STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155193	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenwood Healthcare Center	377 Westridge Blvd Greenwood, IN 46142

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44849 Based on observation, interview, and record review, the facility failed to provide supervision to prevent a resident that resided on a secured memory care unit and was to be receiving one to one staff supervision for exit seeking behavior, from exiting the secured memory care unit through a window in another resident's room. The resident was found by staff approximately 2 miles from the facility. (Resident B) The Immediate Jeopardy began on April 27, 2025, when Resident B exited the secured memory care unit through another residents window. The Administrator, Regional Nurse, and Assistant Director of Nursing were notified of the Immediate Jeopardy on May 6, 2025 at 2:00 p.m. The Immediate Jeopardy was removed, and the deficient practice corrected, on 4/28/25, prior to the start of the survey and was therefore Past Noncompliance. Finding includes: On 5/6/25 at 8:32 a.m., observed Resident B's room. Just past the door and to the left was the restroom. CNA 1 was sitting in a chair just past the restroom. The privacy curtain was pulled around bed A (closest to the door). Resident B was lying in his bed sleeping. His bed was observed to be next to the window (bed B). At that time, CNA 1 indicated Resident B was on one-to-one staff supervision. Resident B was not in her line of site because she was trying to give him privacy due to behaviors. On 5/6/25 at 8:39 a.m., observed the Secured Memory Care Unit 1 secured courtyard area just outside the memory care dining room. The door to enter the secured courtyard was located in the dining room and was unlocked by typing in a code. The courtyard was surrounded by an approximately 6-foot privacy fence with a door that was also secured with a code to unlock. There was a wooden swing and a heavy wrought iron table in the middle of the courtyard. At that time, Activity Director 1 indicated it was her understanding that Resident B took the screws out of the window in a room next to the courtyard, then opened the window and climbed out to the courtyard. Once Resident B was in the courtyard, he used a chair to climb over the fence, so Activity Director 1 removed the furniture from the courtyard. (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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 5/6/25 at 9:30 a.m., the Assistant Director of Nursing (ADON) indicated Resident B was to be receiving one-to-one staff supervision at the time he climbed out the window and left the facility without staff knowledge. Resident B was to be receiving one-to-one staff supervision because he had requested to sign out for a leave of absence some time ago. Resident B was found by staff approximately 2 miles from the facility. The clinical record for Resident B was reviewed on 5/6/25 at 9:39 a.m. The diagnoses included, but were not limited to, dementia, alcohol abuse, and frontotemporal neurocognitive disorder. An Admission Evaluation, dated 12/6/24, indicated Resident B did not have a history of elopements. A Progress Note, dated 12/6/24 at 3:40 p.m., indicated Resident B was admitted to the secured memory care unit 1. Resident B was unhappy about being at the facility and wanted family to come get him. A care plan, dated 12/6/24, indicated Resident B was at risk for elopement related to frontotemporal lobe dementia. The interventions included, but were not limited to, complete a wandering evaluation upon admission, re-admission, quarterly, and as needed (dated 12/6/24) and provide diversionary activities as needed (dated 12/6/24). A care plan, dated 12/12/24, indicated Resident B required a secured unit related to elopement risk and poor cognition. The interventions included, but were not limited to, evaluate for the need of a secured unit (dated 12/12/24) and notify the medical provider and Resident B's representative of behavior changes (dated 12/12/24). A Quarterly Minimum Data Set (MDS) assessment, dated 2/20/25, indicated Resident B had no cognitive impairment. A progress note, dated 2/1/25 at 1:42 p.m., indicated Resident B got out of the building after he was told the door code by one of the other residents. Resident B wanted to leave with his parents after visiting, but his parents refused so he got out on his own. Resident B was accompanied by two staff members while outside the building. Staff tried to encourage him to come in the building. Resident B was finally persuaded to come back in the building after his parents had left, but he would not stop talking about how he intended to leave the building. A progress note, dated 2/8/25 at 10:30 a.m., indicated the writer received a phone call from a CNA who was with Resident B at a grocery store. The CNA reported that Resident B refused to sign the leave of absence book before going to the store. The CNA reported Resident B was unwilling to get back into the car with the CNA to return to the facility. The writer met the CNA and Resident B at the grocery store and Resident B stated he wanted a 2 liter of soda which was purchased. Resident B willingly got into writer's car and returned to facility without incident. Resident B remained his own responsible party and was educated on signing out for a leave of absence. Resident B was not receptive to education on the leave of absence process and was placed on one-to-one staff supervision to ensure that he was safe if attempting to leave the facility for a leave of absence. A Wander Observation Tool, dated 3/7/25 at 2:22 p.m., indicated Resident B was not accepting of the current living environment. Resident B's family/responsible party voiced concern that he might try to leave and had a history of elopement. Resident B was at risk for elopement. