STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155019	A. BUILDING 00 B. WING	01/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GARDEN VILLA - BLOOMINGTON	1100 S CURRY PK BLOOMINGTON, IN 47403

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: January 23, 24, 26, 27, 30 and 31, 2023 Facility number: 000007 Provider number: 155019 AIM number: 100275040 Census Bed Type: SNF/NF: 80 SNF: 11 Total: 91 Census Payor Type: Medicare: 11 Medicaid: 68 Other: 12 Total: 91 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed February 3, 2023.	F 0000	The filing of this plan of correction does not constitute an admission the alleged deficiencies did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirement and to continue providing quality care and services to all residents. Acceptance of this Plan of Correction (POC) provides the facility's credible evidence of compliance effective February 10, 2023. We respectfully request desk review and consideration for paper compliance of substantial compliance based on the Plan of Correction (POC) and supporting documents submitted.	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan,			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Angela Patterson	DON	02/10/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

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	and the residents' choices. Based on observation, interview, and record review, the facility failed to provide repositioning in order to prevent moisture acquired skin damage for 1 of 6 residents reviewed for pressure sores. (Resident 72) Findings include: On 1/26/23, from 2:07 p.m. until 4:30 p.m., Resident 72 was observed in his bed lying on his back. He was not repositioned during this time. On 1/27/23, from 9:30 a.m. until 12:40 p.m., Resident 72 was observed in his bed lying on his back. He was not repositioned during this time. On 1/27/23 at 3:00 p.m., Resident 72's clinical record was reviewed. The diagnoses included, but were not limited to, chronic kidney disease, dementia, and hemiplegia (paralysis of one side of the body). The Significant Change MDS (Minimum Data Set) assessment, dated 10/31/22, indicated the resident was not cognitively intact, always incontinent of urine and bowel, not on a toileting program, required extensive physical assistance of two people to turn or reposition in bed, and was free of moisture acquired skin damage. The Braden Skin Evaluation (an assessment used to determine a person's risk for developing pressure sores), dated 1/18/23, indicated the resident was at high risk for pressure sores and skin friction and shearing due to being very moist, having very limited mobility, and being chairfast. The Skin Only Evaluation, dated, 11/6/22 indicated the resident had moisture acquired skin damage	F 0684	**F684-Quality of Care** **This facility does ensure dependent residents receive Quality of Care.** **1. Corrective actions taken:** Regarding resident #72, auditing forms are in place to ensure repositioning and turning is provided for dependent residents with MASD. Resident #72's MASD is currently healed. In servicing was completed for all staff. **2. How other residents were identified:** All dependent residents who have MASD (Moisture associated skin damage) will be audited for ADL care. All new residents with MASD will be audited. **See attached DON/Designee repositioning audit tool.** **3. Measures in place/system changes:** The Director of Nursing (DON)/designee(s) will audit all dependent residents in the facility who have MASD (Moisture associated skin damage). The DON/designee audits will be ongoing for daily for one week, weekly for four weeks and monthly for a period of four months. **See attached DON/designee repositioning audit tool.** **4. Monitoring of corrective actions taken:** The Quality	02/10/2023

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	(MASD) to the coccyx. The Skin Only Evaluation, dated 11/9/22 indicated the resident had a fluid filled blister on the left buttock. The Skin Only Evaluation, dated 11/16/22 indicated the resident had a fluid filled blister on the left buttock. The Skin Only Evaluation, dated 12/12/22 indicated the resident had MASD to the right buttock. The Skin Only Evaluation, dated 12/27/22 indicated the resident had excoriation (a wearing off of the skin) of the left buttock. The Skin Only Evaluation, dated 1/10/23 indicated the resident had excoriation of the left buttock. The Skin Only Evaluation, 1/25/23 indicated the resident had MASD to the right and left buttock. A care plan with a start date of 7/20/22 and revision date of 1/26/23 indicated the resident was at risk for impaired skin integrity due to incontinence and a need for assistance with toileting and bed mobility. During an interview on 1/30/23 at 10:05 a.m., Licensed Practical Nurse 1 indicated the resident was occasionally resistant to care and repositioning, but was to be repositioned at least every 2 hours to prevent skin damage. During an interview on 1/30/23 at 2:06 p.m., the Director of Nursing indicated the resident had moisture acquired skin damage to his buttocks. He was to be regularly repositioned and was		Assurance and Improvement committee will review compliance of F 684 for dependent residents with MASD and corrective actions as indicated at the next quarterly meeting. Following the quarterly quality assurance compliance reviews and no dependent residents with newly acquired MASD the committee will discontinue audits. **5.** Date of Compliance: February 10, 2023. F684 ATTACHMENTS: NURSING AUDIT FORM. INSERVICING SHEETS.	

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	frequently resistant to hands on care. During an interview on 1/31/23 at 9:45 a.m., Certified Nurse Aide 1 indicated the resident was to be repositioned every 2 hours if possible, however, on extremely busy shifts the resident may have gone without repositioning every 2 hours. On 1/31/23 at 9:30 a.m., the Director of Nursing provided the Repositioning policy with a revised date of May 2013, and indicated this was the policy used by the facility. A review of the policy indicated, "...residents who are in bed should be on at least an every 2 hour repositioning schedule...if ineffective, the turning and repositioning frequency will be increased...record in the resident's medical record the position in which the resident was placed...the name and title of the individual who gave the care...if the resident refused the care...the signature and title of the person recording the data..." 3.1-37(a)			
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.			

