STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155026	A. BUILDING 00 B. WING	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREENWOOD VILLAGE SOUTH	295 VILLAGE LANE GREENWOOD, IN 46143

(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 a State Residential Licensure Survey. Survey dates: August 5, 6, 7, 8, 9, 12, and 13, 2024 Facility number: 000010 Provider number: 155026 AIM number: 100453660 Census Bed Type: SNF/NF: 121 Residential: 39 Total: 160 Census Payor Type: Medicare: 13 Medicaid: 62 Other: 46 Total: 121 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed August 20, 2024.	F 0000	Preparation and execution of this Plan of Correction in no way constitutes an admission or agreement by Greenwood Village South of the truth of the facts alleged in this statement of deficiencies and Plan of Correction. Greenwood Village South reserves the right to challenge, in legal proceedings, all deficiencies, statements, findings and facts and conclusions that form the basis of the deficiency. This Plan of Correction serves as our credible allegation of compliance.	
F 0558 SS=E Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive 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.	F 0558	I Residents 15, 90,	09/12/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Pamela Seegers	Administrator	08/30/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155026	A. BUILDING 00 B. WING	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREENWOOD VILLAGE SOUTH	295 VILLAGE LANE GREENWOOD, IN 46143

(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, record review, and interview, the facility failed to provide reasonable accommodation of needs for 4 of 4 randomly observed residents. Bathroom call lights lacked a pull cord. (Residents 15, Resident 90, Resident 13, Resident 83) Findings include: 1. On 8/5/24 at 9:40 a.m., Residents 13 and Resident 83's bathroom was observed. The emergency call light in the bathroom lacked a pull cord. On 8/6/24 at 10:08 a.m., the same was observed. On 8/7/24 at 8:30 a.m., the same was observed. 2. On 8/5/24 at 9:47 a.m., Residents 15 and Resident 90's bathroom was observed. The emergency call light in the bathroom lacked a pull cord. On 8/6/24 at 10:06 a.m., the same was observed. On 8/7/24 at 8:28 a.m., the same was observed. During an interview on 8/7/24 at 8:53 a.m., Unit Manager 2 indicated residents who used the bathroom could use the call light. During an interview 8/7/24 at 9:50 a.m., the DON indicated all residents should have an accessible call light in their bathroom. On 8/7/24 at 9:50 a.m., the DON provided a policy titled Call System, Residents, dated 9/2022, and indicated it was the current policy being used by the facility. A review of the policy indicated, each resident was provided with a means to call staff		13 and 83 experienced no harm from the broken call light cord in their bathrooms. These specific broken call light cords were immediately replaced at the point the surveyor notified a staff person of the observation. It is the policy of GVS that all residents have a way to directly summon staff for assistance at any time. II All residents have the potential to be affected by a broken call light cord in the event they fall on the floor in their bathroom and cannot reach the cord. A visual check was completed for the entire building to ensure all resident bathroom call light cords were intact and long enough for a resident to reach from the floor. III Education provided to all Pavilion Health Center staff that have the potential to enter a resident room bathroom of the current GVS Call Light Policy, the necessary length of the resident bathroom call light cord and how to submit a work order if the call light cord is broken or missing. Education will be completed by September 12, 2024. IV Director of Nursing or designee will: Audit a random selection of five resident rooms and bathrooms to verify call light cords are intact and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155026	A. BUILDING 00 B. WING	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREENWOOD VILLAGE SOUTH	295 VILLAGE LANE GREENWOOD, IN 46143

(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
	directly for assistance from the bedroom, toileting/bathing facilities, the floor. 3.1-3(v)(1)		within reach of the resident, during all three shifts and at random times, weekly for 3 months, then monthly for 9 months. The results of the audits will be presented to and reviewed by the QAPI Committee on a monthly basis until consistent substantial compliance has been achieved as determined by the committee. The Administrator and Director of Nursing will be responsible for sustained compliance.	
F 9999 Bldg. 00	3.1-14 PERSONNEL (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Specific inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3. This State rule was not met as evidenced by: Based on interview and record review, the facility failed to ensure a new staff member's references were checked prior to being hired for 1 of 5 employees reviewed. (Dietary Aide 4) Finding includes: On 8/9/24 at 11:00 a.m., the Administrator provided Dietary Aide 4's personnel file for	F 9999	I No residents were affected. It is the policy of GVS to obtain satisfactory references for any prospective employee to be considered for employment. Dietary Aide 4 did have a completed criminal history background check completed with no concerns noted, but Dietary Aide 4's personnel file had no record of a personal or professional reference being completed prior to employment. The reference has been completed for Dietary Aide 4 with no concerns. II All residents have the potential to be affected if satisfactory professional and or personal references are not obtained, even in the event the	09/12/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155026	A. BUILDING 00 B. WING	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREENWOOD VILLAGE SOUTH	295 VILLAGE LANE GREENWOOD, IN 46143

