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	12/05/2025

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the resident was included in their care planning process for 1 of 1 resident reviewed for care planning. (Resident 110)Findings include: During an interview on 12/1/25 at 1:59 p.m., Resident 110 indicated she had not been invited to her care plan meeting. On 12/5/25 at 11:08 p.m., the clinical record was reviewed. The diagnoses included, but were not limited to, malignant breast cancer and malnutrition. A Significant Change Minimum Data Set (MDS) assessment, dated 10/15/25, indicated Resident 110 had mild cognitive impairment and the care plan completion date was 10/22/25. The clinical record lacked documentation of resident was included in her care planning process. During an interview on 12/5/25 at 11:42 a.m., the MDS Coordinator indicated the resident and resident's family would be invited to a care plan meeting after the comprehensive MDS assessment was completed. Resident 110 would need to have a care plan meeting after her Significant change MDS, dated [DATE]. The MDS Coordinator indicated she could not find any documentation of Resident 110 being included in her care plan process after 10/15/25. During an interview on 12/5/25 at 12:33 p.m., The Director of Nursing (DON) indicated she could not find any documentation of Resident 110 being included in her care plan process after 10/15/25. On 12/5/25 at 12:15 p.m., the DON provided the facility policy, IDT [Interdisciplinary Team] Comprehensive Care Plan Policy, dated 10/2025, and indicated it was the policy currently being used by the facility. A review of the policy indicated, .Resident, resident's representative, or others as designated by resident will be invited to care plan review 3.1-35(c)(2)(C)

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on record review and interview, the facility failed to ensure an accurate assessment for 1 of 25 residents reviewed for MDS (Minimum Data Set) assessment accuracy. (Resident 85)Finding includes:On 12/4/25 at 2:19 p.m., Resident 85's clinical record was reviewed. The diagnoses included, but were not limited to, generalized anxiety disorder, major depressive disorder, and dementia.The notice of PASARR (Preadmission Screening and Resident Review) Level II Outcome, dated 3/6/25, indicated, Final Determination By: .Determination Date: 3/6/25, Level II Outcome: Long Term Approval without Specialized Services.The Annual MDS assessment, dated 11/19/25, did not indicate Resident 85 had a PASARR level II or depression.The MAR (Medication Administration Record) indicated, from 10/31/24 - 11/27/25 the resident had an active order for mirtazapine (a medication used to treat major depressive disorder) 7.5 mg (milligram), for diagnosis of major depressive disorder.During an interview with the MDS Coordinator on 12/5/25 at 11:15 a.m., she indicated section A1500 on the MDS assessment, dated 11/19/25, was marked no in error and indicated it should have been marked yes, for PASARR Level II. The MDS Coordinator indicated the resident had an active diagnosis of major depressive disorder on 11/19/25. The MDS Coordinator indicated the Annual MDS assessment, dated 11/19/25, was marked no in error and it should have been marked yes, for diagnosis of depression. The MDS Coordinator indicated the facility did not have an MDS policy and they utilized the RAI (Resident Assessment Instrument) tool to complete the MDS assessments.On 12/5/25 at 12:00 p.m., a review of the RAI, Version 3.0 User's Manual, Version 1.20.1 October 2025, for section A1500 of MDS, Code 1, yes: if PASARR Level II screening determined that the resident has a serious mental illness and/or ID (Intellectual disability)/DD (Developmental disability) or related condition . The RAI also indicated for section I5800, Depression, Diagnosis status: Active or Inactive is a 7-day look-back period.3.1-31(d)