STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155412	A. BUILDING 00 B. WING	05/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREENWOOD HEALTH AND LIVING COMMUNITY	937 FRY RD GREENWOOD, IN 46142

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: May 8, 9, 10, and 13, 2024 Facility number: 000509 Provider number: 155412 AIM number: 100266620 Census Bed Type: SNF/NF: 95 Total: 95 Census Payor Type: Medicare: 8 Medicaid: 62 Other: 25 Total: 95 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed May 14, 2024.	F 0000	The plan of correction is to serve as Greenwood Health and Living's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Greenwood Health and Living Community or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations. Greenwood Health and Living Community is respectfully requesting consideration for desk review.	
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Dorian Mihay	HFA	05/24/2024

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

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	comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on observation, interview, and record	F 0656	**F 656 Develop/Implement**	05/29/2024

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	review, the facility failed to develop a person-centered care plan for a resident with a hearing device for 1 of 1 residents reviewed with a hearing device. (Resident 42) Finding includes: On 5/8/24 at 11:03 a.m., Resident 42 was observed resting in bed. During an interview at that time, Resident 42 indicated she was not able to hear or understand what was being said because she was unable to find her amplifier device system (hearing assistance device). On 5/9/24 at 9:24 a.m., Resident 42 was observed resting in bed. Resident 42 was observed putting on a head-set which was attached to an amplifier system. During an interview at that time, Resident 42 indicated she relied on the amplifier device system to be able to hear. On 5/10/24 at 11:15 a.m., Resident 42 was observed resting in bed watching TV. Resident 42 was observed wearing a head-set which was attached to an amplifier device system. On 5/9/24 at 1:06 p.m., Resident 42's clinical record was reviewed. Diagnosis included, but was not limited to, hearing deficit. The Quarterly Minimum Data Set (MDS) assessment, dated 1/30/24, indicated Resident 42 was moderately cognitively intact and utilized "a hearing aid or other hearing appliance." A Quarterly/Annual Nursing Assessment, dated 5/3/24 at 12:24 p.m. indicated Resident 42 had a hearing deficit. On 5/10/24 at 2:03 p.m., the Regional Nurse		**Comprehensive Care Plan** **I. The corrective actions to be accomplished for those residents found to have been affected by the practice.** Resident 42's Amplifier was added to her Care Plan **II. The facility will identify other residents that may potentially be affected by the practice.** Other residents care plan's have been audited and updated to reflect any hearing assistance devices **III. The facility will put into place the following systematic changes to ensure that the practice does not recur.** Nurses who intiate care plans and Social Services are being educated regarding implementation of the individual plan of care including hearing assistance devices **IV. The facility will monitor the corrective action by implementing the following measures.** The DON, or designee, will audit care plans of residents with newly	

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	Consultant provided a copy of Resident 42's audiology assessment dated 9/28/23. A review of the assessment indicated Resident 42 "...uses assistive listening device..." The clinical record lacked a person-centered comprehensive care plan regarding Resident 42's hearing deficit and the use of the amplifier device system. During an interview on 5/09/24 at 2:55 p.m., the Regional Nurse Consultant indicated the clinical record lacked a specific person-centered care plan for Resident 42's hearing deficit and the use of the amplifier device system. The care plan should have been initiated when Resident 42 began using the device. During an interview on 5/10/24 at 11:20 a.m., Resident 42 indicated she has used the amplifier device system "for years." During an interview on 5/10/24 at 11:33 a.m., the Staff Development Coordinator indicated Resident 42 had used the amplifier device system for "a long time." During an interview on 5/13/24 at 10:55 a.m., Qualified Medication Aide (QMA) 2 indicated Resident 42 had used the amplifier device system "for several years." On 5/9/24 at 3:30 p.m., the Regional Nurse Consultant provided a copy of the Care Plans, Comprehensive Person-Centered policy, dated December 2016, and indicated it was the current policy in use by the facility. A review of the policy indicated, "...policy statement: a comprehensive person-centered care plan that includes a measurable objectives and timetables		added hearing devices daily for 4 weeks, weekly for 12 weeks and then quarterly ongoing. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. **V. Plan of Correction completion date.** Date of Compliance: 5/29/24 The Administrator will be responsible for ensuring the facility is in compliance by date of compliance listed.	

