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	05/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenwood Health and Living Community	937 Fry Rd Greenwood, IN 46142

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview and record review, the facility failed to provide reasonable accommodation of needs for 1 of 19 reviewed for call light access. (Resident 73) Finding includes: On 5/20/25 from 8:35 a.m. to 8:40 a.m., Resident 73 was observed resting in bed while eating breakfast. Resident 73's call light was observed approximately 3 feet to the left of the head of the bed. The call light cord and mechanism were observed hanging from the wall to approximately 3 inches above the floor. The observed call light system was not within reach of the resident. During an interview at that time, Resident 73 indicated he did not know where the call light was located. During an interview on 5/20/25 at 8:43 a.m., Scheduler 7 indicated Resident 73's call light was to be kept within reach of the resident. Resident 73 sometimes would throw his call light around. On 5/22/25 at 8:45 a.m., Resident 73 was observed sitting in his wheelchair that was positioned at the foot end on the left side of the bed. Resident 73 was facing away from the head of the bed. Against the wall and to the left of the head of the bed was a small bedside table. The call light cord and mechanism were observed hanging from the wall and resting onto the floor to the left of the bedside table. The observed call light system was not within reach of the resident. During an interview at that time, Resident 73 indicated he did not where the call light was located. During an interview on 5/22/25 at 8:47 a.m., Unit Manager 8 indicated call lights were to be kept within reach of the resident. Resident 73 was known to toss the call light around at times. On 5/20/25 at 1:18 p.m., Resident 73's clinical record was reviewed. The diagnosis included, but was not limited to, hemiplegia and hemiparesis (paralysis) following a stroke affecting the dominant right side. The Annual Minimum Data Set (MDS) assessment, dated 4/29/25, indicated Resident 73 was severely cognitively impaired and was at risk for falls. During an interview on 5/22/25 at 8:29 a.m., the Administrator indicated the facility did not have a specific call light policy. The facility practice was that staff were to ensure the call lights were kept within reach of the residents. 3.1-3(v)(1)

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 - Some	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect the resident's rights to be free from misappropriation of property for 5 of 5 residents reviewed for misappropriation of property. Narcotic medications were missing. (Resident B, Resident C, Resident D, Resident E, Resident F) Findings include: 1. On 5/20/25 at 12:02 p.m., Resident B's clinical record was reviewed. The diagnoses included, but were not limited to, hypertensive chronic kidney disease and osteomyelitis of vertebra (inflammation of bone caused by infection of a spinal disc). The Annual MDS (Minimum Data Set) assessment, dated 4/7/25, indicated Resident B was cognitively intact. The Physician's Orders included, but were not limited to: - Hydrocodone-acetaminophen (narcotic pain medication) 5-325 mg (milligrams), every six hours a day for pain, initiated 3/27/24. 2. On 5/20/25 at 12:05 p.m., Resident C's clinical record was reviewed. The diagnoses included, but were not limited to, osteomyelitis, pneumonia, and acute respiratory distress. The admission MDS assessment, dated 5/1/24, indicated Resident C was cognitively intact. The Physician Order Report, dated 4/30/25, indicated the following: - Oxycodone-acetaminophen (narcotic pain medication) 5-325 mg, one tablet every four hours as needed for acute pain. 3. On 5/20/25 at 12:08 p.m., Resident D's clinical record was reviewed. The diagnoses included, but were not limited to, atrial fibrillation and personal history of traumatic brain injury. The Quarterly MDS assessment, dated 4/11/25, indicated Resident D was severely cognitively impaired. The Physician Order Report, dated 4/18/25 indicated the following: -Tramadol (narcotic pain medication) 50 mg, three times a day. 4. On 5/20/25 at 12:10 p.m., Resident E's clinical record was reviewed. The diagnoses included, but were not limited to, cerebral palsy, contracture of right knee, and acute kidney failure. The Quarterly MDS assessment, dated 5/16/25, indicated Resident E was moderately cognitive impaired. The Physician Order Report, dated 3/28/25 indicated the following: (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Hydrocodone-acetaminophen 5-325 mg tablet oral tab three times a day. 5. On 5/20/25 at 12:15 p.m., Resident F's clinical record was reviewed. