STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155188	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenfield Healthcare Center	200 Green Meadows Dr Greenfield, IN 46140

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to accurately transcribe admission order for Resident D, have pain medication available as ordered for Resident D, and failed to address pain for Resident H for 2 of 2 residents reviewed for pain control.Findings include:1 The clinical record for Resident D was reviewed on 1/7/2026 at 11:41 AM. The resident's diagnoses included, but were not limited to, chronic pain and respiratory failure. An admission Minimum Data Set Assessment, dated 12/25/2025, indicated that Resident D was cognitively intact, utilizes routine and as needed pain medication, and experienced pain occasionally. A care plan, dated 12/22/2025, indicated Resident D had chronic pain. The interventions included, but were not limited to, attempt non-pharmacological interventions, pharmacological interventions, and to report pain to the physician. During an interview with Resident D, on 1/6/2025 at 11:15 AM, the resident indicated when he first admitted to the facility in December of 2025 there was an issue with getting his pain medication as prescribed. Resident D denied having severe uncontrolled pain during that timeframe. Discharge orders used for admitting orders to the facility for Resident D, dated 12/18/2025, indicated the resident took methadone three times a day routinely. The medication administration record reflected a physician's order for Resident D, dated 12/18/2025, of methadone three times a day as needed for pain. No routine order for methadone was added on 12/18/2025. A physician's order, dated 12/19/2025, indicated Resident D to receive methadone three times a day as ordered. Review of the December 2025 Medication Administration Record indicated Resident D did not receive 15 scheduled doses of methadone for a reason of medication unavailable or was left blank. During an interview, on 1/8/2026 at 9:57 AM, LPN 2 indicated the facility has had issues getting methadone and similar medications for residents. During an interview, on 1/9/2026 at 12:43 PM, the DRR indicated it was the responsibility of the admitting nursing staff to assure the accuracy of admission orders. The nursing management team then conducts an additional review on the next business day. It was the expectation the nursing staff would notify the physician for unavailable medications. For Resident D, the medical director had not filled out the prescription correctly for methadone. The on-call provider was notified on 12/20/2025 (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and they had written a script on 12/21/2025, but it was not delivered until 12/22/2025. A policy entitled, Notification of Change of Condition, was provided on DRR on 1/9/2026 at 9:50 AM. The policy indicated, .It is the policy of the facility to provide resident centered care that meets the psychological, physical, and emotional needs, concerns of the residents. 2. The clinical record for Resident H was reviewed on 1/6/26 at 10:37 a.m. Her diagnoses included, but were not limited to, dementia, contusion of rib, and multiple fractures of rib, right side. The pain care plan, revised 12/10/25, indicated to administer non-pharmacological interventions and evaluate the effectiveness of interventions, initiated 7/4/25; and to provide medication per orders and evaluate effectiveness of medication, initiated 7/4/25. The 12/7/25 post fall evaluation, completed by RN (Registered Nurse) 5, indicated she experienced an unwitnessed fall on 12/7/25 at 9:45 a.m. The family/responsible party was notified of the fall on 12/7/25 at 9:55 a.m. The Pain/Skin section of the evaluation indicated she complained of pain on the right side of her back that was new to her. She was able to verbalize her pain level as a 5 on a scale of one to ten. Resident H described her pain as an ache and heavy. The evaluation did not indicate how Resident H's pain level of five was addressed. The physician's orders indicated to administer two 325 mg acetaminophen tablets by mouth three times a day for pain, starting 9/11/25. They indicated to administer two 325 mg tablets of acetaminophen by mouth every six hours as need for pain/fever, starting 9/11/25. There was no other as needed pain medication order in place when Resident H fell on [DATE] at 9:45 a.m. The December, 2025 MAR indicated the first regularly scheduled acetaminophen administration was administered in the morning on 12/7/25 for a pain level of three. There were no as needed administrations of acetaminophen