(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
	review. A review of the personnel file indicated Dietary Aide 4 was hired on 5/14/24. On 8/12/24 at 8:35 a.m., the Administrator provided a copy of Dietary Aide 4's employment application. A review of the document indicated, the employment application was completed and electronically signed by Dietary Aide 4 on 4/10/24 at 2:11 p.m. Dietary Aide 4's application had listed three professional references and their contact information. Dietary Aide 4's personnel file lacked documentation that any professional references were contacted. During an interview on 8/12/24 at 8:40 a.m., the Administrator indicated the facility's policy was to obtain references for all new staff members. Dietary Aide 4's personnel file lacked documented verification that references had been obtained. On 8/12/24 at 8:35 a.m., the Administrator provided a copy of the Employee Handbook, dated 1/1/2019, and indicated it was the current policy in use by the facility. A review of the document indicated, "...in order to be considered for employment at Greenwood Village South, each prospective employee must...provide satisfactory references, both personal and professional..."		prospective employee is a minor or has no employment history. III Education provided to the GVS Human Resources Department on the GVS Personnel Records Policy regarding the importance of making sure reference checks are completed on minors. The Human Resources Department has updated the GVS preemployment task list to ensure satisfactory references are completed in the event the prospective employee is a minor or has no job history. IV Director of Human Resources or designee will: Audit each licensed area prospective employee's onboarding information to assure satisfactory reference checks are completed. Audits will be done prior to each new hire orientation for the next 12 months. The results of the audits will be presented to and reviewed by the QAPI Committee on a monthly basis until consistent substantial compliance has been achieved as determined by the committee. The Administrator and Director of Nursing will be responsible for sustained compliance.	
R 0000 Bldg. 00				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155026	A. BUILDING 00 B. WING	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREENWOOD VILLAGE SOUTH	295 VILLAGE LANE GREENWOOD, IN 46143

(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 visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: August 5, 6, 7, 8, 9, 12, and 13, 2024 Facility number: 000010 Residential Census: 39 These State Residential Findings are cited in accordance with 410 IAC 16.2-5.	R 0000	Preparation and execution of this Plan of Correction in no way constitutes an admission or agreement by Greenwood Village South of the truth of the facts alleged in this statement of deficiencies and Plan of Correction. Greenwood Village South reserves the right to challenge, in legal proceedings, all deficiencies, statements, findings and facts and conclusions that form the basis of the deficiency. This Plan of Correction serves as our credible allegation of compliance.	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to ensure foods were served in a sanitary and safe manner for 3 of 3 kitchen observations. Staff hair was not covered while in the kitchen food preparation area. (Lead Cook 8) Finding includes: 1. During an initial kitchen observation on 8/12/24 from 8:55 a.m. to 9:10 a.m., Lead Cook 8 was observed working at the steamtable area where the breakfast meal was being held. Lead Cook 8 was observed plating the breakfast meal and taking the ending food temperatures. Lead Cook 8	R 0273	I No residents were affected by the lack of proper hair covering by Lead Cook 8. It is the policy of GVS for all employees to wear proper hair restraints while in the kitchen. II All residents have the potential to be affected if GVS employees do not wear proper hair restraints while in the kitchen. III The Food and Beverage Department has updated their “Appearance Standards” document to include the	09/12/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155026	A. BUILDING 00 B. WING	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREENWOOD VILLAGE SOUTH	295 VILLAGE LANE GREENWOOD, IN 46143

