

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155026	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/13/2024
NAME OF PROVIDER OR SUPPLIER  Greenwood Village South		STREET ADDRESS, CITY, STATE, ZIP CODE 295 Village Lane Greenwood, IN 46143	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>35099</p> <p>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)</p> <p>Findings include:</p> <p>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.</p> <p>On 8/6/24 at 10:08 a.m., the same was observed.</p> <p>On 8/7/24 at 8:30 a.m., the same was observed.</p> <p>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.</p> <p>On 8/6/24 at 10:06 a.m., the same was observed.</p> <p>On 8/7/24 at 8:28 a.m., the same was observed.</p> <p>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.</p> <p>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.</p> <p>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 directly for assistance from the bedroom, toileting/bathing facilities, the floor.</p> <p>3.1-3(v)(1)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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