STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155788	A. Building B. Wing	09/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenwood Meadows	1200 N State Road 135 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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 34848 Based on interview and record review, the facility failed to notify a provider of laboratory results that fell outside of clinical reference ranges for 1 of 5 residents reviewed for unnecessary medications. (Resident 105) Findings include: On 9/20/24 at 1:58 p.m., Resident 105's clinical record was reviewed. The diagnoses included, but were not limited to, type 2 diabetes mellitus (DM) with diabetic neuropathy, peripheral vascular disease, and surgical amputation of the right leg (below the knee). A review of the current, September, 2024, physician's orders indicated: On 7/4/24, the resident was ordered insulin aspart U-100 (medication used to treat DM) per sliding scale, at bedtime, 8:00 p.m. The order specified to contact the MD (medical doctor) if blood sugar was great than 400. The resident's blood sugar results on the Electronic Medical Record (EMAR) and vitals login included, but were not limited to: -On 9/8/24 at 9:37 p.m., the resident's blood glucose was 421 mg/dL (milligrams per deciliter). The physician was not notified. -On 8/29/24 at 8:33 p.m., the resident's blood sugar was 414 mg/dL. The physician was not notified. -On 8/29/24 at 7:40 p.m., the resident's blood sugar was 423 mg/dL. The physician was not notified. -On 7/29/24 at 8:11 p.m., the resident's blood sugar was 420 mg/dL. The physician was not notified. -On 7/28/24 at 8:38 p.m., the resident's blood sugar was 437 mg/dL. The physician was not notified. A review of the resident's progress notes, from July to September, 2024, did not indicate a reason why the physician was not notified of any glucose result greater than 400 mg/dL. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/23/24 at 3:53 p.m., the Director of Nursing (DON) indicated the resident blood sugars were documented under a few different spots and the staff would call the on-call provider if the resident had a blood glucose out of parameters. On 9/24/24 at 4:25 p.m., the DON provided the facility policy, Blood Glucose Monitoring, revised on 2/2015, and indicated it was the policy currently being used. A review of the policy indicated, . Residents who have a physician's order to obtain routine capillary blood glucose will have a physician's order specifying the blood glucose parameters requiring physician notification . The physician will be notified when the resident's blood glucose is outside the physician stated parameters . 3.1-5(a)(3)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide enough food/fluids to maintain a resident's health. 36912 Based on observation, interview and record review, the facility failed to monitor weights and implement interventions for a resident with assessed significant weight loss for 1 of 4 residents reviewed for nutrition. (Resident 27) Findings include: On 9/19/24 at 10:18 am, Resident 27 was observed in her bed. Her wrists were small with bony prominence's, and her face showed indications of emaciation with sunken cheeks and hollow eye sockets. On 9/19/24 at 10:40 am, Resident 27's clinical record was reviewed. The diagnoses included, but were not limited to, dementia, hypothyroidism, and vitamin D deficiency. The quarterly review Minimum Data Set assessment, dated 6/3/24, indicated the resident was severely cognitively impaired. The Care Area Assessment Detail Worksheet, dated 3/8/24, indicated the resident had a history of significant weight loss in the prior 180 days. On 4/3/24 the resident weighed 95 pounds. On 7/4/24 the resident weighed 93 pounds. On 8/1/24 the resident weighed 87 pounds, which indicated a significant weight loss of 11.58 percent in 120 days and a significant weight loss of 6.45 percent in 28 days. No weights were recorded between 7/4/24 and 8/1/24. On 8/7/24 the resident weighed 90 pounds. On 9/3/24 the resident weighed 84 pounds, which indicated a significant weight loss of 6.67 percent in 26 days. No weights were recorded between 8/7/24 and 9/3/24. A Follow Up Nutrition Review, dated 9/4/24, indicated, .loss of 5% or more in the last month or loss of 10% or more in the last 6 months .not assessed ., and .gain of 5% or more in the last month or 10% in the last 6 months .yes, on physician-prescribed weight-gain regimen .resident continues on a regular diet . A Dietitian Review, dated 9/9/24, indicated, .resident is at nutritional risk d/t [due to] unintentional weight loss . resident is on regular diet .hx [history] of benecalorie [an