

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  12/10/2024
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)
<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>30344</p> <p>Based on interview and record review, the facility failed to include a resident and a resident's representative in their care plan conferences for 2 of 5 residents reviewed for care planning. (Residents 13 and 104)</p> <p>Findings include:</p> <p>1. The clinical record for Resident 13 was reviewed on 12/4/24 at 12:30 p.m. His diagnoses included, but were not limited to, heart failure.</p> <p>The 7/8/24 Annual, 10/2/24 Quarterly, and 10/24/24 Quarterly Minimum Data Set (MDS) assessments indicated he was cognitively intact.</p> <p>There was no information in the clinical record that indicated a care plan conference was held in coordination with any of the three above referenced MDS assessments.</p> <p>An interview was conducted with Resident 13 in his room on 12/4/24 at 12:42 p.m. He indicated he hadn't been invited to a care plan conference in the facility, but he would like to attend.</p> <p>An interview was conducted with Social Services Director (SSD) 2 on 12/6/24 at 10:45 a.m. She indicated she was responsible for coordinating care plan meetings for the residents on the unit. They were conducted every three months, beginning with the initial, then quarterly thereafter. They usually scheduled the next meeting at the current meeting. She had everything lined up so that meetings were held in line with quarterly assessments. They documented care plan meetings in the progress notes of the electronic health record (EHR). She remembered discussing laundry and Resident 13's wife at Resident 13's last care plan meeting. SSD 2 reviewed Resident 13's EHR at this time and indicated she did not see any documentation of an actual care plan meeting for him in July or October 2024, and suggested there may be documentation in a soft file in another office. She and the Unit Manger (UM) would have been the only staff present.</p> <p>On 12/6/24 at 12:22 p.m., an interview was conducted with SSD 2, who provided the, 10/9/24, handwritten Care Plan Notes for Resident 13 at this time. The notes indicated Resident 13, and his wife were in attendance. The notes were signed by SSD 2, but there was no signature for Resident 13. SSD 2 indicated she was unable to locate any care plan notes for July 2024.</p> <p>(continued on next page)</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
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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted with Resident 13 on 12/10/24 at 11:31 a.m. He indicated he did not recall having a care plan meeting on 10/9/24. He was able to sign his name, as he signed his name every time he withdrew money from his personal funds account and would have signed that he attended the care plan meeting, if asked.</p> <p>2. The clinical record for Resident 104 was reviewed on 12/4/24 at 2:00 p.m. His diagnoses included, but were not limited to, Parkinson's disease, dementia, and intermittent explosive disorder.</p> <p>The 7/17/24 Quarterly and 9/12/24 Significant Change MDS assessments indicated he was severely cognitively impaired.</p> <p>There was no information in the clinical record that indicated a care plan conference was held in coordination with the two above referenced MDS assessments.</p> <p>An interview was conducted with Family Member 3 on 12/4/24 at 2:02 p.m. She indicated she hadn't been invited to a care plan conference in the facility yet.</p> <p>An interview was conducted with SSD 2 on 12/6/24 at 10:55 a.m. She indicated she invited Family Member 3 to Resident 104's care plan meetings, but she wasn't able to attend. SSD 2 did not document care plan invitation in the clinical record, but she invited Family Member 3 to his last care plan meeting. SSD 2 reviewed Resident 104's EHR and indicated she didn't see any documentation of an actual care plan meeting for him in September 2024, and suggested there may be documentation in a soft file in another office. She and the UM would have been the only staff present.</p> <p>On 12/6/24 at 12:22 p.m., an interview was conducted with SSD 2, who provided the, 10/4/24, handwritten Care Plan Notes for Resident 104 at this time. The notes indicated Family Member 3 was unable to attend the meeting and the only people in attendance were SSD 2 and the Unit Manager. SSD 2 indicated she was unable to locate any care plan notes for July 2024.