	OF OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155210	A. BU	A. BUILDING <u>00</u> COMI			SURVEY ETED (2024
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 410 PARK RD GREENSBURG, IN 47240				
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
F 0000 Bldg. 00 F 0609 SS=D Bldg. 00	This visit was for to IN00445105, and In00445105, and Incomplaint IN0044 the allegations are Complaint IN0044 the allegations are Unrelated deficient Survey dates: Oct 2024. Facility number: Oct 2024. Facility number: Oct 2024. Facility number: Oct 2024. Census Bed Type: SNF/NF: 60 Total: 60 Census Payor Type Medicare: 8 Medicaid: 32 Other: 20 Total: 60 These deficiencies accordance with 4	he Investigation of Complaints N00444920. 5105 - No deficiencies related to cited. 4920 - No deficiencies related to cited. cies cited ober 30, 31, and November 1, 000117 155210 266460 e: reflect State Findings cited in 10 IAC 16.2-3.1. mpleted on November 11, 2024.	F 00		Preparation and/or execution of this Plan of Correction do not constitute admission or agreement by the provider of the truth of the facts alleged conclusions set forth in the statement of deficiencies. The Plan of Correction is prepare and/or executed solely because it is required by the provisions of Federal and Stalaw. We respectfully request pap compliance for this survey.	es f or ne ed	

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

Kelsey Meal HFA 11/22/2024

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

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155210		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/01/2024	
	PROVIDER OR SUPPLIER		410 PA	ADDRESS, CITY, STATE, ZIP COD NRK RD NSBURG, IN 47240	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG	REGULATORY OR Based on record reversal failed to ensure an areported to the India (IDOH) within two for 1 of 4 residents of F) Findings include: An anonymous interprocess from Octobethrough November Member 50 indicated Member 11 oddly president F. They we Member 11 lying in Sometimes Staff Member 11 lying in Sometimes Staff Member 11's response with the resident's fondle her breasts and Member 11's response redirected the resident Member 11 sat with the resident's hand of the An anonymous telegible during the survey puthrough November Member 32 indicated Member 11 climb in her head on his ches arms around her anonymous interprocess from Octobethrough November Member 9 indicated Resident F to touch	review during the survey er 30, 2024 at 12:30 P.M., Staff bed together multiple times. ember 11 would be under the dent. When Staff Member 11 room Resident F would and grab her butt. Staff exercise was to giggle and never ent. Over the weekend Staff exercise was to giggle and never ent. Over the weekend Staff exercise the his recliner with on her butt. Pohone interview conducted rocess from October 30, 2024 12:30 P.M., Staff ed they had witnessed Staff exercise was to giggle and never ent. Over the weekend Staff exercise was to giggle and never ent. Over the weekend Staff exercise of the pohone interview conducted rocess from October 30, 2024 1, 2024 12:30 P.M., Staff ed they had witnessed Staff to bed with Resident F and lay st. The resident would put his	F 0609	F609 Reporting of Alleged Violations What corrective action(s) wi be accomplished for those residents found to have bee affected by the deficient practice. Incident report submitted to the Indiana State Department of Health by Executive Director 10/31/2024 for allegation of a Resident remained in facility. Family and MD updated and aware. How other residents having potential to be affected by the same deficient practice will identified and what corrective action(s) will be taken; All residents that reside in the facility have the potential to be affected by the alleged deficient practice. All incidents reported in the last 30 days were reviewed to ensure accurate timing of incident reporting on 11/20/2024 by ED/designee. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur; Executive Director was educated on the incident reporting policing 11/20/2024 by the Chief Oper Officer. How the corrective action(s) will be monitored to ensure deficient practice will not	II In In In In In In In In In