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	to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident...describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychological well-being...comprehensive person-centered care plan is developed within seven (7) days of the completion of the required comprehensive assessment (MDS)..." 3.1-35(a)			
F 0732 SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors.			

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	§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation, interview, and record review, the facility failed to ensure the actual hours worked were posted for 3 of 4 days of the survey. Findings include: On 5/8/24 at 11:45 a.m., observed the posted nursing hours, dated 5/8/24, on the wall behind the nurses station. No other posted nursing hours were observed. The posted nursing hours lacked the actual hours worked. On 5/9/24 at 8:20 a.m., observed the posted nursing hours, dated 5/9/24, on the wall behind the nurses station. No other posted nursing hours were observed. The posted nursing hours lacked the actual hours worked. On 5/10/24 at 8:45 a.m., observed the posted nursing hours, dated 5/10/24, on the wall behind the nurses station. No other posted nursing hours were observed. The posted nursing hours lacked the actual hours worked. During an interview on 5/10/24 at 9:00 a.m., the Director of Nursing (DON) indicated they had posted the actual nursing hours.	F 0732	**F 732 Posted Nurse Staffing Information** **I. The corrective actions to be accomplished for those residents found to have been affected by the practice.** The nurse staffing information was posted with actual hours worked **II. The facility will identify other residents that may potentially be affected by the practice.** The staffing posting now indicated actual hours worked. **III. The facility will put into place the following systematic changes to ensure that the practice does not recur.** The scheduler is being educated to post the staffing hours with actual hours worked.	05/29/2024

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	On 5/10/24 at 9:33 a.m., the DON provided a policy titled Posting Direct Care Daily Staffing Numbers, undated, and indicated it was the current policy being used by the facility. A review of the policy indicated "...g. The actual time worked during that shift of each category and type of nursing staff."		**IV. The facility will monitor the corrective action by implementing the following measures.** The DON, or designee, will audit the staffing posting to ensure that actual hours worked are posted daily for 4 weeks, weekly for 12 weeks and then quarterly ongoing. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. **V. Plan of Correction completion date.** Date of Compliance: 5/29/24 The Administrator will be responsible for ensuring the facility is in compliance by date of compliance listed.	
F 0761 SS=D 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 must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.			

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	§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 observation, interview, and record review, the facility failed to ensure medications were dated for 1 of 2 medication carts of observed. Insulin pens were not dated with an open date. (200 Medication Hall Cart) Findings include: During a medication storage and labeling review, on 5/9/24 at 9:25 a.m., observed 4 opened Insulin Flex Pens 100 units/ml (milliliter) in 200 Hall Medication Cart. The Flex Pens were not labeled indicating the date the Flex pens were opened. During an interview on 5/10/24 at 9:05 a.m., the Regional Nurse Consultant indicated the insulin pens on the cart should have been dated with an open date. On 5/9/24 at 10:15 a.m., the Director of Nursing	F 0761	**F 761 Label/Store Drugs and Biologicals** **I. The corrective actions to be accomplished for those residents found to have been affected by the practice.** The non dated insulin pens on the 200 hall cart were disposed of. **II. The facility will identify other residents that may potentially be affected by the practice.** Other medication carts in the building were audited to ensure that insulin pens were labeled and dated accurately	05/29/2024

