STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155788	A. BUILDING 00 B. WING	10/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREENWOOD MEADOWS	1200 N STATE ROAD 135 GREENWOOD, IN 46142

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00391836, IN00391512, and IN00390215. Complaint IN00391836 - Unsubstantiated due to lack of evidence. Complaint IN00391512 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00390215 - Unsubstantiated due to lack of evidence. Survey dates: October 17, 18, 19, 20, 21, and 24, 2022 Facility number: 012564 Provider number: 155788 AIM number: 201018510 Census Bed Type: SNF/NF: 117 SNF: 19 Total: 136 Census Payor Type: Medicare: 15 Medicaid: 78 Other: 43 Total: 136 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed October 28, 2022.	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
R. Shane McFall	Executive Director	11/17/2022

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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F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, interview, and record review, the facility failed to ensure a self medication administration assessment was completed for 1 of 7 residents observed for medication administration. Staff left medications in the resident room without a self medication administration assessment. (Resident 220) Finding includes: On 10/17/22 at 12:04 p.m., Qualified Medication Aide (QMA) 1 was observed to hand Resident 220 a cup with clonidine HCL (a medication used to treat high blood pressure) 0.2 mg (milligrams) and turn and leave the room. On 10/17/22 at 12:30 p.m., Resident 220's clinical record was reviewed. The diagnosis included, but was not limited to, hypertension. The physician's orders, dated 10/1/22 through 10/21/22, indicated Resident 220's medications included, but were not limited to, clonidine HCL 0.2 mg tablet three times a day. The Significant Change Minimum Data Set (MDS) assessment, dated 8/5/22, indicated Resident 220 was cognitively intact. During an interview on 10/17/22 at 12:49 p.m., QMA 1 indicated Resident 220 was alert and oriented and did not require observation during medication administration.	F 0554	A. The QMA observed handing Resident 220 clonidine and turning and leaving the room received inservice training on the "General Dose Preparation and Medication Administration" policy on 10/21/2022. Resident 220 is observed to ensure medication is consumed as prescribed. B. All residents have the potential to be affected. Inservice training was provided to all staff that administer medications related to policy for "General Dose Preparation and Medication Administration" on 11/16/2022 . Facility completed an audit on all applicable residents to determine if residents could self-administer medications. No residents were determined to self-administer medications per resident preference or ability. C. Inservice training was provided to all staff who administer medications related to policy for "General Dose Preparation and Medication Administration" on 11-16-2022. All new residents who request or residents with a change of condition will be assessed for self administration of medication by DNS/Designee The facility will complete an audit	11/21/2022

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	During an interview on 10/21/22 at 10:30 a.m., the Director of Nursing Services (DNS) indicated Resident 220 had not had a medication self administration assessment completed and it had not been normal practice to leave medications at the bedside. On 10/24/22 at 2:17 p.m., the DNS provided the facility policy, "General Dose Preparation and Medication Administration" dated 12/1/2007, and indicated it was the policy currently being used by the facility. A review of the policy indicated, "... 5. During medication administration, facility staff should take all measures required by facility policy and applicable law, including, but not limited to the following ... 5.9 observe the resident's consumption of the medication [s] ..." 3.1-11(a)		of the Self-Administration Assessments on appropriate residents D. Observational Rounds Medication Administration tool will be completed by DNS/Designee daily x4 weeks, weekly x4 week and monthly for 6 months. Medication Administration QAPI tool will be completed monthly for 3 months, then Quarterly for 3 quarters. If 95% compliance is not achieved, an action plan will be developed.	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form			

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	of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).			
	Based on observation, interview, and record review, the facility failed to notify the physician of a change in condition for 1 of 4 residents reviewed for falls. The physician was not notified of new onset pain and low blood pressure following a fall. (Resident 105) Finding includes:	F 0580	A. The nurse responsible for resident 105 on 9/10, and 9/11, received inservice training related to post fall physician notification on 10/24/2022. Physician has been notified of the fall, pain and low blood pressure. No new orders were received.	11/21/2022