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL		
		155210	B. W	ING	_	11/01/	2024	
NAME OF D	PROVIDER OR SUPPLIER		1	STREET A	ADDRESS, CITY, STATE, ZIP COD			
				410 PA				
WILLOW	S OF GREENSBUF	RG		GREEN	ISBURG, IN 47240			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	recur, i.e., what quality		DATE	
	During an interview	with the Administrator on			assurance program will be p	ut		
	_	M., she indicated there was an			into place;	u.		
		opriate behavior reported to			Incident Reporting QAPI tool v	vill		
	her by two facility s	staff members last week. A staff			be evaluated 5 days a week x			
		orporate office came to the			weeks, 3 days a week x 4 wee			
		te the allegations. She had not			then weekly by ED/designee.			
	ı .	ions to the State prior to their			100% threshold did not achiev			
	_	Staff Member was suspended returned to work on Monday			plan of action will be initiated a			
	after a coaching ses	-			this information will be presen to the QAPI committee during			
	_	llowing care plans, and			monthly meeting.	u IC		
	redirecting residents				monany meeting.			
		for Resident F was reviewed on						
		M. A Quarterly Minimum Data						
		ent, dated 08/30/24, indicated						
	_	tion was severely impaired.						
	1	hoses include, but were not						
	stroke.	hypertension, depression, and						
	stroke.							
	A current care plan,	, with initiated date of 04/18/24,						
	indicated Resident l	F made sexual gestures						
		f and a history of inappropriate						
	_	ventions included, but were						
		14/18/24, if behavior occurs						
		nre, preserve residents' rights						
	dignity and safety, a	and then step away.						
	A current care plan.	, with initiated date of 5/24/24,						
		F had manipulative behaviors						
		uring care. The interventions						
		not limited to, dated 5/24/24,						
		a calm manner with smile; do						
		esident; and try to find a						
	resolution to the res	sidents' concerns.						
	An investigation do	cument, dated 10/22/24,						
	_	past two weeks, it has been						
	maicaica Over the	pasi two weeks, it iias been						

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155210	(X2) MUL A. BUIL B. WING	DING	nstruction 00	(X3) DATE : COMPL 11/01/	ETED
	PROVIDER OR SUPPLIER S OF GREENSBUR			410 PAF	DDRESS, CITY, STATE, ZIP COD RK RD SBURG, IN 47240		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	some concerns they	tion by several co-workers have [Staff Member 11] [Resident F] to touch her					
	P.M., indicated Star Resident F attempti Member 11's butt. On to tell the resident t	ocument, dated 10/22/24 at 9:40 ff Member 4 witnessed ing continuously to grab Staff Other staff members attempted o stop. Staff Member 11 or attempted to correct him or					
	Member 11 indicate behaviors of grabbi	or on 11/01/24 at 9:55 A.M., Staff ed Resident F had some ng at staff inappropriately. en the plan since admission.					
		incident, dated 10/31/24 at 3:30 vas reported that a male resident a nurse's breasts.					
	08/28/23, titled "Red Occurrences, Abuse Investigation Policy on 11/01/24 at 11:5 All residents have t sexual, physical, in place that prohib reporting of alleged means as soon as pe hours after the allege that cause the allege abuseany staff to Incidents of mistror abuse must be Long-Term Care D Department of Hea	policy, with a revised date of eportable Incidents and Unusual eprevention, Reporting, and y", was provided by Corporate 4 A.M. The policy indicated " he right to be free from and mental abuseprocedures it mistreatmentImmediate I violationsImmediate I violationsImmediately possible, but no later than two gation is made, if the events atton involve abusesexual resident sexual contact teatment, exploitation, neglect, reported immediately to the ivision of the Indiana State Ith, adult protective services in accordance with state law					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPLETED	
		155210	B. WI	NG		11/01	/2024
				CTREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIE	R		l	ARK RD		
\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	S OF GREENSBU	DC.			NSBURG, IN 47240		
VVILLOVV	3 OF GREENSBU	NG .		GREEI	13BURG, IN 47240		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	ed immediately, but no later					
	than two (2) hours	after the allegation is made"					
	3.1-28(e)						
F 0641	483.20(g)						
SS=D	Accuracy of Asse	essments					
Bldg. 00							
		ion, record review, and	F 06	541	F641 Accuracy of Assessme		11/22/2024
		ity failed to ensure the			What corrective action(s) will	(I	
		t (MDS) assessments were			be accomplished for those		
		ted for 1 of 4 residents related to			residents found to have been	n	
	behaviors. (Residen	nt F)			affected by the deficient		
					practice;		
	Findings include:				Resident F MDS assessment		
	D	. 1: / 11/01/04			modified on 11/22/2024 by Sc	cial	
	_	tion and interview on 11/01/24			Services Director/MDS		
		sident F was observed punching			Coordinator/Designee to refle	CI	
	the side of his whe	eichair.			behaviors.	41	
	During an interview	w with the Director Of Nursing			How other residents having		
	_	4 9:51 A.M., she indicated			potential to be affected by the same deficient practice will l		
	1 1	naviors of grabbing since the			identified and what corrective		
		interventions were to redirect.			action(s) will be taken;	е	
	beginning and the	mici ventions were to redirect.			All residents that reside in the		
	A Quarterly MDS	assessment, dated 06/06/24,			facility have the potential to be		
		F's cognition was severely			affected by the alleged deficie		
		dependent on staff for activities			practices	116	
	_	e Resident had no behaviors			Social Services Director/design	inee	
		ction E Behavior Symptoms of			completed chart audit for MDS	•	
		shing, scratching, or sexual			assessments completed in the		
	acts.	8,			last 30 days to ensure accura		
					assessment on by Kelsey	-,	
	The behavior log d	lated from May 30, 2024 to June			Meal		
	_	the resident had exhibited			What measures will be put in	nto	
		s on the following dates:			place and what systemic	-	
					changes will be made to		
	- 05/30/24,				ensure that the deficient		
	- 05/31/24,				practice does not recur;		
	- 06/01/24,				Social Services		