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease, physical debility, and type 2 diabetes mellitus. The admission MDS assessment, dated 4/28/25, indicated Resident F was moderately cognitive impaired. The Physician Order Report, dated 4/21/25 indicated the following: - Hydrocodone-acetaminophen 5-235 mg, one by mouth every six hours as needed. During an interview on 5/21/25 at 2:18 p.m., the Director of Nursing (DON) and Administrator indicated that on 5/7/25 it was brought to their attention that there were a few discrepancies in the narcotic count. During the facility investigation it was discovered that on 5/5/25, LPN 4 took possession of 30 tablets of hydrocodone-acetaminophen 5-325 mg and a card of Ambien prescribed for Resident B. LPN 4 did return the Ambien for destruction but indicated she did not know what happened to Resident B's 30 tablets of hydrocodone-acetaminophen that she had removed for destruction. The DON and Administrator indicated at that time that LPN 4 also signed out an oxycodone-hydrocodone 5-325 mg for Resident C. Resident C was not in facility at that time. It was also noted a Tramadol 50 mg tablet was obtained from the narcotic lock box as an as needed medication for Resident D. Resident D did not have an order for Tramadol as needed, only scheduled times. The DON and Administrator indicated that further investigation revealed hydrocodone-acetaminophen 5-325 mg was missing from the narcotic lock box for Resident E. Resident E was missing 44 hydrocodone-acetaminophen 5-325 mg. LPN 4 was placed on leave pending the investigation and terminated. The DON called LPN 4 who indicated she accidentally took the 44 hydrocodone-acetaminophen 5-325 mg from the facilities lock box and would return them. On 5/22/25 at 9:49 a.m., the facility investigation into the missing narcotic pain medication was reviewed. The investigation indicated the following: - Resident B's Controlled Drug Record indicated the resident should have had 30 hydrocodone-acetaminophen 5-325 mg on the cart. The tablets were missing. - Resident C Oxycodone-acetaminophen 5-325 mg, one tablet every four hours as needed for acute pain. The facility investigation indicated that one medication was missing - Resident D's Tramadol 50 mg three times a day. The facility investigation indicated one Tramadol was missing. - Resident E's hydrocodone-acetaminophen 5-325 mg tablet, oral tab three times a day. The facility investigation indicated one hydrocodone-acetaminophen was missing. - Resident F's hydrocodone-acetaminophen 5-235 mg, one by mouth, every six hours as needed. The facility investigation indicated that 44 hydrocodone-acetaminophen were missing. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/22/25 at 10:34 a.m., LPN 10 indicated that when narcotics needed to be destroyed the Unit Manager was notified and if a resident refused a narcotic, then two nurses would sign off on the destruction. During an interview on 5/22/25 at 10:55 a.m., RN 12 indicated the DON took care of destruction of narcotics unless it was a single dose refusal then two nurses signed off on the destruction. On 5/22/25 at 8:54 a.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 5/22/25 at 8:42 a.m., the Administrator (ADM) provided the facility policy, Clinical- Policy and Procedure for Scheduled Drugs, undated, and indicated it was the policy currently being used by the facility. A review of the policy indicated, . 2, 2.3, Discontinued schedule II, III, IV and V drugs are to be destroyed in the Community in the presence of the Director of Nursing (DON) or designee and a registered nurse employed by Community and their disposal record in accordance with the procedures for destruction of controlled drugs as provided in section 3. 4, 4.1, At the beginning of an associate's shift they must be count and account for all scheduled drugs, including refrigerated drugs with the outgoing associate. 4.2, At the end of an associate's shift they must count and account for all scheduled drugs, including refrigerated drugs with the oncoming associate. This citation relates to the Complaint IN00459109. 3.1-28(a)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview, and record review, the facility failed to develop care plans for 5 of 19 residents reviewed. Care plans were not developed for skin conditions, use of an electric wheelchair, and non-compliance. (Resident F, Resident 28, Resident 73, Resident 56, Resident 74) Finding includes: 1. On 5/20/25 at 8:30 a.m., observed Resident F in the hallway. Resident F was observed sitting in his manual wheelchair in the hall way. Resident F was wearing short pants. Multiple dried scabs were noted on his bilateral lower extremities. An open area was observed on his left knee and no dressing was observed. During an interview on 5/20/25 at 9:30 a.m., Resident F indicated the facility took his electric wheelchair