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	On 10/18/22 at 2:25 p.m., non-skid strips were observed to be on the floor beside Resident 105's bed. On 10/21/22 at 10:22 a.m., Resident 105 was observed to be lying in bed with non-skid strips beside her bed. On 10/20/22 at 9:55 a.m., Resident 105's clinical record was reviewed. The diagnoses included, but were not limited to, dementia, anxiety, and right hip fracture. The Quarterly Minimum Data Set (MDS) assessment, dated 7/14/22, indicated Resident 105 had moderately impaired cognition. A Fall Event, dated 9/10/22 at 9:19 p.m., indicated Resident 105 was found lying on her right side in her room. She had a bruise to her forehead. A progress note, dated 9/11/22 at 3:58 a.m., indicated Resident 105 had pain in her right leg. The pain radiated from her right hip to her right knee. Her blood pressure was 74/47 mm/Hg (millimeters/Mercury) while lying down and 80/54 mm/Hg while sitting. The September 2022 PRN (as needed) Medication Administration History indicated the following: -On 9/11/22 at 3:57 a.m., Resident 105 was administered hydrocodone-acetaminophen (a narcotic pain medication) 5-325 mg (milligrams) for pain. The pain medication was not effective. -On 9/13/22 at 4:18 a.m., Resident 105 was administered hydrocodone-acetaminophen 5-325 mg (milligrams) for pain. The pain medication was		B. All residents have the potential to be affected. Inservice training was provided to all nurses related to post fall physician notification on 11/16/2022. C. Inservice training was provided to all nurses related to post fall physician notification for complaints of pain or any notable change in condition. Each fall event will reviewed by the IDT overseen by the DNS/designee daily including ensuring physician notification. D. Review of all fall events will be conducted via Falls audit tool monthly by DNS/Designee at QAPI meeting for a period of at least 6 months or until 6 months at 100%. They will be reviewed quarterly for 6 months afterward remaining at 100%. Any issues related to the proper notification of physician that arise will be addressed via corrective action plan through QAPI committee.	

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	somewhat effective. The Hospitalist Post-Acute Care note, dated 9/12/22 (no time indicated), indicated Resident 105 had complaints of right hip pain after fall on 9/10/22. She had pain with ambulation and range of motion. She had hypotension (low blood pressure) throughout the weekend. The recommendation was a right hip x-ray. The x-ray dated, 9/13/22 at 8:33 a.m., indicated right hip fracture. The clinical record lacked documentation of physician notification of right hip pain or low blood pressure on 9/11/22. During an interview on 10/21/22 at 11:55 a.m., the Director of Health Services (DHS) indicated she could not provide documentation of the nurse practitioner or physician being notified on 9/11/22 when Resident 105 complained of right hip and knee pain or low blood pressure. On 10/21/22 at 2:20 p.m., the DHS provided the facility's policy, "Fall Management Policy," with a revised date of 8/2022, and indicated this was the policy currently being used by the facility. A review of the policy indicated..."3. The physician will be contacted immediately, if there are injuries, and orders will be obtained..." On 10/24/22 at 2:18 p.m., the DHS indicated they did not have a physician notification policy. 3.1-5(a)(1)			
F 0656 SS=D Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans			