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Event ID:

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	B NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	(X2) MULTIPLE CONSTRUCTION			SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		155210	B. WI	NG		11/01	/2024
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹		410 PA			
WILLOW	'S OF GREENSBUF	RG			ISBURG, IN 47240		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	- 06/02/24,				Director/Designess educated of	on	
	- 06/04/24, and				ensuring accuracy of		
	- 06/05/24				assessments are completed o	n	
					11/19/2024 by MDS		
	A Quarterly MDS a	assessment, dated 08/30/24,			consultant/SS Consultant.		
	indicated Resident	F's cognition was severely			How the corrective action(s)		
	impaired. He was d	ependent on staff for activities			will be monitored to ensure t	he	
	of daily living. The	Resident had no behaviors			deficient practice will not		
	documented on Bel	navior Symptoms of hitting,			recur, i.e., what quality		
	kicking, pushing, so	cratching, or sexual acts.			assurance program will be p	ut	
					into place;		
		pation note, dated 08/24/24 at			MDS accuracy QAPI tool will be	ре	
		d the Activity Department			completed weekly X 4 weeks,		
	_	esident F to an event via the			bi-monthly X 2 and monthly X	4	
	facility bus. The res	sident was uncooperative on			months by MDS		
		not leave the emergency			coordinator/designee. If 100%	, D	
		ne on the windows. He began			threshold is not achieved an a	ction	
	_	as hard as he could making the			plan will be developed. This		
		out. The resident grabbed hold			information will be presented t	0	
		would not let go. Nursing staff			the QAPI committee during the	Э	
	had to get the reside	ent back off of the bus.			monthly meeting.		
		te, dated 08/27/24 at 10:05					
		sident F had increased					
		ssness that shift with and					
	without care. Four	staff members were required to					
		esident to a chair due to his					
	grabbing and swatti	ing at staff.					
	The behavior log la	cked documentation related to					
		iors on 08/24/24 and 08/27/24.					
	A current care plan,	, with initiated date of 5/24/24,					
	indicated Resident	F had manipulative behaviors					
		f his wheelchair and grabbed					
		he care plans lacked revised					
		ns for the residents identified					
	ongoing behaviors.						