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A Letter of Guardianship, dated 3/12/25, indicated Resident B was an incapacitated adults and granted guardianship to family members. A progress note, dated 4/27/25 at 3:00 p.m., indicated evening one-to-one staff reported to Secured Memory Care Unit 1 and Resident B was unable to be found. A window in another residents room was found to be open with the screen out and a screws securing the window were unscrewed and lying on the window seal. The window lead out to a secured courtyard. A chair was pushed up against the fence and appeared that Resident B had climbed over the fence. Facility initiated head count and found Resident B to be the only resident not to be in his room or in the facility. The police and staff returned to facility with Resident B. During an interview on 5/6/25 at 10:01 a.m., the Regional Nurse indicated the staff that was to be providing the one-to-one supervision had been told to perform other work duties for other residents due to call offs. On 5/6/25 at 10:10 a.m., the ADON provided a copy of a timeline of events when Resident B exited the facility through the window, on 4/27/25. A review of the timeline indicated: - At approximately 1:40 p.m., Resident B was seen at nurse's station. - At 2:20 p.m., the CNA arrived on the Secured Memory Care Unit 1 and could not locate Resident B. - A window in another resident's room was found to be open with the screen pushed out to the courtyard. - At 2:50 p.m., a staff member found Resident B approximately 2 miles from the facility at a fire station on a busy main road. Resident B refused to return to facility with staff. - At approximately 2:56 p.m., the ADON arrived at Resident B's location and Resident B refused to return with the ADON. - At approximately 3:00 p.m., a staff member contacted the police. - At approximately 3:08 p.m., police arrived at Resident B's location. - At approximately 3:10 p.m., the Director of Nursing (DON) arrived at Resident B's location. - At approximately 3:30 p.m., Resident B was returned to the facility by the police. During an interview on 5/6/25 at 1:03 p.m., CNA 2 indicated, on 4/27/25, she was scheduled to do one-to-one staff supervision with Resident B for day shift, but when she arrived to work she was asked to perform her normal work duties with other residents on the Secured Memory Care Unit 1. Resident B was not on one-to-one supervision, on 4/27/25 during day shift. CNA 2 left the facility before Resident B exited the facility through the window on evening shift. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 5/6/25 at 1:10 p.m., Qualified Medication Aide (QMA) 1 indicated Resident B normally displayed exit seeking behaviors. Resident B would case other resident's rooms and try to watch visitors type in the codes to unlock the doors. On 4/27/25 from 6:00 a.m. until 2:00 p.m., Resident B was to be receiving one-to-one staff supervision with CNA 2, but CNA 2 was asked to perform her normal work duties with other residents on the secured memory care unit. Resident B did not receive one-to-one staff supervision during the day shift. Resident B was upset because a lighter had been removed from his room. QMA 1 last saw Resident B standing at the nurse's station, on 4/27/25 at approximately 1:40 p.m. QMA 1 was unaware that Resident B exited the facility until approximately 2:20 p.m., when CNA 3 reported to QMA 1 that she could not locate Resident B. Resident B was located by staff and returned to the facility with the ADON. Resident B told staff he left the facility because it was too easy. Resident B exited the facility approximately 3 months ago, on a weekend, through the window in his own room. QMA 1 could not remember the details of that incident. On 5/6/25 at 1:43 p.m., observed Resident B's door to be shut and CNA 4 standing in the hallway. Resident B was sitting on his bed in his room with no staff present in the room. At that time, CNA 4 indicated Resident B should have been receiving one-to-one supervision. On 5/6/25 from 2:10 p.m. until 2:30 p.m., observed the likely path Resident B walked when he exited the facility and was found approximately 2 miles away. Resident B climbed out a window of another resident's room. The window lead to a secured courtyard with a privacy fence approximately 6 feet tall. Resident B placed a chair against the fence near the fence's door and climbed over the fence. Once over the fence there was a small sidewalk that lead around the facility and large grassy field surrounded by trees with a residential neighborhood just past the trees. Approximately 200 yards from the courtyard was a residential street with well-kept sidewalk on each side. Once in the residential neighborhood the roads were windy, and [NAME] like with speed limit of 25 miles per hour. After approximately 1.8 miles the road through the residential neighborhood met a busy main road with no sidewalk on the south side of the road and on the north side just past the road the land slopes down approximately 10 feet to an asphalt sidewalk. The sidewalk led to a driveway and then the fire station where Resident B was located. During an interview on 5/7/25 at 8:14 a.m., Resident B indicated he exited the facility through a window across the hall, climbed over the privacy fence in the courtyard, walked toward the woods at the back of the facility, and through the neighborhood to where the staff located him. Resident B did not remember removing any screws from the window. Resident B also remembered walking alone to a grocery store a few months ago. Resident B was able to open the memory care door by entering the code into the secured unit exit door and then he pushed on the service door and walked out. The service door was (Resident B accurately pointed in the direction of the service door) that way. Then he walked through the parking lot and down the street to the grocery store. During an interview on 5/7/25 at 9:40 a.m., CNA 4 indicated when she came to work, on 4/27/25 at approximately 2:00 p.m., she was not made aware that the staff for the day shift one-to-one supervision was asked to do general work duties with the other residents. CNA 4 was not aware there was no staff with Resident B. When CNA 3 came to the unit, she said she couldn't locate Resident B, and staff started looking for him. Resident B had been on one-to-one supervision for a couple months after he exited the facility through the window in his room and walked to the grocery store approximately 1.0 miles from the facility. CNA 4 was not at work when Resident B exited through the window in his room, but she received the information in report when she came in to work the day that happened. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 5/6/25 at 9:30 a.m., the Administrator provided a copy of an undated facility policy, titled Elopement Prevention and Management Overview, and indicated this was the current policy used by the facility. A review of the policy indicated an elopement is when a resident leaves the premises or a safe area without authorization or necessary supervision. The past noncompliance Immediate Jeopardy began on 4/27/25. The Immediate Jeopardy was removed and the deficient practice corrected by 4/28/25 after the facility implemented a systemic plan that included the following actions: audits of elopement evaluations and care plans, inservicing staff on elopement procedures and one-to-one staff supervision, and ongoing monitoring. This citation relates to Complaint IN00458484. 3.1-45(a)(2)