</p> <p>An interview was conducted with Family Member 3 on 12/6/24 at 12:13 p.m. She indicated she did not recall being invited to a care plan meeting held on 10/4/24. She would have been able to attend, but didn't know anything about it. She tried to come to the facility two to three times a week, and moving forward, she would very much like to be invited to care plan meetings to be kept in the loop.</p> <p>The Plan of Care Overview policy was provided by the Executive Director on 12/6/24 at 12:00 p.m. It read, The facility will .vii. support and encourage resident/representative participation including but not limited to working cooperative to .3. schedule meeting to accommodate a resident's representative that may include conference calls, video conference sessions or live sessions .Attendees will sign and date care plan meeting agendas/documents.</p> <p>3.1-35(d)(2)(B)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide activities to meet all resident's needs.</p> <p>30344</p> <p>Based on interview and record review, the facility failed to provide weekend activities, as preferred, for 2 of 4 residents reviewed for activities (Residents 13 and 71). This had the potential to affect 19 of 19 residents on the Reflections 1 Unit of the facility.</p> <p>Findings include:</p> <p>1. The clinical record for Resident 71 was reviewed on 12/4/24 at 12:30 p.m. Her diagnoses included, but were not limited to, dementia. She resided on the Reflections 1 Unit, a memory care unit, of the facility.</p> <p>The activities care plan, revised 3/11/24, indicated she had a cognitive deficit that required supervised activities with staff. She enjoyed painting, coloring, small group events, and bingo. A goal was to show engagement in activities of interest through the next review. Two of the interventions were to encourage attendance to entertainment programs, large and small group activities, volunteer demonstrations, and religious activities and to invite her to scheduled activities.</p> <p>2. The clinical record for Resident 13 was reviewed on 12/4/24 at 12:30 p.m. His diagnoses included, but were not limited to, heart failure. He resided on the Reflections 1 unit in a room with Resident 71.</p> <p>The activities care plan, revised 10/5/23, indicated he enjoyed small group activities. The goal was for him to show engagement in activities of interest through the next review. Three of the interventions were to encourage him to participate in music and memory programs; encourage attendance to entertainment programs, large and small group activities, volunteer demonstrations, and religious activities; and to provide activity materials of interest such as library books, word puzzles, and magazines.</p> <p>The 10/24/24 Quarterly Minimum Data Set (MDS) assessment indicated he was cognitively intact.</p> <p>An interview was conducted with Resident 13, on 12/4/24 at 12:31 p.m., in his room in the presence of Resident 71. He indicated the facility had no scheduled weekend activities, and he was bored with that. They had church service once a month on a weekend but would like to have it every Sunday.</p> <p>The December 2024 Reflections 1, Reflections 2, and Rosewood Units Activity Calendar was posted on the wall in the hallway outside of the dining room on the Reflections 1 Unit. It indicated the following weekend activities:</p> <p>Sunday, 12/1/24 - no activities scheduled, just a picture of candy canes,</p> <p>Saturday, 12/7/24 - Weekend Worksheet Packets,</p> <p>Sunday, 12/8/24 - Pics (Pictures) with Santa,</p> <p>Saturday, 12/14/24 - Weekend Worksheet Packets,</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Sunday, 12/15/24 - no activities scheduled, just a picture of holiday bells,</p> <p>Saturday, 12/21/24 - Weekend Worksheet Packets,</p> <p>Sunday, 12/22/24 - Weekend Worksheet Packets,</p> <p>Saturday, 12/28/24 - no activities scheduled, just a picture of a holiday mug, and</p> <p>Sunday, 12/29/24 - no activities scheduled, just a picture of gingerbread man.</p> <p>The Weekend Worksheet Packet for the Reflections 1 Unit was provided by the Infection Preventionist on 12/10/24 at 10:45 a.m. It included a stapled packet of four word searches and four coloring pages.