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No facility policy was provided. The facility used

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155210		ì	JILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/01/2024		
	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP COD 410 PARK RD GREENSBURG, IN 47240			
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COM	(X5) PLETION
TAG		ement Instrument (RAI) as a essments.		TAG	DEFICIENCE	D	ATE
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing						
	observation, the face behavior plan of car of 4 residents review (Resident F) Findings include: The clinical record 11/01/24 at 8:16 A. Set (MDS) assessm the resident's cognit. The resident's diagralimited to, aphasia, stroke. A current care plan, indicated Resident I towards female staft touching. The intervnot limited to, dated immediately stop car dignity and safety, a A current care plan, indicated Resident I of hitting the arm of staff during care. Twere not limited to, approach in a calmargue with the residence of the	with initiated date of 5/24/24, F had manipulative behaviors f his wheelchair and grabbed the interventions included, but dated 5/24/24, always manner with smile; do not ent; and try to find a idents' concerns.	F 06	657	F657 Care Plan Timing/Revision What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident F behavior care plan reviewed and updated on 11/21/2024 by Social Services Director /Designee. Two staff members are to be present will providing ADL care. How other residents having potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; Resident's that reside in the facility have the potential to be affected by the alleged deficient practice. A facility wide audit will be completed by Kelsey Meal to ensure that all behavior interventions are updated and place on behavior care plan. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur. Social Services Director/Designals of the process of the process of the practice of the process of the practice of	n was shile the see see sent	2/2024
	A current care plan, indicated Resident I of hitting the arm of staff during care. T were not limited to, approach in a calm argue with the resid	with initiated date of 5/24/24, F had manipulative behaviors of his wheelchair and grabbed the interventions included, but dated 5/24/24, always manner with smile; do not ent; and try to find a idents' concerns.			A facility wide audit will be completed by Kelsey Meal to ensure that all behavior interventions are updated and place on behavior care plan. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur.	nto	

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155210	B. W			11/01/	
		.002.10		_	_	, • .,	
NAME OF I	PROVIDER OR SUPPLIEF	3		STREET A	ADDRESS, CITY, STATE, ZIP COD		
TWINE OF I	ROVIDER OR SOLIEE			410 PA	RK RD		
WILLOW	S OF GREENSBUI	RG		GREEN	ISBURG, IN 47240		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	interventions for th	e residents identified ongoing			behavior care plan next busine	ess	
	behaviors.				day following behavior inciden	t by	
	An Activity Participation note, dated 08/24/24 at				MDS consultant/designee on		
					11/19/2024.		
	7:30 P.M., indicated the Activity Department				How the corrective action(s)		
	attempted to take Resident F to an event via the				will be monitored to ensure t	he	
	_	sident was uncooperative on			deficient practice will not	-	
	1	not leave the emergency			recur, i.e., what quality		
		ne on the windows. He began			assurance program will be p	ut	
		as hard as he could making the			into place;		
	_	out. The resident grabbed ahold			Care Plan Timing/Revision QA	\PI	
		ould not let go. Nursing staff			tool will be evaluated 5 days a		
		ent back off the bus.			week x 4 weeks, 3 days a wee		
	had to get the resid	on ouck off the ous.			4 weeks, then weekly by	,	
	A Health Status not	te, dated 08/27/24 at 10:05			MDS/designee. If 100% thresh	oold	
		sident F had increased			_		
	· ·				did not achieve a plan of actio		
	_	ssness that shift with and			be initiated and this informatio	n	
		staff members were required to			will be presented to the QAPI		
		esident to a chair due to			committee during the monthly		
	grabbing and swatti	ing at staff.			meeting.		
	An Administration	note, dated 09/02/24 at 7:35					
		sident F was striking out at the					
		moving his legs and yelling					
		thods were ineffective.					
	A Health status not	e, dated 09/20/24 at 2:24 P.M.,					
		F was reported to have been					
		ped with his hand during a					
	_	a skin tear on his finger.					
	Shower and caused	a skin tear on ms ringer.					
	A Heath Status note	e, dated 09/25/24 at 10:57					
		sident F was restless and					
		re it took five staff members to					
		he resident due to him yelling					
	and attempting to g	140 Statt and Items.					
	A habi 1	to 1 10/12/24 of 10:05 P.34					
	· ·	ated 10/12/24 at 10:05 P.M.,					
		F continuously grabbed staffs'					
	breasts and butt. Re	edirecting was unsuccessful					