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

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	the requirements set forth in paragraph (c) of this section. Based on observation, interview, and record review, the facility failed to implement care plan interventions for 1 of 4 residents reviewed for falls. Neon tape was not applied to the wheelchair breaks. (Resident 11) Finding includes: On 10/17/22 at 10:37 a.m., Resident 11 was observed sitting in her wheelchair with significant left-sided facial bruising and a large bandage on the back of her right hand. The bruising varied in coloration from deep purple to red, extending from her forehead down to her left cheek, and a large hematoma was observed above the resident's left eyebrow. There was no neon tape applied to the resident's wheelchair breaks at this time. On 10/17/22 at 10:40 a.m., Resident 11's clinical record was reviewed. The diagnoses included, but were not limited to, difficulty in walking, age-related physical debility, muscle weakness, and osteoarthritis. A fall event report, dated 10/9/22 at 8:11 a.m., indicated the resident had an unwitnessed fall after she attempted to reposition herself in her unlocked wheelchair. The Progress Notes indicated the following: - On 10/9/22 at 9:33 a.m., the resident was heard yelling from her room. She was found sitting on the floor next to her wheel chair and stated she forgot to lock the wheelchair before she repositioned herself which caused the wheelchair to move away. The resident stated that she	F 0656	A. Neon tape was replaced on resident 11's wheelchair on 10/21/2022 B. All residents have the potential to be affected. Resident care sheets were reconciled to the fall interventions for all residents to ensure they were in place on 10/24/2022. C. An inservice was provided to all nursing staff and facility management staff pertaining to fall interventions and utilizing resident care sheets. Daily checks on fall interventions will be completed daily via Care Companion Journals submitted for each resident. D. Care companion journals will be reviewed weekly for 2 months by the ED/designee. Care companion journals will be reviewed monthly for 12 months at QAPI committee. Any issue related to fall interventions will be addressed through corrective action plan through the QAPI committee.	11/21/2022

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	bumped her left side of forehead on the floor and sustained a left-sided forehead hematoma and a right hand skin tear. - On 10/10/22 at 11:49 a.m., an IDT (interdisciplinary team) review note indicated the resident had a bruise to her left eye which was 100% purple in color. She also had sustained a left eye and right hand skin tear. A new care plan intervention initiated was to apply neon tape to her wheelchair breaks. - On 10/18/22 at 2:18 p.m., the resident continued to have bruising to left eye and skin tears to her right hand and left forehead. Resident 11's current care plan, dated 2/9/17 with a goal date of 11/15/22, indicated an intervention was implemented on 10/9/22, for neon tape to be applied to her wheelchair breaks. During an interview on 10/21/22 at 1:01 p.m., the resident indicated she had a fall which resulted in the left side of her face hitting the floor. The large hematoma remained over brow and a foam dressing remained to the back of her hand. The resident was observed sitting up in her wheelchair without neon tape in place on the breaks. On 10/24/22 at 10:56 a.m., an observation of the resident's wheelchair indicated no neon tape was applied to her wheelchair brakes. During an interview on 10/24/22 at 11:43 a.m., the Director of Health Services (DHS) indicated per a signature log that the neon tape was applied on 10/10/22. She did not know for certain if the staff applied the neon tape to the resident's wheelchair breaks or if the resident removed the tape.			

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	3.1-35(g)(2)			
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 observation, interview, and record review, the facility failed to ensure care and services were provided to maintain the residents highest practicable well being for 1 of 2 residents reviewed for skin conditions and 1 of 3 residents reviewed for hospitalizations. Vital signs, blood sugars, and a thorough assessment were not completed following a change in condition and a skin rash was not reevaluated after treatment. (Resident 90, Resident 88) Findings include: 1. On 10/20/22 at 11:23 a.m., Resident 88's clinical record was reviewed. The diagnoses included, but were not limited to, metabolic encephalopathy and Type II diabetes mellitus with diabetic neuropathy. A review of the Progress Notes for Resident 88 included the following: - On 9/22/22 at 3:55 a.m., "Resident vomited in bed, gave prn [as needed] zophran [sic, a medication to prevent nausea and vomiting]	F 0684	A. Nurse responsible for the care of resident 88 on 9/22 was provided inservice training related to appropriate interventions for residents will diabetes after a noted change in condition on 10/24/2022. Nurses responsible for the care of resident 90 were provided inservice training related to follow up on significant rashes on 11/19/2022. B. All residents have the potential to be affected. All facility nurses were provided inservice training on “Change in Condition” policy specifically related to diabetes patients on 11/16/2022. All facility nurses were provided inservice training to follow-up treatment results for patients with significant rashes. C. Inservice training was provided to all nurses to review “Change in Condition” policy specifically related to diabetes patients and those with significant	11/21/2022