away from him. On 5/20/25 at 10:00 a.m., Resident F's clinical record was reviewed. The diagnoses included, but were not limited to, physical debility and muscle weakness. An admission Assessment, dated 4/21/25, indicated Resident F arrived to the facility with a motorized wheelchair. An admission Minimum Data Set (MDS) assessment, dated 4/28/25, indicated Resident F was cognitively intact. A Physician's Order, dated 4/13/25 with no end date, indicated clean open scab on left knee every other day with normal saline and cover with a border dressing every evening and every shift as needed for soilage or dislodgement. An Occupational Therapy Note, dated 5/15/25, indicated Resident F had several incidents where he had run into objects with his power wheelchair. The facility would prohibit the use of the electric wheel chair until further assessments and training were completed. The clinical record lacked a comprehensive care plan related to the use of Resident F's electric wheel and skin conditions. During an interview on 5/21/25 at 1:00 p.m., the Administrator indicated the electric wheelchair was taken away for safety issues. Resident F was to be evaluated by Occupational Therapy to determine if the resident was safe to use the electric wheelchair. During an interview on 5/21/25 at 1:33 p.m., the Administrator indicated the clinical record lacked a care plan regarding the electric wheelchair. During an interview on 5/24/25 at 2:33 p.m., the Director of Nursing indicated the clinical record lacked a care plan regarding Resident F's skin conditions. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On 5/24/25 at 12:00 p.m., the clinical record of Resident 74 was reviewed. The diagnoses included but was not limited to, vascular dementia and type 2 diabetes mellitus. A Skin Assessment, dated 2/26/25, indicated an open area on Resident 74's right heel. A Physician's order, dated 3/29/25, indicated, cleanse right heel with normal saline or wound cleanser. Pat dry and paint with betadine pad with ABD pad and wrap with kerlix. The clinical record lacked a care plan related to the pressure ulcer on Resident 74's right heel. On 5/24/25 the Administrator indicated the facility was unable to locate a current skin care plan that included the pressure ulcer on Resident 74's right heel. 3. On 5/19/25 from 9:40 a.m. to 9:50 a.m., Resident 56 was observed resting in bed. The bed was observed to be in the highest position, approximately 40 inches above the floor. The handheld bed control device was observed on the bed and within reach of the resident. No staff were visible in the area during that time. During an interview at that time, Resident 56 indicated she liked the bed being so high above the floor so she could watch people walking in the hall. On 5/19/25 from 11:25 a.m. to 11:35 a.m., Resident 56 was observed resting in bed. The bed was observed to be in the highest position, approximately 40 inches above the floor. The handheld bed control device was observed on the bed and within reach of the resident. No staff were visible in the area during that time. During an interview on 5/19/25 at 11:37 a.m., LPN 5 indicated she did not know the reason for Resident 56's bed to have been left in the highest position. LPN 5 was observed exiting Resident 56's room without lowering the height of the bed. During an interview on 5/19/25 at 11:37 a.m., CNA 6 Indicated Resident 56's bed was not usually kept in the highest position and there were times when Resident 56 would adjust the height of the bed. CNA 6 was observed adjusting the bed into a lower position. On 5/19/25 at 11:45 a.m., Resident 56's clinical record was reviewed. The diagnoses included, but were not limited to, dementia, mood disturbance, and anxiety. The Quarterly Minimum Data Set (MDS) assessment, dated 3/4/25, indicated Resident 56 was severely cognitively impaired. The clinical record lacked a care plan related to Resident 56's non-compliance with keeping the bed in the low position. During an interview on 5/21/25 at 4:15 p.m., the Administrator indicated Resident 56's care plan should have reflected her non-compliance with keeping the bed in the low position. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. On 5/20/25 from 8:35 a.m. to 8:40 a.m., Resident 73 was observed resting in bed while eating breakfast. Resident 73's call light was observed approximately 3 feet to the left of the head of the bed. The call light cord and mechanism were observed hanging from the wall to approximately 3 inches from the floor. The observed call light system was not within reach of the resident. During an interview at that time, Resident 73 indicated he did not know where the call light was located. During an interview on 5/20/25 at 8:43 a.m., Scheduler 7 indicated Resident 73's call light was to be kept within reach of the resident. Resident 73 sometimes would throw his call light around. On 5/22/25 at 8:45 a.m., Resident 73 was observed sitting in his wheelchair that was positioned at the foot end of the left side of the bed. Resident 73 was facing away from the head of the bed. Against the wall and to the left of the head of the bed was a small bedside table. The call light cord and mechanism were observed hanging from the wall to the floor to the left of the bedside table. The observed call light system was not within reach of the resident. During an interview at that time, Resident 73 indicated he did not where the call light was located. During an interview on 5/22/25 at 8:47 a.m., Unit Manager 8 indicated call lights were to be kept within reach of the resident. Resident 73 was known to toss the call light around at times. On 5/20/25 at 1:18 p.m., Resident 73's clinical record was reviewed. The diagnosis included, but was not limited to, hemiplegia and hemiparesis (paralysis) following a stroke affecting the dominant right side. The Annual MDS assessment, dated 4/29/25, indicated Resident 73 was severely cognitively impaired and at risk for falls. Resident 73's clinical record lacked a care plan to address Resident 73's behavior for throwing the call light beyond his capacity to retrieve the call light. 5. During an observation on 5/21/25 at 11:00 a.m., Resident 28's coccyx and right ankle treatments were observed as ordered by the physician. Unit Manager 8 was observed cleansing the right ankle with normal saline, patting it dry, and applying a collagen sheet with silver and covering the area. Unit Manager 8 was also observed applying a thin layer of triad wound dressing to Resident 28's coccyx area. On 5/21/25 at 9:23 a.m., Resident 28's clinical record was reviewed. The diagnoses included, but were not limited to, sepsis, disorder of the muscle and abnormal posture. Current Physician Orders included, but was not limited to, the following: - Dated 3/19/25 with no end date noted, indicated Cleanse wound to [right] ankle with [normal saline], pat dry, apply collagen sheet with silver, cover with island dressing .daily . - Dated 5/15/25 with no end date noted, indicated triad wound dressing paste, thin amount - topical .apply thin layer to [moisture associated skin damage] .every shift . (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Annual MDS assessment, dated 3/3/25, indicated Resident 28 was moderately cognitively impaired. Section M: Skin Conditions indicated Resident 28 was at risk of developing pressure ulcers and currently had one stage 2 pressure ulcer and one stage 3 pressure ulcer. On 5/22/25 at 9:22 a.m., the Administrator provided a copy of the current Wound Evaluation and Management Summary document that was completed by the Wound Physician on 5/21/25. A review of the document indicated Resident 28 currently had a stage 2 pressure wound on the coccyx and a stage 3 wound on the right ankle. The wounds had been present for at least 98 days and were considered in the healing process. Resident 28's clinical record lacked a a care plan for the two pressure ulcers. During an interview on 5/21/25 at 4:15 p.m., the Director of Nursing indicated Resident 28's care plan should have reflected the coccyx and right ankle-related skin conditions. On 5/22/25 at 1:21 p.m., the Administrator provided a copy of the Care Pans, Comprehensive Person-Centered policy, dated December 2016, and indicated it was the current policy being used by the facility A review of the document included, .A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident .assessments of the residents are ongoing and care plans are revised as information about the residents and the residents' condition change . 3.1-35(a)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. Based on observation, record review, and interview, the facility failed to provide care in accordance with the plan of care for 1 of 1 residents reviewed for skin conditions. Physician's orders were not followed for skin treatments. (Resident F) Finding includes: On 5/20/25 at 8:30 a.m., observed Resident F in the hallway. Resident F was observed sitting in his wheelchair in the hall way. Resident F was wearing short pants. Multiple dried scabs were observed on both of his legs. An open area was observed on his left knee. No dressing was observed. On 5/21/25 at 9:00 a.m., observed Resident F in the hallway wearing short pants. Multiple dried scabs were observed on his both of his legs. An open area was observed on his left knee. No dressing was observed. On 5/22/25 at 9:18 a.m., Resident F was observed sitting in the hallway in his wheelchair wearing shorts. Dried red drainage was observed on his left leg. Open area's on both legs and his left knee were observed to be exposed. On 5/23/25 at 9:48 a.m., Resident F's clinical record was reviewed. The diagnosis included, but was not limited to, type 2 diabetes mellitus with neuropathy. A Physician's Order, initiated 4/13/25, indicated to clean the open scab on the left knee every other day with normal saline and cover with a border dressing every evening and every shift as needed for soilage or dislodgement. During an interview on 5/22/25 at 1:30 p.m., the Director of Nursing indicated the facility was to follow the physicians orders for the treatment of Resident F's lower extremities and should have had a dressing as ordered by the physician. 