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CENTERS FOR	R MEDICARE & MEDIC				Ol	MB NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		1	ESURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00		LETED
		155210	B. WING		11/0	1/2024
	PROVIDER OR SUPPLIE		410 PA			
WILLOW	S OF GREENSBU	RG	GREEN	NSBURG, IN 47240		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECT	ΓΙΟΝ	(X5)
PREFIX	,	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR	LD BE ROPRIATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
		ontinued during patient care. rvention was staff leaving the				
	During an observat	ion and interview on 11/01/24				
	at 10:29 A.M., CN.	A 30 indicated they had just				
	finished providing	care for the resident and				
		y grabby today. The Resident				
	_	atedly punching the side of his				
	wheelchair.					
	An ananymous inte	erview during the survey				
		per 30, 2024 9:00 A.M. through				
	*	12:30 P.M., Staff Member 27				
		dent F grabbed at female				
		and it didn't matter what you				
		m to let go he would just				
		e resident would beat on his				
	chair constantly at					
	1	policy titled, "Behavior				
		y" dated 11/28/19, indicated, "				
		have been identified as				
		ehaviors/mood alterations, a				
	_	hould be utilized for all				
		urses should be informed				
		tnessed an on-going or chronic				
		require trackingwill use				
		ntation to guide in the IDT				
	1	ng Residents with symptoms				
		ss of interventions. If				
		erventions were not effective,				
		v and determine if new				
		d be initiatedwill				
	staff via the Care P	nmended interventions to all				
	Stall via the Care P	iaii.				
	The current undate	d facility policy titled,				
		are Plans" indicated. "				

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...comprehensive care plan will include measurable

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		r í		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPLETED	
		155210	B. WI	NG		11/01/2	024
	PROVIDER OR SUPPLIER		-	STREET ADDRESS, CITY, STATE, ZIP COD 410 PARK RD GREENSBURG, IN 47240			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE .	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	monitor the resident	frameswill be utilized to t's progress. Alternative e documented, as needed."					
	3.1-37(a)						
F 0740 SS=D Bldg. 00	483.40 Behavioral Health	Services					
	review, the facility of document, and addressed to health serveriewed. (Resident Findings include: During an observation at 10:29 A.M., CNA finished providing of Resident F was very was observed repeat wheelchair. An anonymous interprocess with Staff N 2024 9:00 A.M. through the would grab at the areas. If staff told hid digging his fingernal dislocated thumbs of An anonymous interprocess with Staff N 2024 9:00 A.M. through the work of the staff of the digging his fingernal dislocated thumbs of An anonymous interprocess with Staff N 2024 9:00 A.M. through the staff of	cobservation, and record failed to monitor, completely ess a residents behaviors vices for 1 of 4 residents vices for the resident and vices for the resident and vices vices during the side of his vices during the survey vices during the survey vices during the survey vices vices for the resident vices for the resident vices	F 07	740	F740-Behavioral Health What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 7 behaviors are bein tracked and monitored for pro- interventions. How other residents having a potential to be affected by the same deficient practice will a identified and what corrective action(s) will be taken; Resident's that reside in the facility with behavioral health needs have the potential to be affected by the alleged deficite practice. A facility wide audit was completed 11/21/2024 for all residents requiring behavior tracking to ensure that all behaviors are properly tracked documented, and managed. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;	n ng per the ne pe re	11/22/2024