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	sublingual [under the tongue]. CNA [certified nursing assistant] cleaning resident up." - On 9/22/22 at 5:16 a.m., "Resident vomited in bed again, asked her if she thinks it may be something she ate that is making her sick, resident states she is not sure. Set HOB [head of bed] at 45 degrees, notified MD [medical doctor] in communication book." - On 9/22/22 at 8:09 a.m., "Writer checked resident glucose and reading hi [high]. Writer rechecked glucose and reading was hi again. Resident was lethargic and unable to answer neurological questions. Writer notified on call MD [medical doctor] and new orders given. Writer notified son of new orders and he understood. Son stated that his mother called him last night and stated that she was not feeling well and that she was nauseated. Writer informed son that prn medication was given. Resident was transferred to [hospital name] for further evaluation and treatment." The Vitals Report for Resident 88 indicated the following: 9/22/22 at 12:23 a.m., oxygen saturation 95%, blood pressure 132/69, respirations 18, pulse 67, temperature 98.4. 9/22/22 at 6:43 a.m., oxygen saturation 93% and temperature 96.8. 9/22/22 at 7:03 a.m., blood sugar 498. 9/22/22 at 8:39 a.m., blood sugar 500. 9/22/22 at 11:47 a.m., blood sugar off scale: high.		rashes. All nurses were trained to add significant rashes to the skin team monitoring list to ensure timely treatment and resolution. D. Residents with significant changes or significant skin issues will be identified by DNS/designee utilizing the Activity Summary Report and Abnormal Vitals report daily. Activity Summary Reports and Abnormal Vitals reports will be reviewed by Change in Condition QAPI tool at QAPI committee monthly for 6 months then quarterly for 6 additional months.	

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	The clinical record lacked documentation of vital signs, blood sugar, and a thorough assessment being completed from the time the resident started vomiting at 3:55 a.m. until 7:03 a.m. A document titled, "Internal Medicine Attending Attestation" dated 9/22/22, at 2:58 p.m., for Resident 88 indicated the resident "presents due to mental state change ... Assessment/Plan 1. Acute metabolic encephalopathy 2. diabetic ketoacidosis without coma 3. acute UTI [urinary tract infection] 4. elevated troponin 5. hyperkalemia 6. AKI on chronic kidney disease 7. coronary artery disease 9. chronic heart failure ..." During an interview on 10/21/22 at 9:50 a.m., the Director of Nursing Services (DNS) indicated the night shift nurse did not check Resident 88's blood sugar or vital signs on 9/22/22 after the resident started vomiting. During an interview on 10/21/22 at 10:51 a.m., Licensed Practical Nurse 1 indicated Resident 88 was cognitively not acting right when she came on shift the morning of 9/22/22. She immediately checked her blood sugar and it was high. She checked it again and it was high. It was unusual for the resident to vomit so she called the nurse practitioner for new orders. During an interview on 10/21/22 at 12:24 p.m., Registered Nurse 1 indicated Resident 88 started vomiting about 3:30 a.m. She could not remember if she took or vital signs or blood sugar that night. On 10/21/22 at 11:15 a.m., the facility indicated they did not have a policy related to completing vital signs, blood sugars, or a thorough assessment for a resident with diabetes mellitus who starts vomiting. 2. On 10/18/22 at 10:14 A.M.,			

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	155788	A. BUILDING 00 B. WING	10/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREENWOOD MEADOWS	1200 N STATE ROAD 135 GREENWOOD, IN 46142