unflavored supplement that could increase the calorie and protein content of most foods and beverages] supplement in oatmeal which was providing additional 330 kcals [kilocalories]. Resident stopped eating her oatmeal with benecalorie in it . (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Physician orders indicated the resident was prescribed benecalorie to be added to her oatmeal from 6/12/24 until discontinued on 8/15/24. No further dietary, nutritional, or pharmacological interventions were ordered or implemented after 8/15/24. The resident was not on a physician-prescribed weight-gain regimen after 8/15/24. On 9/23/24 at 4:20 p.m., the Director of Nursing provided the Resident Weight Monitoring policy, revised 9/2024, and indicated this was the policy used by the facility. A review of the policy indicated, .bi-monthly weights will be obtained at a minimum for .residents who have experienced a significant weight loss of 5% in 30 days, 7.5% in 90 days or 10% in 180 days . During an interview on 9/23/24 at 4:22 p.m., the Director of Nursing indicated residents identified with significant weight loss underwent a minimum of bi-monthly weight monitoring. 3.1-46(a)(1)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38312 Based on interview and record review, the facility failed to ensure a resident with a diagnosis of type 2 diabetes mellitus (chronic high blood sugar which could be controlled with diet, exercise, and some medications) received a therapeutic diet for 1 of 7 residents reviewed for food. (Resident 283) Findings include: During an interview on 9/18/24 at 11:34 a.m., Resident 283 indicated she was a diabetic and was getting cakes with frosting and doughnuts. She should not be getting those desserts because she was a diabetic. On 9/20/24 at 10:25 a.m., Resident 283's clinical record was reviewed. The diagnoses included, but were not limited to, left femur fracture and type 2 diabetes mellitus with diabetic neuropathy (pain and numbness in hands and feet). The After Visit Summary, dated 9/12/24 at 3:28 p.m., indicated diet instructions were progress as tolerated. The After Visit Summary lacked documentation of Resident 283's diet as regular. The dietary order, dated 9/12/24, indicated a regular diet. The Discharge summary, dated 9/12/24 at 10:39 a.m., indicated she had diagnosis of diabetes mellitus for [AGE] years. Her glucose was 183 on 9/10/24 and 163 on 9/9/24. Her diet was a diabetic diet. The Hospitalist Post-Acute Care Note, dated 9/13/24, indicated the resident had diagnosis of diabetes mellitus. The note lacked documentation of resident's diet. The Hospitalist Post-Acute Care Note, dated 9/16/24, indicated the resident had blood sugars of 140-260. The note lacked documentation of resident's diet. The Initial Nutrition Review, dated 9/16/24 at 1:19 p.m., indicated the current diet order was a regular diet. The special diet prior to admission was low sugar. The clinical record lacked documentation once the facility received the discharge summary and saw the diet was a diabetic diet they clarified the diet with the doctor. During an interview on 9/23/24 at 2:45 p.m., Resident 283 indicated when she was at home prior to her admission to the facility her accu-checks were 130-180 mg/dl (milligrams/deciliter). Since she had been at the facility and was getting regular desserts, her accu-checks had been higher. The other day, she received a sugar cream pie. She was unsure if it was a diabetic pie or regular pie, ate the pie, and her accu-check was around 260 mg/dl. (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 9/23/24 at 2:54 p.m., the Director of Nursing Services (DON) indicated when a resident was discharged from the hospital, they would follow the diet they had in the hospital. The facility's diet for diabetics was carbohydrate controlled diet. During an interview on 9/23/24 at 4:24 p.m., the DON indicated when Resident 283 was admitted , they only had the After Visit Summary. They did not receive the Discharge Summary until the next morning. She indicated she did not have any documentation of notifying the doctor of the diet which was on the discharge summary or that he wanted to continue with the regular diet after the discharge summary was received. On 9/23/24 at 4:30 p.m., the DON provided the facility's policy, Nursing Admission/Return Admission Policy and Procedure, dated 7/2024 and indicated it was the policy being used by the facility. A review of the policy indicated .b. Diet - transcribe the diet using the correct terminology .1. Resident being admitted from the hospital must have a discharge summary. If not present at admission, contact the transferring facility for a copy . 1.3-20(a)