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155210	B. W	ING		11/01/	/2024
				CENTER	ADDRESS STEW STATE SID COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
\A/II O\A	10 OF OBEENOBLE	20		410 PA			
WILLOW	'S OF GREENSBU	RG		GREEN	ISBURG, IN 47240		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S DI AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEELCHER(Y)	TC	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	IE	DATE
	told by the resident	to let him see the staff's			Director/Designee was educat	ed	
	breasts.				on 11/19/2024 by the Social		
					Services Consultant on the		
	An anonymous inte	erview during the survey			behavior tracking and monitor	ina	
		Member 16 from October 30,			program.	9	
	_	ough November 1, 2024 12:30			All nursing staff was educated	on	
		d Resident F once grabbed			by the DNS/Designee on the	J11	
	I -	pulled it down to see their			behavior management prograi	m	
		ed to stick his hand down their			and documenting resident		
		resident to please stop and let			behaviors.		
		another staff member walked			Behaviors will be reviewed five	ے	
		lent F had his hand on their			days per week during the IDT		
		ted he did this to all female			meeting. Interventions will be		
	staff.	ted he did this to an Temale			reviewed to ensure proper bel		
	Starr.				management.	lavioi	
	An anonymous inte	rview during the survey			How the corrective action(s)		
		Member 27 from October 30,			will be monitored to ensure t		
	^	ough November 1, 2024 12:30			deficient practice will not	116	
		d Resident F grabbed at female			recur, i.e., what quality		
		and it didn't matter what you			assurance program will be p	ıı t	
		squeeze harder. The resident			into place;	ut	
		hair constantly at the nurses'			QAPI tool Behavior Managem	ont	
	station.	nan constantly at the naises			will be completed weekly X 4	CIII	
	Station.				weeks, bi-monthly X 2 and		
	Δ behavior note da	ated 10/12/24 at 10:05 P.M.,			monthly X 4 months by Execu	tivo	
		F continuously grabbed staffs'			Director/Designee. If 100%	uvc	
		edirecting was unsuccessful			threshold is not achieved an a	ction	
		ontinued during patient care.			plan will be developed. This	Cuon	
		vention was staff leaving the			information will be presented t	.0	
	room.	vention was starr leaving the			the QAPI committee during the		
	100111.				monthly meeting.	,	
	A Heath Status note	e, dated 09/25/24 at 10:57			inonting meeting.		
		sident F was restless and					
	· ·	re it took five staff members to					
	-	he resident, due to him yelling					
	and attempting to g						
	and autinping to g	140 Statt and Items.					
	An Intradicainline	y Team (IDT) note, dated					
		P.M., lacked documentation					
		ents behavior resulting in the					

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CENTERS FO	R MEDICARE & MEDIC				ON	MB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155210	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	COMP	E SURVEY LETED 1/2024
	PROVIDER OR SUPPLIE		410 PA	ADDRESS, CITY, STATE, ZIP COD RK RD NSBURG, IN 47240		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR	TION .D BE COPRIATE	(X5) COMPLETION
TAG	skin tear.	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	A Health status not indicated Resident hitting the shower and caused An Administration A.M., indicated Rebed and repeatedly out. Distraction medicated Reagitation and restle without care. Four safely transfer the grabbing and swatt An Activity Partici 7:30 P.M., indicated attempted to take Refacility bus. The resthe bus and would release handles aloo hitting the window back window pop to hold of a seat belt a staff had to get the During an interview 11/01/24 at 11:01 A Service Director we (the Administrator).	te, dated 09/20/24 at 2:24 P.M., F was reported to have been bed with his hand during a a skin tear on his finger. note, dated 09/02/24 at 7:35 esident F was striking out at the moving his legs and yelling ethods were ineffective. te, dated 08/27/24 at 10:05 esident F had increased ssness that shift with and staff members were required to resident to a chair due to ing at staff. pation note, dated 08/24/24 at the definition of the desident F to an event via the sident was uncooperative on not leave the emergency me on the windows. He began as hard as he could making the put. The resident grabbed a land would not let go. Nursing resident back off the bus. We with the Administrator on A.M., she indicated the Social as currently on leave and she of was covering her duties. It, with initiated date of 04/18/24, F made sexual gestures ff and a history of inappropriate				
	touching. The inter	ventions included, but were				