(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 observed wearing a ball cap that covered the hair from the ears to the top of the head. The hair, approximately 1 inch in length, from the ears to the neckline was observed to not be covered. 2. During a follow-up kitchen observation on 8/12/24 from 10:40 a.m. to 10:45 a.m., Lead Cook 8 was observed walking through out the kitchen area and working at the steamtable, where the noon meal was being held. Lead Cook 8 was observed taking the noon meal starting temperatures. Lead Cook 8 was observed wearing a ball cap that covered the hair from the ears to the top of the head. The hair, approximately 1 inch in length, from the ears to the neckline was observed to not be covered. 3. During a follow-up kitchen observation on 8/12/24 from 1:05 p.m. to 1:10 p.m., Lead Cook 8 was observed returning inside the kitchen through the kitchen's back door. Lead Cook 8 washed his hands and went directly to the steamtable to take the noon meal's ending temperatures. Lead Cook 8 was observed to have full facial hair, approximately ½ inch in length, that was observed to not be covered at that time. Lead Cook 8 was observed wearing a ball cap that covered the hair from the ears to the top of the head. The hair, approximately 1 inch in length, from the ears to the neckline was observed to not be covered. During an interview at that time, Lead Cook 8 indicated hair that was longer than "an inch or two" was to be covered while in the kitchen and facial hair was to be covered. During an interview on 8/12/24 at 1:20 p.m., the Dietary Manager indicated all hair was to be covered while in the kitchen. On 8/12/24 at 1:20 p.m., the Dietary Manager		requirement for beard nets to be worn, if applicable and permission to wear a ball cap, but only when accompanied by a hairnet underneath so that all hair is covered. Education will be provided regarding the "Appearance Standards" and the GVS Policy for Preventing Foodborne Illness- Employee Hygiene and Sanitary Practices for all Food and Beverage employees by September 12, 2024. IV The Food and Beverage Supervisor or designee will: Audit the Residential Kitchen staff on duty, on random days and random shifts, for proper use of hair coverings one time per week for one month, then one time per month for a total of 12 months. The results of the audits will be presented to and reviewed by the QAPI Committee on a monthly basis until consistent substantial compliance has been achieved as determined by the committee. The Administrator and Director of Nursing will be responsible for sustained compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155026	A. BUILDING 00 B. WING	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREENWOOD VILLAGE SOUTH	295 VILLAGE LANE GREENWOOD, IN 46143

(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
	provided a copy of the Preventing Foodborne Illness - Employee Hygiene and Sanitary Practices, dated November 2022, and indicated it was the current policy in use by the facility. A review of the document indicated, "...food and nutrition services employees follow appropriate hygiene and sanitary procedures to prevent the spread of foodborne illness...hair nets or caps and/or beard restraints are worn when cooking, preparing, or assembling food to keep hair from contacting exposed food, clean equipment, utensils ands linens..." On 8/12/24 at 3:30 p.m., a review of the Indiana Food Establishment Sanitation Requirements, Title 410 IAC 7-24, effective November 13, 2004, indicated, "...food employees shall wear hair restraints, such as hats, hair coverings or nets...that are designed and worn to effectively keep their hair from contacting...exposed food..."			
R 0306 Bldg. 00	410 IAC 16.2-5-6(g)(1-9) Pharmaceutical Services - Noncompliance (g) Medications administered by the facility shall be disposed in compliance with appropriate federal, state, and local laws, and disposition of any released, returned, or destroyed medication shall be documented in the resident ' s clinical record and shall include the following information: (1) The name of the resident. (2) The name and strength of the drug. (3) The prescription number. (4) The reason for disposal. (5) The amount disposed of. (6) The method of disposition. (7) The date of the disposal. (8) The signature of the person conducting the disposal of the drug. (9) The signature of a witness, if any, to the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155026	A. BUILDING 00 B. WING	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREENWOOD VILLAGE SOUTH	295 VILLAGE LANE GREENWOOD, IN 46143