administered on 12/7/25. The 12/7/25, 9:45 a.m., 10:00 a.m., 10:15 a.m., 10:30 a.m., 10:45 am., and 11:00 a.m., neurological assessments did not reference pain levels. The vitals section of the electronic health record included only one pain assessment on 12/7/25 prior to Resident H being sent to the hospital. It was a level of 3 in correlation with the regularly scheduled acetaminophen administration. The 12/7/25, 1:18 p.m. nurse's note, written by RN 5, indicated, res had unwitnessed fall in the morning [sic] with back hurts and a scratch on her ryt [sic] back and complains she feel pain when she takes breath her family notified and also DON [Director of Nursing] due to her family requested resident sent to ER with family for further evaluation. The note did not indicate any as needed pain medication was administered or any nonpharmacological interventions were implemented. RN 5 was not available for interview, as she was out of the country, and unable to be reached by telephone. On 1/8/26 at 2:03 p.m., an interview was conducted with CNA (Certified Nursing Assistant) 6, who found Resident H on the floor in her room on 12/7/25 at 9:45 a.m. after she fell. She indicated she was walking down the hall and saw Resident H sitting on the floor in her room with her back against her bathroom door. CNA 6 called for RN 5 to come down to the room. They both remained in the room for (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a while after assisting her up and into her chair. After getting her into her recliner, Resident H informed RN 5 that her rib cage was sore. CNA 5 was unsure how RN 5 addressed the pain. CNA 5 did not witness any administrations of pain medication to Resident H. The post fall evaluation, dated 12/7/25, completed by RN 5, indicated the physician was notified of the fall on 12/7/25 at 1:47 p.m. The content of discussion with physician section indicated, unwitnessed fall with no injury res. [resident] complain back hurts and abrasion noted on her right side of back transfer to ER due to family requested. An interview was conducted with Family Member 5 on 1/6/26 at 12:52 p.m. She indicated when Resident H fell on [DATE], Family Member H arrived at the facility within an hour of being notified. Upon arrival, Resident H was crying and complaining of pain on her right side. Family Member 5 insisted Resident H be sent to the emergency room. The nurse's note, dated 12/7/25 at 5:37 p.m., written by the DON indicated Resident H was transported to the emergency room at approximately 1:15 p.m. on 12/7/25. The 12/7/25 emergency department note indicated Resident H was seen by a provider at 1:36 p.m. on 12/7/25. She reported right rib and right abdominal pain, which was exacerbated by breathing. There was tenderness to palpation of the right ribs and abdomen. The discharge problem was contusion of rib and fracture of rib. The nurse practitioner note, dated 12/8/25, indicated she had a fall that resulted in an ER visit. Hospital found the patient has rib fracture of 8, 9, and 10. An interview was conducted with the DDR (Divisional Director of Risk) on 1/9/26 at 10:40 a.m. She indicated they had no verification Resident H's pain level of 5 on 12/7/25 was addressed. All they had was the December, 2025 MAR to verify she received her regularly scheduled acetaminophen for her pain level of three that morning. The Pain Management and Assessment policy was provided by the DDR on 1/8/26 at 12:00 p.m. It indicated, It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. Safety is a primary concern for our residents, staff and visitors. The purpose of this policy is to provide guidance to the clinical staff to support the intent of 483.25 (k) that based on the comprehensive assessment of a resident, the facility must ensure that residents receive the treatment and care in accordance with professional standards of practice, the comprehensive care plan, and the resident's choices, related to pain management. There is no objective test that can measure pain. The clinician must accept the resident's report of pain. Clinical observations clarify information from the resident. Site of discomfort may direct the nurse to specific types of pain-relief measures. Break-through Pain Management.b. Pain that is above the routine pain and requires interventions along with the current pain management regime. c. May require, on occasion, adjuvant therapies including pharmacological and non-pharmacological interventions for enhancing pain relief .Documentation a. Medication pain relief and response. b. Non-pharmacological measures attempted and the resident response. This citation relates to Intake 2661565. 3.1-37(a)