3.1-37(a)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interview, and record review, the facility failed to ensure a resident's enteral feeding (tube feeding) was signed and dated for 1 of 1 resident reviewed for enteral feeding devices. (Resident 253) Finding includes: On 5/19/25 at 11:45 a.m., Resident 253's clinical record was reviewed. The diagnoses included, but were not limited to, atherosclerotic heart disease (a build-up of plaque in artery walls) and unspecified dysphagia (difficulty swallowing). Physician's Orders indicated Resident 253 had an order for Osmolite 1.2 (a type of enteral tube feeding) to run at 65 mL/hr (milliliters per hour) and H20 (water) at 53 mL/hr bolus (dose) to run continuously on each shift. On 5/19/25 at 12:45 p.m., Resident 253 was observed resting in bed. Next to the bed was an IV pole with an electronic pump device connected to Resident 253. The device was noted to be running at the time of observation. The tube feeding container running into the pump device was labeled as Osmolite 1.2 roughly three fourths full of a tan colored liquid and an unlabeled bag filled with clear liquid also running into the pump device. The feeding container had areas where staff could sign and date it, but they were blank. The clear plastic bag of clear fluid was also unlabeled or dated. The tubing itself was unlabeled or dated. On 5/20/25 at 8:40 a.m., Resident 253 was observed sitting up in his wheelchair. Next to the wheelchair was an electronic pump device connected to Resident 253. The device was noted to be running at the time of observation. The tube feeding container running into the pump device was an Osmolite 1.2 mostly full of a tan colored liquid and an unlabeled bag filled with clear liquid also running into the pump device. The feeding container had areas where staff could sign and date it, but they were blank. The clear plastic bag of clear fluid was also unlabeled or dated and the top of the bag was open. The tubing itself was unlabeled or dated. During an interview on 5/20/25 at 8:58 a.m., LPN 9 indicated that the feeding container and water flush bag should both be labeled, and that the flush bag should not be open. LPN 9 closed the water flush bag and indicated another nurse had started Resident 253's tube feeding earlier, but LPN 9 would find out when it was signed out and have it labeled appropriately. During an interview on 5/22/25 at 9:00 a.m., the DON (Director of Nursing) and Administrator indicated that the tube feeding bag should have been signed and dated. 3.1-47(a)(2)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on interview and record review, the facility failed to ensure residents were provided a two-step tuberculin skin test upon admission for 1 of 5 resident reviewed for tuberculin skin tests. (Resident 50) Finding includes: On 5/19/25 at 12:45 p.m., Resident 50's clinical record was reviewed. The diagnoses included, but were not limited to, chronic respiratory failure, chronic pulmonary edema (an abnormal build up of fluid in the lungs), and type 2 diabetes mellitus (a chronic condition causes high blood sugar levels). Resident 50 had an admission date of 3/29/25. Resident 50's TB (Tuberculin) test administration history indicated that resident had a first step TB skin test administered on 3/29/25 and a first step TB skin test administered on 4/30/25. The two skin tests were each read with negative results and they were administered 32 days apart. Both tests were labeled in the system as first step TB skin tests and there was no timely second step associated with either. During an interview on 5/22/25 at 9:00 a.m., the DON (Director of Nursing) indicated that Resident 50's two step TB skin tests were being repeated as the first two were administered too far apart chronologically. On 5/22/25 at 9:22 a.m., the Administrator provided a copy a policy titled Tuberculosis Infection Control Program, dated October 2017, and indicated it was the policy currently in use by the facility. A review of the policy indicated, A. Screening Admissions or Readmissions .4. If the first TST [tuberculin skin test] is negative, a follow-up TST will be administered 1 to 3 weeks after the initial test is read. 3.1-18(f)