

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

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155193	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2026
NAME OF PROVIDER OR SUPPLIER Greenwood Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. Based on interview and record review, the facility failed to ensure a resident's oxycodone (narcotic pain medication) was accounted for after the medication had been delivered for 1 of 3 residents reviewed for misappropriation of property. (Resident B) The deficient practice was corrected on June 12, 2026, prior to the start of the survey, and was therefore past noncompliance. Findings include: During an interview on 7/23/26 at 9:48 a.m., the Director of Nursing (DON) indicated, on 6/9/26 at approximately 6:00 a.m., she had been notified that two packets of 30 oxycodone (narcotic pain medication) 10 milligrams (mg) tablets (60 tablets in total) had been delivered the day before, but there was only one packet of 30 tablets left in the locked narcotic box. The oxycodone 10 mg tablets were delivered on 6/8/26. Resident B's oxycodone 10 mg tablets were accepted and signed for by Licensed Practical Nurse (LPN) 1. Two packets of Resident B's oxycodone 10 mg and two folded narcotic count sheets were wrapped together with a rubber band and were taken to RN 1 who had been caring for Resident B that day. When the night shift Qualified Medication Aide (QMA) came to work for third shift the narcotic count was reconciled as usual and Resident B had only one narcotic count sheet and only one packet of oxycodone. At some time during the early morning hours, on 6/9/26, the QMA noticed the number at the top of the narcotic count sheet indicated 60 tablets had been delivered but had been marked over with black ink with the number 30. When the DON interviewed RN 1, first she admitted that she had used a black sharpie to change the number of tablets but then said she felt like she had been pressured when she said that and never admitted to diverting any medications. RN 1 quit over the phone. During an interview on 7/23/26 at 1:46 p.m., LPN 1 indicated on 6/8/26, she had signed for two packets of 30 tablets of oxycodone 10 mg for Resident B. LPN 1 took Resident B's oxycodone 10 mg tablets to RN 1 and RN 1 walked down the hall to her cart. LPN 1 did not witness RN 1 put the oxycodone in the locked narcotic box on the medication cart. LPN 1 received a message on her phone that the night shift QMA noticed the number of tablets delivered had been written over and changed the number from 60 tablets to 30 tablets and there was only one narcotic count sheet instead of two. That morning on 6/9/26, LPN 1 came into work and asked RN 1 why the numbers were drawn over, she didn't really respond and grabbed her things and left work. The clinical record for Resident B was reviewed on 7/23/26 at 10:02 a.m. The diagnoses included, but were not limited to, multiple sclerosis, pressure ulcer, and diabetes. A Physician's Order, started on 3/27/25, indicated oxycodone 10 mg, administer two tablets by gastric tube every four hours as needed for pain. There was no discontinue date noted. A Controlled Substance Administration Record, dated 6/8/26, indicated, prescription number *****, two packets of 30 tablets of oxycodone 10 mg for Resident B were received by RN 1 as indicated by the signature at the top of the document. Under RN 1's signature box was another box that indicated amount received and indicated 30 in thick black ink. The label on the document indicated quantity 30 of 60 tablets with a line drawn through 60 and 30 written on the label. A pharmacy packing slip, dated 6/8/26, indicated Resident B, prescription (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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	number *****, two packets of 30 tablets (60 tablets total) oxycodone 10 mg were delivered on 6/8/26, and signed for by LPN 1. On 7/24/26 at 10:38 a.m., the Administrator provided a copy of a transcribed phone interview with RN 1, the Regional Director of Nursing (RDCO), and the Administrator, dated 6/8/26, and indicated it was the transcribed interview with RN 1 regarding Resident B's missing oxycodone. A review of the interview indicated RN 1 admitted to using a black sharpie to change the number of cards delivered from two to one because she had only received one card of 30 tablets. RN 1 denied taking any medications. On 7/23/26 at 9:27 a.m., the DON provided a copy of an undated facility policy, titled Abuse and Neglect and Misappropriation of Property, and indicated this was the current policy used by the facility. A review of the policy indicated it was the intent of the facility to prevent misappropriation of property. This deficient practice was corrected on June 12, 2026, after the facility implemented a systemic plan that included the following actions: staff education on narcotic pain medication reconciliation and ongoing monitoring. This citation relates to Intake 3039358.410 IAC (Indiana Administrative Code) 16.2-3.1- 28(a)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, and record review, the facility failed to ensure a physician's order for nephrostomy tube (a tube inserted through the skin of the lower back and advanced into the kidney to drain urine) site care was clarified for 1 of 3 residents reviewed for tube site care. (Resident C) Findings include: During an interview on 7/23/26 at 1:18 p.m., Registered Nurse (RN) 2 indicated Resident C has a nephrostomy tube on each side of the lower back. The facility provided nephrostomy site care when they were soiled or no longer secured. Each drainage bag had been emptied and measured each shift. Resident C had refused to allow staff to change the nephrostomy tube site dressings in the past and the physician had been notified. During an interview on 7/23/26 at 1:29 p.m., Resident C indicated the staff check in on him so often that he had to tell them to stop. The staff cared for his nephrostomy tube site dressings the way the doctor told him to care for them. Resident C's doctor told him that the nephrostomy dressings were to have been changed when soiled or when the dressings were no longer secured in place. Resident C had explained this to staff several times. The nurses had changed the nephrostomy tube site dressings in the past because they were loose. The clinical record for Resident C was reviewed on 7/23/26 at 3:54 p.m. The diagnoses included, but were not limited to, artificial opening of the urinary tract, quadriplegia, and respiratory failure. A Quarterly Minimum Data Set (MDS) assessment, dated 4/30/26, indicated Resident C was not cognitively impaired and had rejected care. A care plan, dated 10/29/25, indicated Resident C had nephrostomy tubes. Interventions included, but were not limited to, change nephrostomy site dressing per physician's order. A Physician's Order, started on 10/23/25, indicated cleanse nephrostomy tube site with soap and water and cover with sterile dressing. The order was not routinely scheduled. There was no discontinue date noted. During an interview on 7/23/26 at 4:58 p.m., RN 3 indicated the physician's order, dated 10/23/25, for Resident C's nephrostomy site care should have been clarified. On 7/24/26 at 9:00 a.m., RN 1 assisted Resident C to his right. A nephrostomy tube was observed on the lower right and left sides of Resident C's back. Each dressing was clean, secured in place, and dated 7/23/26. On 7/24/26 at 10:08 a.m., the Director of Nursing (DON) provided a copy of an undated facility policy, titled Plan of Care Overview, and indicated this was the current policy used by the facility. A review of the policy indicated the facility will review and update the plan of care quarterly or with a change. This citation relates to Intake 3073585.410 IAC (Indiana Administrative Code) 16.2-3.1 -35(g)(1)		