monthly to the interdisciplinary team for 3 months	09/02/2022

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	07/26/2022

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
	This Federal tag relates to Complaint IN00384162. 3.1-50(a)(2)		during QAPI Meeting. The IDT will determine if the audits are necessary to continue after 6 months with 100% compliance achieved. Date of completion: 09/02/2022	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or			

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	07/26/2022

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
	infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			

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	07/26/2022

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
	Based on observation and interview, the facility failed to promote infection control by placing soiled linen on the floor, holding unbagged soiled linen against the clothing, and having a soiled linen container in a resident hallway without a lid for 2 of 4 units reviewed. Findings include: An observation on 7/20/2022 at 2:03 p.m. indicated CNA 17 placing wet and visibly soiled wash cloth on the floor of a resident's room. After finishing caring for the resident, she left the room then returned to place the soiled linen into a plastic bag to take to the soiled utility. An interview with CNA 17 indicated she placed them on the floor because she didn't have an empty bag on her at the time An observation on 7/21/2022 at 2:10 p.m. indicated soiled bed linens removed from 58's bed. CNA 16 was making the bed in the resident's room before she went and scooped the soiled linen up to hold against her shirt, placed it upon the new linen on the bed then placed it into a plastic bag. An interview with CNA 16 indicated she placed the linen on the floor because she hadn't had time to place them in a bag yet, that's how she's always done it. An observation on 7/25/2022 at 12:50 p.m., indicated an unlidded soiled linen container in the hallway of memory care unit 2. Resident 57 had walked by and touched inside of the soiled linen before wandering down the hallways. An observation on 7/25/2022 at 1:43 p.m., indicated the unlidded soiled linen container	F 0880	Victoria Gunter, RN Division IP / Clinical Nichol Cardwell RN, Regional Director of Clinical Operations David Mlodecki Regional Director of Operations Andrew Clark Executive Director Tim Vickery LPN Infection Preventionist Dr. Pragnesh Radadiya MD Medical Director An observation on 7/20/2022 at 2:03 p.m. indicated CNA 17 placing wet and visibly soiled wash cloth on the floor of a resident's room. After finishing caring for the resident, she left the room then returned to place the soiled linen into a plastic bag to take to the soiled utility. An interview with CNA 17 indicated she placed them on the floor because she didn't have an empty bag on her at the time An observation on 7/21/2022 at 2:10 p.m. indicated soiled bed linens removed from 58's bed. CNA 16 was making the bed in the resident's room before she went and scooped the soiled linen up to hold against her shirt, placed it upon the new linen on the bed then placed it into a plastic bag. An interview with CNA 16 indicated she placed the linen on the floor because she hadn't had time to place them in a bag yet, that's how she's always done it.	09/02/2022

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	07/26/2022

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
	remained in the hallway of memory care unit 2. A policy entitled, "Infection Control Practices for Laundry/Linen", was provided by UM 1 (Unit Manager) on 7/22/2022 at 2:00 p.m. The policy indicated, " ...Soiled linen carts or hampers shall be covered with a lid ...should not come in contact with the employee's uniform." 3.1-19(g)(1)		An observation on 7/25/2022 at 12:50 p.m., indicated an unlidded soiled linen container in the hallway of memory care unit 2. Resident 57 had walked by and touched inside of the soiled linen before wandering down the hallways. An observation on 7/25/2022 at 1:43 p.m., indicated the unlidded soiled linen container remained in the hallway of memory care unit 2. /p> Lack of staff execution and management validation through rounding to ensure all soiled linen containers have lids and that lids are placed on top at all times. A root cause analysis (RCA) was conducted with the company Division (Consultant) Infection Preventionist (IP), with input and review from the Medical Director, IP, Executive Director, Director of Nursing, and Regional Director of Clinical Operations to determine the root cause resulting in the facilities Infection Control citation. The facility leadership failed to ensure full implementation through clear education / direction and direct observation of staff for the following: 1. Proper transportation of	

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	07/26/2022

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
			soiled linen to prevent cross contamination 2. Proper lids for soiled linen containers in resident hallways. The solutions and systemic changes developed by the Division (Consultant IP), DON, and facility IP include: The DON or designee will complete the following: · Ensure staff involved are educated on proper transportation of soiled and clean linen to prevent cross contamination during the transportation of linen. Staff are also educated on laundry policies related to soiled or contaminated linen. Follow CDC and facility policy. Policy: Infection Control Practices for Laundry/Linen · Ensure staff are educated on proper covering for soiled linen containers at all times. DON, IP or designee will enforce corrective measures and education if deficiencies are observed. 1. The IP nurse/DON/Designee will monitor each solution and systemic change identified in RCA and as noted above, daily or more often as necessary for 6 weeks and until compliance is	

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	07/26/2022

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
			maintained. Ensure soiled and clean linen on being properly transported to prevent cross contamination Ensure all soiled linen containers have lids and are on at all times 2. The IP nurse/DON/Designee will complete daily visual rounds throughout the facility to ensure staff are practicing appropriate Infection Control Practices and complying with the solutions identified as above. This will occur for 6 weeks and until compliance is maintained Ensure soiled and clean linen are being properly transported to prevent cross contamination Ensure all soiled linen containers have lids and are on at all times **Quality Assurance and Performance Improvement (QAPI):** The facility through the QAPI program, will review, update and make changes to the DPOC as needed for sustaining substantial compliance for no less than 6 months. **Root Cause Analysis Worksheet for Planning a Performance Improvement Project**	

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	07/26/2022

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
			Date of meeting: 8/12/2022 Greenfield HealthCare Center F 880 ***Steps:*** **1. Identify the event to be investigated and gather preliminary information**. Events and issues can come from many sources (i.e. incident reports, risk management referrals, resident or family concerns, health department citations) F 880 facility failed to follow Centers for Disease Control (CDC) guidance during the COVID-19 pandemic and ensure infection control practices were followed when: 1. Staff placing soiled linen on the floor. 2. Staff holding unbagged soiled linen against the clothing. 3. Having soiled linen containers in a resident hallway without lids. **2. Charter Team Members involved in planning:** **(Appointed by Leadership due to personal knowledge of systems involved.) List names and title below** **3.Describe what happened** *Collect and organize the facts surrounding the event to understand what happened.* **4.Identify contributing factors** *The situations, circumstances or conditions that increased the*	

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	07/26/2022

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
			likelihood if the events are identified. **5. Identify root cause** *A thorough analysis of contributing factors leads to identification of the underlying process of system issues (root causes).* **6. Design and implement changes to eliminate the root causes** *The team determines how best to change processes and systems to reduce the likelihood of another similar event.* **7. Measure the success of changes** *Like all improvement projects, the success of improvement actions is evaluated.*	