| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155188 | A. Building<br>B. Wing | 01/09/2026 |

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

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>Based on observation, interview, and record review, the facility failed to provide showers as scheduled for 1 of 4 residents reviewed for Activities of Daily Living (ADLs). (Resident G)Findings include:The clinical record for Resident G was reviewed on 1/7/2026 11:46 a.m. The resident's diagnoses included, but were not limited to, weakness, depression, and nicotine dependence.The admission Minimum Data Set (MDS) assessment, dated 12/18/25, indicated Resident G was cognitively intact and used a wheelchair for ambulation.During an observation and interview with Resident G on 1/6/25 at 11:25 a.m., he indicated he had not had a shower for weeks and staff had just been cleaning him up when they were changing him in the bed. Resident G's hair was observed being shoulder length, greasy and tangled. Resident G indicated it was his fault and should have asked for one.During an observation of Resident G on 1/7/26 at 11:28 a.m., his hair appeared greasy and tangled. Resident G indicated no one had come in to ask him if he wanted a shower and he thought his shower days were Wednesdays and Saturdays.During an observation and interview with Resident G on 1/8/25 at 9:41 a.m., Resident G indicated no staff had come in to offer him a shower and that he just needed to tell them. The resident had a strong, sweaty, body odor and greasy tangled hair were observed.The Electronic Health Record (EHR) indicated Resident G had a shower documented on 12/31/25. No showers or any other type of bathing was documented in EHR from 1/1/26 through 1/8/25. The EHR indicated there were no refusals of showers documented for Resident G.A plan of care, dated 9/26/24, indicated Resident G had Activities of Daily Living (ADL) deficit related to weakness and impaired mobility. The interventions included, but were not limited to, the resident requiring substantial/maximal assistance with helper doing more than half of the effort and 2 or more helpers were required with shower transfers.During an interview with Licensed Practical Nurse (LPN) 2 on 1/8/26 at 1:20 p.m., they indicated they did not know why Resident G had not had a shower in over 7 days. LPN 2 indicated it should trigger on her dashboard on the computer if a refusal or no care was done, so that was how she knew a follow up was needed and she did not receive any documentation regarding Resident G not receiving showers. LPN 2 indicated it was herself, also the unit manager, who was responsible to ensure residents were offered and given showers as scheduled or as needed.A Routine Resident Care policy was provided by the Divisional Director of Risk (DDR) on 1/9/26 at 9:20 a.m. It indicated .to promote resident centered care by attending to the total medical, nursing, physical, emotional, mental, needs. 3. Unlicensed staff: b. Routine care by a nursing assistant included, but is not limited to the following: i. Assisting or provides for personal care 1. Bathing.vii. A. Observing and documenting all aspects of care. 3.1-38(a)(3) |

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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| F 0685<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Assist a resident in gaining access to vision and hearing services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to timely ensure vision services were provided for 2 of 2 residents reviewed for vision and hearing services. (Residents B and H)Findings include:<br><br>1.The clinical record for Resident H was reviewed on 1/6/26 at 10:37 a.m. Her diagnoses included, but were not limited to, photophobia, anxiety, and dementia. She was admitted to the facility on [DATE].<br><br>The Request For Service form, dated 7/7/25, signed by Family Member 4, indicated they would make alternate arrangements for eye care services.<br><br>The impaired visual function care plan, initiated 7/3/25, indicated an intervention was to arrange consultation with eye care practitioner as needed, initiated 7/3/25.<br><br>An interview was conducted with Family Member 4 on 1/6/26 at 12:49 p.m. She indicated Resident H had macular degeneration and needed to be seen by the eye doctor. She informed the MCUM (Memory Care Unit Manager) of this the other day. She also informed the unit's previous unit manager over two months ago and no one followed through with scheduling an appointment.<br><br>There were no progress notes or eye consultation notes in the clinical record to indicate Resident H was seen by the eye doctor or that an appointment was scheduled.