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	08/12/2024

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 38312 Based on observation, interview, and record review, the facility failed to ensure a resident could self-administer medication for 1 of 1 randomly observed resident (Resident 38). Finding include: On 8/7/24 at 2:41 p.m., Resident 38 was observed to be resting in her bed. A bottle of Tums (antacid) was observed to be on her bedside table. On 8/8/24 at 11:15 a.m., Resident 38 was observed to be resting in her bed. A bottle of Tums was observed to be on her bedside table. On 8/12/24 at 10:58 a.m., Resident 38 was observed to be resting in bed with a bottle of Tums lying in bed beside her. On 8/12/24 at 11:37 a.m., Resident 38's clinical record was reviewed. The diagnoses included, but were not limited to, end stage renal disease (ESRD) and gastro-esophageal reflux disease (GERD). The Self Administration of Medication Assessment, dated 10/14/22 at 12:20 p.m., indicated Resident 38 could administer Halls throat lozenges. The Order Summary Report, dated 8/12/24, lacked a physician order for Tums or to self-administer medication. The care plan lacked a care plan to self-administer medication. During an interview on 8/12/24 at 11:46 a.m., LPN 1 indicated if a resident wanted to self-administer medication at bedside, a self-administer medication assessment would need to be completed. During an interview on 8/12/24 at 4:00 p.m., the Director of Nursing (DON) indicated Resident 38's clinical record lacked a recent self-administer medication assessment. She would need one to administer medication at bedside. (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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/12/24 at 4:15 p.m., the DON provided the facility's policy, Resident Self-Administration of Medications, undated, and indicated it was the policy being used by the facility. A review of the policy indicated, .a. Resident may not self-administer medications until the assessment is completed by the IDT [interdisciplinary team] team and determined to be safe to do so . 3.1-11(a)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 50647 Based on record review and interview, the facility failed to ensure the written notification required for a transfer and discharge was provided to the resident and/or the resident representative for 4 of 4 residents reviewed for hospitalization and discharge. (Resident 96, Resident 148, Resident 145, and Resident 160) Findings include: 1. On 8/9/24 at 1:00 p.m., Resident 96's clinical record was reviewed. The diagnoses included, but were not limited to, opioid dependence and acute respiratory failure with hypoxia (an absence of enough oxygen in the tissues to sustain bodily functions). Residents 96's transfer forms indicated the resident was sent to the hospital on 5/12/24 and 6/23/24. The clinical record lacked documentation of written Notice of Transfer and Discharge forms having been provided to the resident and/or the resident representative. 2. On 8/12/24 at 2:27 p.m., Resident 148's clinical record was reviewed. The diagnoses included, but were not limited to, asthma, tracheostomy (procedure to help air and oxygen reach the lungs by creating an opening into the trachea (windpipe) from outside the neck), dependence on respirator/ventilator (a machine that helps you breathe or breathes for you), acute and chronic respiratory failure with hypoxia, and gastrostomy (creation of an artificial external opening into the stomach for nutritional support) status. Residents 148's transfer form indicated the resident was sent to the hospital on 5/30/24. The clinical record lacked documentation of written Notice of Transfer and Discharge forms having been provided to the resident and/or the resident representative. 38312 3. On 8/12/24 at 11:17 a.m., Resident 145's clinical record was reviewed. The diagnoses included, but were not limited to, pressure ulcer and osteomyelitis (bone infection). A Progress Note, dated 7/30/24 at 4:33 p.m., indicated Resident 145 was transferred to the hospital for worsening of a wound. The clinical record lacked documentation of written Notice of Transfer and Discharge forms having been provided to the resident. During an interview on 8/12/24 at 3:55 p.m., the Director of Nursing (DON) indicated they did not have a written notification of the Transfer and Discharge forms provided to the resident. 35318 4. Resident 160's clinical record was reviewed on 8/12/24 at 3:02 p.m. The diagnosis included, but was not limited to, encephalopathy. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 160's progress notes indicated the resident was sent to the hospital on 6/5/24 and 7/17/24. The clinical record lacked documentation of written Notice of Transfer and Discharge forms having been provided to the resident and the resident's representative. During an interview on 8/12/24 at 11:50 a.m., the DON indicated there had been no documentation of the Notice of Transfer or Discharge forms having been provided to the resident and/or the resident representative for Resident 96, Resident 148, Resident 145, and Resident 160. On 8/12/24 at 4:00 p.m., the Director of Nursing provided the facility's policy,Transfer and Discharge Policy undated, and indicated it was the policy currently being used by the facility. A review of the policy indicated, . 4. A letter containing admission/discharge/transfer and appeal rights will be discussed with the resident or responsible party and will be mailed to them as soon as practical . 