STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155412	A. Building B. Wing	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenwood Health and Living Community	937 Fry Rd 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38312 Based on interview and record review, the facility failed to protect the resident's rights to be free from misappropriation of property for 1 of 1 allegation of misappropriation of property. (Resident B) Finding include: On 4/30/25 at 12:02 p.m., Resident B's clinical record was reviewed. The diagnoses included, but were not limited to, diabetes mellitus, right tibia (shin bone) fracture, cellulitis, and pain in right leg. The annual MDS (Minimum Data Set) assessment, dated 3/7/25, indicated Resident B was cognitively intact. The Physician Order Report, dated 4/30/25, indicated the following: - Oxycodone-acetaminophen (pain medication) 7.5-325 mg (milligrams), twice a day for pain, initiated 1/13/25. - Oxycodone-acetaminophen 7.5-325 mg, every 4 hours as needed for right leg pain, initiated 1/13/25. Resident B's Controlled Drug Record for Oxycodone-acetaminophen 7.5-325 mg had a tablet signed out on 4/11/25 at 10:00 a.m. by Licensed Practical Nurse (LPN) 1. Four tablets remained. During an interview on 4/30/25 at 1:08 p.m., the Director of Nursing (DON) indicated on 4/11/25, when LPN 1 started her day shift, she counted the medications which were in the lock box on the 200 medication cart. At 10:00 a.m., LPN 1 administered Resident B an Oxycodone-acetaminophen 7.5-325 mg ordered twice a day for pain. There were 4 tablets left on the medication card. At the end of her day shift (2:30 p.m.), LPN 1 went to count the medication in the 200 medication cart lock box, and Resident B's Oxycodone-acetaminophen 7.5-325 mg medication card was missing. During LPN 1's shift, she gave the 200 hall medication cart keys to the Unit Manager (UM). The UM placed another resident's medication in the lock box on the 200 hall medication cart. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(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	During an interview on 4/30/24 at 1:53 p.m., the UM indicated on 4/11/25, a resident was moving to the 200 hall. She got the 200 hall medication cart keys from LPN 1. With LPN 2, she placed three medication cards in the lock box. The UM did not indicate she and LPN 1 counted the lock box after the UM placed the medication in the 200 hall medication lock box. During an interview on 4/30/25 at 2:00 p.m., RN 1 indicated she worked evening shift on 4/11/25. At the beginning of her shift, RN 1 and LPN 1 counted the medication cards in the 200 medication lock box. LPN 1 was checking the Controlled Drug Records in the narcotic binder and RN 1 was counting the medication on the card. LPN 1 indicated Resident B had 4 Oxycodone-acetaminophen 7.5-325 mg tablets on the card. RN 1 indicated Resident B did not have a card with Oxycodone-acetaminophen 7.5-325 mg tablets. LPN 1 indicated Resident B had Oxycodone-acetaminophen 7.5-325 mg at 10:00 a.m., and should have had 4 left on her card. RN 1 indicated Resident B medication card was not in the cart. RN 1 reported to the DON Resident B's Oxycodone-acetaminophen 7.5-325 mg tablets were missing. On 4/30/25 at 2:54 p.m., the Administrator (ADM) provided the facility policy, Abuse, Neglect, and Misappropriation Prohibition and Prevention Policy, with a revision date of 6/4/19, and indicated it was the policy currently being used by the facility. A review of the policy indicated, .It is the policy of [NAME] & Associates, Inc. and its member Communities to provide each resident with an environment that is free from . misappropriation of their property . On 4/30/25 at 2:54 p.m., the Administrator (ADM) provided the facility policy, Drug Storage, undated, and indicated it was the policy currently being used by the facility. A review of the policy indicated, 10. All Class II drugs must be stored under double lock at all time . This citation relates to the Complaint IN00457431. 3.1-28(a)