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not limited to, dated 4/18/24, if behavior occurs

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED		
155210		155210	B. WING			11/01/2024		
NAME OF PROVIDER OR SUPPLIER WILLOWS OF GREENSBURG				STREET ADDRESS, CITY, STATE, ZIP COD 410 PARK RD GREENSBURG, IN 47240				
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE			I	ID PROGRESSION OF CONTROL OF			(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	T-	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION				CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE		
	immediately stop care, preserve residents' rights							
	dignity and safety and then step away.							
	A current care plan, indicated Resident I of hitting the arm of staff during care. Twere not limited to, approach in a calm argue with the resid resolution to the res residents' routine an meet resident's requested. The residents clinic Service follow up of to the behaviors. The clinical record 11/01/24 at 8:16 A.J. Set (MDS) assessm the resident's cognit The resident's diagn limited to, Aphasia, and stroke. The Behavior log, diagnetic to the symptoms of the fol repeated movement hitting, pushing, grapinching/scratching	with initiated date of 5/24/24, F had manipulative behaviors of his wheelchair and grabbed the interventions included, but dated 5/24/24, always manner with smile; do not ent; and try to find a idents' concerns; learn and do not change if possible; tests promptly. al record lacked any Social r revised interventions related for Resident F was reviewed on M. A Quarterly Minimum Data ent, dated 08/30/24, indicated tion was severely impaired. tooses include, but were not Hypertension, depression, lated 08/01/24 through if the resident had behavior flowing: frequent crying, tyelling/screaming, kicking						
	inappropriate, and r	ejection of care indicated the						
	following:							
		or log from 08/01/24 to the resident had these llowing dates:						

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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155210 D. WING	COMPLETED				
1997 IO	11/01/2024				
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP COD 410 DARK DD					
	410 PARK RD				
WILLOWS OF GREENSBURG GREENSBURG, IN 47240					
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDERS PLAN OF CORRECTION	(X5)				
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION				
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY)	DATE				
- 09/03/24,					
- 09/05/24,					
- 09/06/24,					
- 09/08/24,					
- 09/25/24,					
- 09/28/24,					
- 09/30/24,					
- 10/04/24,					
- 10/09/24,					
- 10/10/24,					
- 10/20/24,					
- 10/25/24, and					
- 10/29/24.					
The behavior log lacked documentation to					
indicate the resident expressed behaviors on					
8/24/24 and 8/27/24, 09/02/24, 09/20/24, and					
10/12/24.					
The current facility policy titled, "Behavior					
Management Policy" dated 11/28/19, indicated, "					
For residents who have been identified as					
having on-going behaviors/mood alterations, a					
behavior tracking should be utilized for all					
observed issues. Nurses should be informed					
when staff have witnessed an on-going or chronic					
symptom that may require trackingwill use					
Behavior Documentation to guide in the IDT					
discussion regarding Residents with symptoms					
and the effectiveness of interventions. If					
behavior/mood interventions were not effective,					
the IDT will review and determine if new					
interventions should be initiatedwill					
communicate recommended interventions to all					
staff via the Care Plan.					
3.1-37(a)					

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