(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 observed lying in his bed. The skin on his hands, arms, chest, face, and legs was dry, red, and flaking. At that time, Resident 90 indicated his skin was itchy and stinging. Resident 90 was unsure if he was receiving treatment for his skin. On 10/19/22 at 11:05 A.M., Resident 90 was observed lying in his bed. The skin on his hands, arms, chest, face, and legs was dry, red, and flaking. At that time, Resident 90 indicated his skin was itchy and uncomfortable. On 10/20/22 at 11:26 A.M., Resident 90 was observed lying in his bed. The skin on his hands, arms, chest, face, and legs was dry, red, and flaking. At that time, Resident 90 indicated his skin was itchy and uncomfortable. On 10/19/22 at 2:40 P.M., Resident 90's clinical record was reviewed. The diagnoses included, but were not limited to, acute kidney failure, congestive heart failure, and anxiety disorder. The Admission MDS (Minimum Data Set) assessment, dated 9/19/22, indicated the resident was cognitively intact. A nursing progress note, dated 10/12/2022 at 9:08 A.M., indicated, "Resident with rash all over body, warm to touch...put in communication book..." A nursing progress note, dated 10/14/2022 at 3:16 P.M., indicated, "...Patient with red rash and dry skin. NP [Nurse Practitioner] aware. Patient has hx [history] of allergic reaction to previous antibiotic. Benadryl given per orders." A nursing progress note, dated 10/17/2022 at 1:06			

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	A.M., indicated, "...New skin issue on L arm, resident scratched himself since it's too itchy..." The resident's admission face sheet, dated 9/13/22, indicated, "...no known drug allergies..." A physician's order with a start date of 10/12/22 and a discontinue date of 10/14/22 indicated the resident was prescribed 25 mg (milligrams) of benadryl every 8 hours for 3 days. The clinical record lacked follow up for Resident 90's continued skin rash following treatment. During an interview on 10/21/22 at 9:45 AM, the Director of Nursing indicated the resident developed an allergic reaction to an antibiotic which caused his skin to be red, dry, and itchy. The resident was given benadryl for several days. 3.1-37(a)			
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 ensure ongoing assessment and oversight of the resident before, during, and after dialysis treatments, including monitoring the resident's condition during treatments, and failed to have ongoing communication and collaboration with the dialysis facility for 1 of 1 resident reviewed for dialysis services. (Resident 11)	F 0698	A. Dialysis notes have been received for resident 11 Information was requested for resident 11 from the appropriate dialysis facility on 10/24/2022. B. All residents who receive dialysis has the potential to be affected. Information was	11/21/2022

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	Findings include: On 10/19/22 at 9:40 a.m., Resident 11's clinical record was reviewed. The diagnoses included, but were not limited to, end stage renal disease and dependence on renal dialysis. The resident's dialysis communication documents from September 2022 to October 24, 2022, indicated 15 out of 23 visits had no dialysis nurse communication notes. The dialysis nursing sections were blank. During an interview on 10/24/22 at 10:58 a.m., the Director of Health Services (DHS) indicated the dialysis communication tool is not always returned to the facility. She indicated staff would sometimes try to call the dialysis center to see if they could get information. On 10/24/22 at 2:15 p.m., the DHS provided the facility policy, "Dialysis Care," revised on November, 2017, and indicated it was the policy currently being used. A review of the policy indicated, "...Ongoing assessment of the resident's condition and monitoring for complications before and after dialysis treatments received at a certified dialysis facility ... Ongoing assessment and oversight of the resident before, during, and after dialysis treatments, including monitoring of the resident's condition during treatment, monitoring for complications ... Ongoing communication and collaboration with the dialysis facility regarding dialysis care and services..." 3.1-37(a)		requested and received for all residents receiving dialysis from their providers on 10/24/2022. C. The Dialysis communication tool will be sent and collected following each visit. Medical Records staff will ensure the return and completion of that tool by our dialysis providers. Any missing information will be requested immediately by Medical Records staff. DNS/Designee provided an inservice to licensed staff regarding the dialysis communication tool. D. Transfer of information to and from dialysis will be ensured and monitored by “Dialysis Care” tool monthly at QAPI meeting for 6 months at 100%. It will be monitored a further 6 months on a quarterly basis. Any issues with the receipt of dialysis center documentation will be remedied by corrective action plan through QAPI committee.	