STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155188	A. Building B. Wing	06/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenfield Healthcare Center	200 Green Meadows Dr Greenfield, IN 46140

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)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25054 Based on interview and record review the facility failed to provide medications as ordered by the physician for 1 of 3 residents reviewed for medication administration. (Resident C) Finding include: During an interview with Resident C's family, on 6/24/24 at 12:35 p.m., indicated the resident did not receive all his medications as ordered by the physician when admitted to the facility on [DATE]. The resident was discharged on [DATE]. The clinical record of Resident C was reviewed on 6/25/24 at 12:40 p.m. The diagnoses included, but were not limited to, diabetes, severe protein calorie malnutrition, convulsions, sepsis, major depressive disorder, stiff man syndrome, hypotension, and pulmonary nodule. Review of the physician orders for Resident C, dated 11/23/24, indicated the resident was ordered and did not receive the following medications: tamsulosin 0.4 milligrams (mg) every morning (urinary retention medication), mirtazapine 15 mg at bedtime for depression, amoxicillin 500 mg; two capsules in the morning and at bedtime for an infection, midodrine 10 mg three times a day for hypotension, pantoprazole sodium 40 mg in the morning and at bedtime for digestive aid, and gabapentin 800 mg at bedtime for polyneuropathy. During an interview with the Regional Director of Clinical Operations, on 6/26/24 at 2:20 p.m., verified Resident C did not receive the medications as ordered by the physician and these medications were available in the Emergency Drug Kit (EDK) located in the facility. The floor nurse who admitted Resident C was responsible to obtain these medications out of the EDK and administer them to Resident C. The Emergency Pharmacy Service and Emergency kit policy provided by the Executive Director, on 6/26/24 at 3:19 p.m., indicated emergency pharmacy service was available 24 hours a day. Emergency needs for medication are met by using the facility's approved emergency medication supply. The provider pharmacy supplies emergency medication included, but were not limited to, emergency drugs and antibiotics. The nurse records the medication use from the emergency kit on the use form and seals the kit with a color-coded seal to indicate the need for replacement. This citation relates to Complaint IN00423037. (continued on next page)

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

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155188	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/26/2024
NAME OF PROVIDER OR SUPPLIER Greenfield Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Green Meadows Dr Greenfield, IN 46140	

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)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-25(a)