<br><br>An interview was conducted with the SSD (Social Services Director) on 1/8/26 at 2:14 p.m. She indicated she was responsible for contacting the facility's eye care provider, if a resident needed to be seen. When a resident was admitted to the facility, she collected ancillary consent forms at their initial care plan meeting to be signed by the resident or their representative. Whether or not the resident wished to be seen by the eye doctor was revisited at each subsequent care plan meeting. She was not the SSD when Resident H was admitted to the facility in July, 2025.<br><br>She reviewed Resident H's electronic clinical record and indicated there were no eye care consultation notes for her. The facility's eye care provider was in the facility on the following dates: 11/17/25, 9/16/25, and 7/22/25. Resident H was not seen on any of those dates.<br><br>2. The clinical record for Resident B was reviewed on 01/07/2026 at 9:12 a.m. The resident's diagnoses included, but were not limited to, Bell's Palsy (sudden, temporary facial paralysis or weakness, usually on one side, caused by inflammation of the cranial nerve), cerebral aneurysm, and anxiety.<br><br>The Annual Minimum Data Set (MDS) assessment, dated 12/4/25, indicated Resident B was cognitively intact.<br><br>During an interview with Resident B on 1/5/26 at 1:48 p.m., they indicated they needed to be seen by the eye doctor. Resident B indicated their eyes were always bothering them, the resident always felt like something was in their eyes, they blinked a lot, and it was very painful. Resident B indicated she notified the nurse practitioner about it.<br><br>During an interview with Divisional Director of Risk (DDR) on 1/8/26 at 11:49 a.m., they indicated Resident B had not been seen by the eye doctor since 2022.<br>(continued on next page) |

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| F 0685<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A physician's order, dated 5/20/22, indicated Resident B could consult optometry services.<br><br>A plan of care, dated 9/2/25, indicated Resident B had impaired visual function related to Bell's Palsy and dry eyes.<br><br>During an interview with DDR on 1/9/26 at 9:30 a.m., they indicated the facility does not have a policy regarding ancillary services.<br><br>3.1-39(a)(b) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>Based on observation, interview, and record review, the facility failed to ensure a resident was seen by urology for 1 of 2 residents reviewed for catheter care. (Resident 111)Findings include: The clinical record for Resident 111 was reviewed on 01/07/2026 10:45 a.m. The resident's diagnoses included, but were not limited to, Spina Bifida (a birth defect where the spine and spinal cord don't close properly in early pregnancy) and obstructive and reflux uropathy (obstruction and backward flowing in the urinary tract). During an observation and interview with Resident 111 on 1/6/26 at 12:12 p.m., they indicated their urinary catheter always had a lot of sediment and the catheter leaks a lot due to it getting clogged up from thick sediment and bladder spasms. Resident 111 indicated they wake up two to three times a week needing a complete bed change because their catheter had leaked all over their bed due to being clogged. Resident 111's foley catheter tubing was observed with pale yellow urine with thick sediment. The Annual Minimum Data Set (MDS) assessment, dated 12/17/25, indicated Resident 111 was cognitively intact, had an indwelling catheter, and was always incontinent of urine. A plan of care, dated 1/16/23, indicated Resident 111 had an indwelling catheter related to obstructive uropathy and bladder spasms. A Telehealth progress note, dated 11/22/25, indicated Resident 111 had been seen for foley leaking. Per the nurse the resident had multiple episodes of catheter leaking when having bladder spasms. A urology consult was placed for assessment. A physician's order, dated 11/22/25, indicated for the resident to have a urology consult. A progress note, dated 12/23/25, indicated Resident 111 was seen for a follow-up positive urinalysis and was being sent for a urology consult. The Electronic Health Record (EHR) indicated no follow up was recorded until 1/6/26 at 9:51 a.m. A nurse's note indicated phoned urology for consult. During an interview with the Divisional Director of Risk (DDR) on 1/8/26 at 11:12 a.m., they indicated the urology order was placed 11/22/25, the facility faxed over the initial referral and face sheet, then we called urology. DDR indicated urology had them leave their name and number for a call back, but they never returned the call. The DDR indicated there was no documentation in the EHR until two days ago for the appointment to be made again and followed up on. During an interview with the Director of Nursing (DON) on 1/9/26 at 10:41 a.m., she indicated the unit manager was responsible to follow up on any consults made for residents. A Catheter Care policy was provided by DDR on 1/9/26 at 9:20 a.m. It indicated .It is the policy of this facility to provide resident care that meets the psychological, physical, and emotional needs and concerns of the residents. 