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	provided a policy titled, Insulin Packaging G-24, from Policy and Procedure Manuel, undated, and indicated it was the current policy being used by the facility. A review of the policy indicated "...1. "When activating a bottle of insulin, remove the bottle from the box, Date the bottle, Retain the bottle for 28 days, then discard". 3.1-25(j)		**III. The facility will put into place the following systematic changes to ensure that the practice does not recur.** Licensed nurses are being educated to date insulin pens with an open date. **IV. The facility will monitor the corrective action by implementing the following measures.** The DON, or designee, will round the facility and observe that insulin pens are dated accurately with an open date daily for 4 weeks, then weekly for 8 weeks, then monthly for 3 months, then quarterly ongoing. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. **V. Plan of Correction completion date.** Date of Compliance: 5/29/24	

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F 0814 SS=C Bldg. 00	483.60(i)(4) Dispose Garbage and Refuse Properly §483.60(i)(4)- Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to ensure the top dumpster lids were kept closed when not in use and that the dumpster area was free of rubbish for 2 of 3 observations. Finding includes: 1. During the initial facility tour with the Regional Dietary Consultant, on 5/8/24 from 10:30 a.m. to 10:35 a.m., the dumpster container area was observed. The dumpster area was located approximately 30 yards from the kitchen's rear exit door. The following was observed: - Two dumpster containers were observed. The trash dumpster was located on the right side and had two top lids. One of the two top lids was observed to not be closed. Multiple filled trash bags were visible inside the dumpster container. - Next to the dumpster container were multiple broken-down boxes and one large un-broken down box leaning against the trash dumpster container. - No staff were visible near the dumpster area. During an interview at that time, the Regional Dietary Consultant indicated the dumpster area	F 0814	The Administrator will be responsible for ensuring the facility is in compliance by date of compliance listed. **F 814 Dispose Garbage and Refuse Properly** **I. The corrective actions to be accomplished for those residents found to have been affected by the practice.** The Dumpster lids were closed and the dumpster area was free of rubbish **II. The facility will identify other residents that may potentially be affected by the practice.** The Dumpster lid will remain closed when not in use and will remain free of rubbish **III. The facility will put into place the following systematic changes to ensure that the practice does not recur.** Staff are being educated to keep the dumpster lid closed when not in use and to keep the dumpster area free of rubbish.	05/29/2024

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	was to be kept clean, free of debris and the top lids were to be kept closed when not in use. 2. During a follow-up observation, on 5/9/24 at 10:56 a.m., with the Regional Dietary Manager the following was observed: - The recycle dumpster, located next to the trash dumpster container was observed. The recycle dumpster had two top lids. Both top lids were observed to not be closed. Multiple broken-down and unbroken-down boxes were visible inside and hanging on the outside of the recycle dumpster container. - No staff were observed in the area at the time. During an interview at that time, the Regional Dietary Manager indicated the lids were to be kept closed and all the boxes were to be broken-down when placed into the recycle dumpster container. On 5/9/24 at 10:55 a.m., the Regional Nurse Consultant provided a copy of Food-Related Garbage and Rubbish Disposal policy, dated December 2008, and indicated it was the current policy in use by the facility. A review of the policy indicated, "...food-related garbage and rubbish containing shall be disposed of in accordance with current state laws regulating such matters...all garbage and rubbish containers shall be provided with tight-fitting lids or covers...outside dumpsters provided by garbage pick-up services will be kept closed and free of surrounding litter..." On 5/10/24 at 3:10 p.m., a review of the Retail Food Establishment Sanitation Requirements - Title 410 IAC 7-24, effective November 13, 2004, indicated, "...receptacles and waste handling units for		**IV. The facility will monitor the corrective action by implementing the following measures.** The Maintenance Director, or designee, will audit the dumpster area to ensure that the dumpster lid is closed when not in use and the area is free of rubbish daily for 4 weeks, weekly for 12 weeks and then quarterly ongoing. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. **V. Plan of Correction completion date.** Date of Compliance: 5/29/24 The Administrator will be responsible for ensuring the facility is in compliance by date of compliance listed.	

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	refuse, recyclables and returnables shall be kept covered with tight-fitting lids or doors if kept outside...accumulation of debris...are minimized...effective cleaning is facilitated around...the unit..." 3.1-21(i)(5)			