(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
	disposal of the drug. Based on record review and interview, the facility failed to document the drug dispositions for 2 of 2 closed records reviewed for drug dispositions. (Resident 60 and Resident 61) Findings include: 1. Resident 60's closed clinical record was reviewed on 8/12/24 at 9:17 a.m. Resident 60 was discharged from the facility on 6/15/24. The diagnoses included but were not limited to, diverticulosis (condition that occurs when small pouches form in the colon's wall and push outward through weak spots), constipation, stage 4 chronic kidney disease, nausea, pain, dry eye syndrome, GERD (gastro-esophageal reflux disease), and xerosis cutis (extremely dry skin). Physician's Orders, dated June 2024 and current at the time of Resident 60's discharge from the facility, included but were not limited to the following: - Lactobacillus acidophilus capsule 500 million cell; take 2 capsules daily for diverticulosis - Bisacodyl suppository 10 milligrams (mg), insert 1 suppository daily as needed for constipation - Hyoscyamine sulfate tablet 0.125 mg, take 1 tablet every 2 hours as needed for excess secretions related to stage 4 chronic kidney disease - Ondansetron tablet 4 mg, take 1 tablet every 6 hours as needed for nausea - Sennosides-ducusate sodium tablet 8.6-50 mg, take 1 tablet daily for constipation - Acetaminophen tablet 325 mg, take 2 tablets every 4 hours as needed for pain - Clear eyes natural tears eye drops 0.5-0.6%, take	R 0306	I Resident 60 and Resident 61 were not affected. II All residents discharging have the potential to be affected. It is the policy to properly document all drug dispositions upon discharge. III The discharge instructions task list that nursing uses to prepare for a resident discharge has been updated to include instructions on how to confirm each medication is reconciled and its drug disposition is properly documented upon death or discharge. The instructions have also been updated to remind nursing staff that this also includes PRN meds, eye drops, topicals, etc. Education will be provided regarding the updated discharge instructions and GVS Policy for Discharge Medications for all nursing staff in the Residential area by September 12, 2024. IV Director of Residential Area or designee will: Audit all Residential area discharge records to ensure they include proper documentation of disposition of all medications and other pharmaceutical products upon discharge. Audits will be completed monthly on all	09/12/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155026	A. BUILDING 00 B. WING	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREENWOOD VILLAGE SOUTH	295 VILLAGE LANE GREENWOOD, IN 46143

(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
	1 drop in each eye every 4 hours as needed for dry eyes - Polyethylene glycol 3350 powder 17 gram/dose, take once daily as needed for constipation - Tums (calcium carbonate) 300 mg, take 2 tablets every 4 hours as needed for GERD - Ammonium lactate lotion 12%, apply topically to bilateral lower extremities at bedtime Resident 60's closed clinical record lacked a drug disposition record for the prescribed medications listed above. 2. Resident 61's closed clinical record was reviewed on 8/12/24 at 9:45 a.m. Resident 61 was discharged from the facility on 7/5/24. The diagnoses included but were not limited to, bilateral keratoconjunctivitis (a chronic condition that causes the conjunctiva and cornea to dry out due to insufficient tear production or rapid evaporation) and glaucoma (disease that damages your optic nerve). Physician's Orders, dated July 2024 and current at the time of Resident 61's discharge from the facility, included but were not limited to the following: - Clear eyes natural tears eye drops 0.5-0.6%, take 1 drop in each eye every 4 hours as needed for dry eyes - Xalatan drops 0.005%, take 1 drop in each eye at bedtime Resident 61's closed clinical record lacked a drug disposition record for the prescribed medications listed above. During an interview on 8/13/24 at 9:45 a.m., the Director of Nursing (DNS) indicated Resident 60		discharges for a total of 12 months. The results of the audits will be presented to and reviewed by the QAPI Committee on a monthly basis until consistent substantial compliance has been achieved as determined by the committee. The Administrator and Director of Nursing will be responsible for sustained compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155026	A. BUILDING 00 B. WING	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREENWOOD VILLAGE SOUTH	295 VILLAGE LANE GREENWOOD, IN 46143

(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 Resident 61's clinical files lacked a drug disposition record for all their medications upon their discharge from the facility. All of the resident's medications were either destroyed or returned to the pharmacy. The facility failed to document the disposition of the all the prescribed medications. On 8/13/24 at 10:01 a.m., the DNS provided a copy of the Discarding and Destroying Medications policy, dated November 2022, and indicated it was the current policy in use by the facility. A review of the document indicated, "...medications that cannot be returned to the dispensing pharmacy (e.g., non unit-doze medications, medications refused by the resident, and/or medications left by residents upon discharge) are disposed of in accordance with federal, state, and local regulations governing management of non-hazardous pharmaceuticals, hazardous waste and controlled substances...non-controlled and schedule V (non-hazardous) controlled substances are disposed of in accordance with state regulations and federal guidelines regarding disposition of non-hazardous medications..."			