3.1-41(a)(2) |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate pain management for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to accurately transcribe admission order for Resident D, have pain medication available as ordered for Resident D, and failed to address pain for Resident H for 2 of 2 residents reviewed for pain control.Findings include:1 The clinical record for Resident D was reviewed on 1/7/2026 at 11:41 AM. The resident's diagnoses included, but were not limited to, chronic pain and respiratory failure.<br><br>An admission Minimum Data Set Assessment, dated 12/25/2025, indicated that Resident D was cognitively intact, utilizes routine and as needed pain medication, and experienced pain occasionally.<br><br>A care plan, dated 12/22/2025, indicated Resident D had chronic pain. The interventions included, but were not limited to, attempt non-pharmacological interventions, pharmacological interventions, and to report pain to the physician.<br><br>During an interview with Resident D, on 1/6/2025 at 11:15 AM, the resident indicated when he first admitted to the facility in December of 2025 there was an issue with getting his pain medication as prescribed. Resident D denied having severe uncontrolled pain during that timeframe. Discharge orders used for admitting orders to the facility for Resident D, dated 12/18/2025, indicated the resident took methadone three times a day routinely.<br><br>The medication administration record reflected a physician's order for Resident D, dated 12/18/2025, of methadone three times a day as needed for pain. No routine order for methadone was added on 12/18/2025.<br><br>A physician's order, dated 12/19/2025, indicated Resident D to receive methadone three times a day as ordered.<br><br>Review of the December 2025 Medication Administration Record indicated Resident D did not receive 15 scheduled doses of methadone for a reason of medication unavailable or was left blank.<br><br>During an interview, on 1/8/2026 at 9:57 AM, LPN 2 indicated the facility has had issues getting methadone and similar medications for residents.<br><br>During an interview, on 1/9/2026 at 12:43 PM, the DRR indicated it was the responsibility of the admitting nursing staff to assure the accuracy of admission orders. The nursing management team then conducts an additional review on the next business day. It was the expectation the nursing staff would notify the physician for unavailable medications. For Resident D, the medical director had not filled out the prescription correctly for methadone. The on-call provider was notified on 12/20/2025 and they had written a script on 12/21/2025, but it was not delivered until 12/22/2025.<br><br>A policy entitled, Notification of Change of Condition, was provided on DRR on 1/9/2026 at 9:50 AM. The policy indicated, .It is the policy of the facility to provide resident centered care that meets the psychological, physical, and emotional needs, concerns of the residents.<br><br>2. The clinical record for Resident H was reviewed on 1/6/26 at 10:37 a.m. Her diagnoses included, but were not limited to, dementia, contusion of rib, and multiple fractures of rib, right side.<br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The pain care plan, revised 12/10/25, indicated to administer non-pharmacological interventions and evaluate the effectiveness of interventions, initiated 7/4/25; and to provide medication per orders and evaluate effectiveness of medication, initiated 7/4/25.<br><br>The 12/7/25 post fall evaluation, completed by RN (Registered Nurse) 5, indicated she experienced an unwitnessed fall on 12/7/25 at 9:45 a.m. The family/responsible party was notified of the fall on 12/7/25 at 9:55 a.m. The Pain/Skin section of the evaluation indicated she complained of pain on the right side of her back that was new to her. She was able to verbalize her pain level as a 5 on a scale of one to ten. Resident H described her pain as an ache and heavy. The evaluation did not indicate how Resident H's pain level of five was addressed.