3.1-12(a)(6)(A)(i) 3.1-12(a)(6)(A)(iii)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 50647 Based on interview and record review, the facility failed to ensure the notification of the bed-hold policy required for a resident who transferred to the hospital was provided in writing to the resident or the resident representative for 4 of 4 residents reviewed for hospitalization and discharge. (Resident 96, Resident 148, Resident 145, and Resident 160) Findings include: 1. On 8/9/24 at 1:00 p.m., Resident 96's clinical record was reviewed. The diagnoses included, but were not limited to, opioid dependence and acute respiratory failure with hypoxia (an absence of enough oxygen in the tissues to sustain bodily functions). Residents 96's transfer forms, indicated the resident was sent to the hospital on 5/12/24 and 6/23/24. The clinical record lacked documentation of written notification of the bed-hold policy having been provided to the resident or the resident representative. 2. On 8/12/24 at 2:27 p.m., Resident 148's clinical record was reviewed. The diagnoses included, but were not limited to, asthma, tracheostomy (procedure to help air and oxygen reach the lungs by creating an opening into the trachea (windpipe) from outside the neck), dependence on respirator/ventilator (a machine that helps you breathe or breathes for you), acute and chronic respiratory failure with hypoxia, and gastrostomy (creation of an artificial external opening into the stomach for nutritional support). Residents 148's transfer form, indicated the resident was sent to the hospital on 5/30/24. The clinical record lacked documentation of written notification of the bed-hold policy having been provided to the resident or the resident representative. 38312 3. On 8/12/24 at 11:17 a.m., Resident 145's clinical record was reviewed. The diagnoses included, but were not limited to, pressure ulcer and osteomyelitis (bone infection). A Progress Note dated, 7/30/24 at 4:33 p.m., indicated Resident 145 was transferred to the hospital for worsening of wound. The clinical record lacked documentation of written notification of the bed-hold policy having been provided to the resident. During an interview on 8/12/24 at 3:55 p.m., the Director of Nursing (DON) indicated they did not send the bed hold policy with the resident when they went to the hospital. 35318 (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Resident 160's clinical record was reviewed on 8/12/24 at 3:02 p.m. The diagnosis included, but was not limited to, encephalopathy. Resident 160's progress notes indicated the resident was sent to the hospital on 6/5/24 and 7/17/24. The clinical record lacked documentation of written notification which specified the facility's bed-hold policy having been provided to the resident or the resident's representative. During an interview on 8/12/24 11:50 a.m., the DON indicated there was no documentation of the bed-hold policy having been provided to the resident or the resident representative for Resident 96, Resident 148, Resident 145, and Resident 160. On 8/12/24 at 4:14 p.m., the Director of Nursing provided the facility's policy,Bed Hold Policy undated, and indicated it was the policy currently being used by the facility. A review of the policy indicated, . b. If applicable according to state law if the bed hold authorization form cannot be signed prior to the resident leaving and needs to be mailed, it must be mailed certified return receipt . e. The business office manager or designee will follow all state specific guidelines upon resident return regarding notifying resident or responsible part of amount of bed hold days used and left . 3.1-12(a)(25) 3.1-12(a)(26)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 36912 Based on observation, interview, and record review, the facility failed to ensure residents were provided an adequately lit, homelike environment for 1 of 7 units reviewed for environmental concerns. (Unit G) On the following dates and times the main hallway of the secured Unit G was observed to have dim, flickering overhead fluorescent lights, and dark colored walls void of homelike decor or adornment: - On 8/6/24 at 12:35 p.m. - On 8/6/24 at 2:40 p.m. - On 8/7/24 at 10:40 a.m. - On 8/7/24 at 12:50 p.m. - On 8/7/24 at 3:05 p.m. - On 8/8/24 at 9:28 a.m. - On 8/8/24 at 2:26 p.m. - On 8/9/24 at 12:27 p.m. - On 8/9/24 at 3:10 p.m. - On 8/12/24 at 9:45 a.m. - On 8/12/24 at 12:05 p.m. Confidential interviews were conducted during the course of the survey from 8/6/24 through 8/12/24. These interviews indicated the secured Unit G was consistently dimly lit with flickering overhead fluorescent lights. The hallway walls were dark and lacked decor indicative of a homelike environment. During an interview on 8/12/24 at 12:15 p.m., the Administrator indicated the main hallway of the secured Unit G was dimly lit, with flickering overhead fluorescent lights, and the walls were dark and lacking homelike decor or adornment. On 8/12/24 at 10:20 a.m., the Assistant Director of Nursing provided the Residents Rights and Facility Responsibilities, undated, and indicated these were the resident rights currently used by the facility. A review of the Resident Rights and Facility Responsibilities indicated, .the resident has a right to a safe, clean, comfortable and homelike environment .adequate and comfortable lighting levels in all areas . (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-19(f)