</p> <p>An interview was conducted with Resident 13 and Resident 71 in their room on 12/10/24 at 11:27 a.m. Resident 13 looked over the Reflections 1 Weekend Worksheet Packet and indicated no one provided him this over the weekend. It looked familiar to him, but he hadn't received one of these for a long time. Resident 71 indicated she liked word searches and would do them if provided, preferably with Resident 13.</p> <p>An interview was conducted with Qualified Medication Aide (QMA) 5, who was working the Reflections 1 Unit, on 12/10/24 at 11:40 a.m. She indicated she sometimes worked the unit on weekends, and she'd seen coloring pages for residents before, but never a packet, nor had she seen anyone pass out a packet on the unit. She stated, Activities needs a lot of work.</p> <p>An interview was conducted with Certified Nursing Assistant (CNA) 6 and CNA 7 on 12/10/24 at 11:47 a.m. They indicated the facility needed more activities on the weekends. Activity staff were amazing, but only there Monday through Friday.</p> <p>On 12/9/24 at 12:16 p.m., an interview was conducted with Unit Manager (UM) 4, who managed the Reflections 1, Reflections 2, and Rosewood Units of the facility. She indicated there was a new Activity Director (AD) in the facility, who was working on having scheduled weekend activities. There used to be weekend packets for residents to do, that consisted of word searches, coloring, and some tactile simulations to pull out. The packet was different for each unit and not everyone received one. She occasionally worked on weekends and sometimes saw residents play Uno on the Reflections 1 Unit. On the Rosewood Unit, they watched a movie and had a snack or a game. None of it was scheduled and hadn't been in the past. She thought the facility was moving towards scheduled weekend activities.</p> <p>An interview was conducted with the AD on 12/9/24 at 2:02 p.m. She indicated she began working at the facility a week ago, and was told there were no weekend activities. There was church service the first Sunday of every month, but that was all she knew of on weekends. There was someone currently scheduled to be interviewed for weekends and evening activities.</p> <p>An interview was conducted with the Executive Director (ED) on 12/10/24 at 10:48 a.m. He indicated they were working on hiring someone for weekend activities.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The Activities Program policy was provided by the Infection Preventionist on 12/10/24 at 10:22 a.m. It indicated, It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents .Procedure: I. The activity program is .b. Scheduled daily and residents are given an opportunity to contribute to the planning, preparation, conducting, cleanup and critique of the program .f. Reflect the schedules, choices and rights of the resident i. Are offered at hours convenient to the residents, including holidays and weekends.</p> <p>3.1-33(a)</p> <p>3.1-33(c)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>45291</p> <p>Based on interview, observation, and record review, the facility failed to ensure Resident 36's indwelling urinary catheter remained free of contact with the floor while in bed for 1 of 2 residents reviewed for indwelling urinary catheters.</p> <p>Findings include:</p> <p>The clinical record for Resident 36 was reviewed on 12/4/2024 at 1:45 p.m. The medical diagnoses included obstructive uropathy.</p> <p>A Quarterly Minimum Data Set assessment, dated 11/22/2024, indicated Resident 36 utilized an indwelling urinary catheter, dependent on staff assistance for toileting needs, and dependent on staff for transferring regarding activities of daily living.</p> <p>During an observation on 12/4/2024 at 12:45 p.m., Resident 36 was in bed with his urinary catheter drainage bag laying on the floor.</p> <p>During an interview on 12/4/2024 at 1:30 p.m., Certified Nursing Assistant (CNA) 7 indicated urinary catheter drainage bags should remain free of contact with the ground.</p> <p>During an observation on 12/10/2024 at 10:45 a.m., Resident 36 was in bed with his urinary catheter drainage bag laying on the floor.</p> <p>A policy entitled, Catheter Care, was provided by the Executive Director on 12/10/2024 at 12:30 p.m. The policy indicated to ensure the collection bag is not on the floor .</p> <p>3.1-41(a)(2)</p>