<br><br>The physician's orders indicated to administer two 325 mg acetaminophen tablets by mouth three times a day for pain, starting 9/11/25. They indicated to administer two 325 mg tablets of acetaminophen by mouth every six hours as need for pain/fever, starting 9/11/25. There was no other as needed pain medication order in place when Resident H fell on [DATE] at 9:45 a.m.<br><br>The December, 2025 MAR indicated the first regularly scheduled acetaminophen administration was administered in the morning on 12/7/25 for a pain level of three. There were no as needed administrations of acetaminophen administered on 12/7/25.<br><br>The 12/7/25, 9:45 a.m., 10:00 a.m., 10:15 a.m., 10:30 a.m., 10:45 am., and 11:00 a.m., neurological assessments did not reference pain levels.<br><br>The vitals section of the electronic health record included only one pain assessment on 12/7/25 prior to Resident H being sent to the hospital. It was a level of 3 in correlation with the regularly scheduled acetaminophen administration.<br><br>The 12/7/25, 1:18 p.m. nurse's note, written by RN 5, indicated, res had unwitnessed fall in the morning [sic] with back hurts and a scratch on her ryt [sic] back and complains she feel pain when she takes breath her family notified and also DON [Director of Nursing] due to her family requested resident sent to ER with family for further evaluation. The note did not indicate any as needed pain medication was administered or any nonpharmacological interventions were implemented.<br><br>RN 5 was not available for interview, as she was out of the country, and unable to be reached by telephone.<br><br>On 1/8/26 at 2:03 p.m., an interview was conducted with CNA (Certified Nursing Assistant) 6, who found Resident H on the floor in her room on 12/7/25 at 9:45 a.m. after she fell. She indicated she was walking down the hall and saw Resident H sitting on the floor in her room with her back against her bathroom door. CNA 6 called for RN 5 to come down to the room. They both remained in the room for a while after assisting her up and into her chair. After getting her into her recliner, Resident H informed RN 5 that her rib cage was sore. CNA 5 was unsure how RN 5 addressed the pain. CNA 5 did not witness any administrations of pain medication to Resident H.<br><br>The post fall evaluation, dated 12/7/25, completed by RN 5, indicated the physician was notified of the fall on 12/7/25 at 1:47 p.m. The content of discussion with physician section indicated, unwitnessed fall with no injury res. [resident] complain back hurts and abrasion noted on her right side of back transfer to ER due to family requested.<br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An interview was conducted with Family Member 5 on 1/6/26 at 12:52 p.m. She indicated when Resident H fell on [DATE], Family Member H arrived at the facility within an hour of being notified. Upon arrival, Resident H was crying and complaining of pain on her right side. Family Member 5 insisted Resident H be sent to the emergency room.<br><br>The nurse's note, dated 12/7/25 at 5:37 p.m., written by the DON indicated Resident H was transported to the emergency room at approximately 1:15 p.m. on 12/7/25.<br><br>The 12/7/25 emergency department note indicated Resident H was seen by a provider at 1:36 p.m. on 12/7/25. She reported right rib and right abdominal pain, which was exacerbated by breathing. There was tenderness to palpation of the right ribs and abdomen. The discharge problem was contusion of rib and fracture of rib.<br><br>The nurse practitioner note, dated 12/8/25, indicated she had a fall that resulted in an ER visit. Hospital found the patient has rib fracture of 8, 9, and 10.<br><br>An interview was conducted with the DDR (Divisional Director of Risk) on 1/9/26 at 10:40 a.m. She indicated they had no verification Resident H's pain level of 5 on 12/7/25 was addressed. All they had was the December, 2025 MAR to verify she received her regularly scheduled acetaminophen for her pain level of three that morning.<br><br>The Pain Management and Assessment policy was provided by the DDR on 1/8/26 at 12:00 p.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. Safety is a primary concern for our residents, staff and visitors. The purpose of this policy is to provide guidance to the clinical staff to support the intent of 483.25 (k) that based on the comprehensive assessment of a resident, the facility must ensure that residents receive the treatment and care in accordance with professional standards of practice, the comprehensive care plan, and the resident's choices, related to pain management. There is no objective test that can measure pain. The clinician must accept the resident's report of pain. Clinical observations clarify information from the resident. Site of discomfort may direct the nurse to specific types of pain-relief measures. Break-through Pain Management.b. Pain that is above the routine pain and requires interventions along with the current pain management regime. c. May require, on occasion, adjuvant therapies including pharmacological and non-pharmacological interventions for enhancing pain relief .Documentation a. Medication pain relief and response. b. Non-pharmacological measures attempted and the resident response.<br><br>This citation relates to Intake 2661565.<br><br>3.1-37(a) |

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| F 0806<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide a substitute at lunch as requested by the resident for 1 of 1 residents reviewed for nutrition (Resident 70).Review of the clinical record of Resident 70 on 1/07/2026 11:55 a.m., indicated the resident's diagnoses included, but were not limited to, vascular dementia, cerebral vascular disease, major depression disorder, adult failure to thrive and hypertension. The food preference assessment for Resident 70, dated 11/21/25, indicated the resident typically consumed salads. The resident requested salads for breakfast, lunch and dinner. The resident also liked fruit, chocolate milk, eggs, cheese, potatoes, fish, grilled cheese and peanut butter and jelly sandwiches. The Registered Dietician assessment for Resident 70, dated 11/26/25, indicated the resident Body Mass Index (BMI) was 15.9 indicating the resident was underweight. The resident did not have signs of of a swallowing disorder, oral/mouth problems and did not utilize adaptive eating equipment. The resident was not on a prescribed physician weight loss regimen. The resident's current body weight required increased nutrition to promote weight gain. The resident was malnourished. The care plan for Resident 70, dated 11/25/25, indicated the resident had protein calorie malnutrition, adult failure to thrive, dysphagia, vitamin b12 deficiency, iron deficiency anemia, Body Mass Index (BMI) underweight. The interventions included, but were not limited to, offer substitutions if provided meal was declined. The admission Minimum Data (MDS) assessment for Resident 70, dated 11/28/25, indicated the resident was severely impaired for daily decision making. The resident required set up only for eating. The physician recapitulation for Resident 70, dated January 2026, indicated the resident was ordered lacto-Ovo Vegetarian diet (excludes meat, but includes dairy and eggs diet), dysphagia advanced diet (moist and tender food) and thin liquids consistency. During an interview with Resident 70's family on 1/06/2026 at 10:32 a.m., the family member indicated the resident required more protein. The resident liked salads, but also liked eggs, fish and cream of wheat. The facility needed to offer the resident more choices to ensure she was receiving enough protein. During an interview with Resident 70, on 1/07/2026 at 1:09 p.m., she indicated she did not eat her salad for lunch today because she wanted something else. The resident indicated she wanted spaghetti with sauce. The resident asked the staff for spaghetti with sauce and was told the facility did not have it. The resident described the staff member she requested the substitute from. During an interview with CNA 1, on 1/7/26 at 1:18 p.m., the CNA indicated Resident 70 did request spaghetti with pasta sauce for lunch and she told the resident that the facility did not have that. CNA 1 indicated the resident only drank chocolate milk for lunch. During an interview with the Dietary Manager [NAME] on 1/8/26 at 11:40 a.m., she indicated she was not aware of a staff member requesting spaghetti and sauce for Resident 70 yesterday. The Dietary Manager verified with the dietary staff that the staff did not request spaghetti and sauce yesterday for lunch for Resident 70. The Dietary Manager indicated the facility had several substitutes at meal time. The Dietary Manager indicated the dietary department did have spaghetti and sauce available and would have made Resident 70 spaghetti and sauce yesterday if they had been aware after the main meal was completed. During an interview with the Regional Director of Clinical Operations on 1/9/26 at 10:42 a.m., indicated the facility did not have a policy for food substitutions, but there were several substitutions available daily. 1.3-21(a)(4) |