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	§483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. Based on observation, interview, and record review, the facility failed to apply a hand splint on a resident with an assessed limited range of motion (amount of movement around a specific joint) for 1 of 5 residents review for mobility. (Resident 24) Findings include: During an interview on 1/24/23 at 11:09 a.m., Resident 24 indicated he had a stroke and had impaired mobility of his left hand and left leg. He was unsure if he was receiving nursing services for the impaired mobility of his left arm and leg. During an observation on 1/26/23 at 10:26 a.m., Resident 24 was observed to be actively participating in activities. He was observed to have his left hand resting on his left leg with no splint on his left hand. During an observation on 1/30/23 at 3:07 p.m., Resident 24 was observed to be propelling himself in his wheelchair. He was observed not to have on a splint on his left hand. During an observation on 1/31/23 at 11:12 a.m., Resident 24 was observed to be sitting in his wheelchair with no hand splint on his left hand. On 1/27/23 at 2:32 p.m., Resident 24's clinical record was reviewed. The diagnoses included, but were not limited to, cerebral infarction (stroke), left	F 0688	**F688-ADL Prevent decrease in Range of Motion.** **This facility does ensure residents abilities are maintained.** **1. Corrective actions taken:** Regarding resident #24, The Residents most current BIM's (Brief Interview for Mental Status) dated 2/2/2023 indicated the Resident was a 15 out of 15. This indicates the Resident as cognitively intact. The residents hand splint is no longer ordered daily as the Resident consistently refuses to have the splint applied. His order has been changed to PRN (as desired) as the Resident has requested. **2. How other residents were identified:** All residents' orders will be reviewed to determine any resident who has an order for a hand splint. Ongoing, all residents who are ordered a hand splint will be audited during the daily Clinical management meeting and then reviewed for compliance by the Unit Managers. **See attached order review audit form**. **3. Measures in place/system**	02/10/2023

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	side hemiplegia (weakness on entire side the body), and left hand contracture (permanent shortening of a muscle or joint). The Quarterly Minimum Data Set (MDS) assessment, dated 11/2/22, indicated Resident 24 was cognitively intact, had limited range of motion (amount of movement around a specific joint) of upper and lower extremity on one side; had no days of active or passive range of motion restorative program; and had no days of splint or brace assistance. A care plan, dated 10/18/21 and current through target date 2/27/23, indicated Resident 24 had left side hemiplegia due to cerebral infarction and had a contracture to left hand. The care plan lacked interventions of left hand splint or any range of motion to left arm or left leg. A care plan, dated 10/18/21 and current through target date 2/27/23, indicated Resident 24 had the potential for impaired skin integrity related to left side hemiplegia. The intervention was to apply left hand splint in the morning and remove at bedtime. The care plan lacked any intervention of any range of motion to left arm or left leg. The Therapy Communication to Nursing for Functional Program Maintenance dated 12/23/21, indicated Resident 24 to wear a hand splint when up in wheelchair. Resident 24's Order Summary Report dated 1/30/23, indicated apply the left hand splint on in the morning and off at bedtime with a start date of 10/25/21. The care plan lacked documentation of Resident 24 refusing to wear his left hand splint.		**changes:** The Director of Nursing (DON)/designee will audit orders for splint placement and will communicate with the unit managers. The DON/designee audits will be completed on all residents with hand splint orders daily for two weeks, weekly for four weeks and monthly for a period of four months. **See attached DON/designee nurse audits.** **4. Monitoring of corrective actions taken:** In services were provided for staff. The Quality Assurance and Improvement committee will review compliance of F 688 at the quarterly meeting. Following the quarterly quality assurance compliance reviews and no resident with hand splint compliance audits will be discontinued. **5.** Date of Compliance: February 10, 2023. F688 ATTACHMENTS: NURSING AUDITS FORMS REGARDING SPLINT COMPLIANCE. STAFF IN SERVICING.	

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	The progress notes dated, 1/4/23 through 1/30/23, lacked documentation of Resident 24 refusing to wear his left hand splint. The Medication and Treatment Administration Record dated, 1/1/23 through 1/31/23, lacked documentation of Resident 24 refusing to wear his left hand splint. During an interview on 1/30/23 at 10:53 a.m., Qualified Medication Aide (QMA) 1 indicated Resident 24 wore a splint to his left hand. If he wanted to remove the splint, she would inform her nurse so the nurse could document this in his nurses notes. During an interview on 1/31/23 at 10:23 a.m., the Director of Nursing (DON) indicated they do not have a nursing restorative program. During an interview on 1/31/23 at 11:29 a.m., the Licensed Practical Nurse (LPN) 2 indicated Resident 24 wore a splint to his left hand. If he refused to wear the splint, they would document the refusal in the nurses notes. During an interview on 1/31/23 at 11:53 a.m., the DON indicated Resident 24 was one of the few residents who wore their splints. On 1/31/23 at 12:25 p.m., the Administrator provided the facility policy, "Nurse Aide Qualifications and Training Requirements," revised date of 8/22, and indicated it was the policy currently being used by the facility. A review of the policy indicated, "...j. basic restorative services...(6) care and use of prosthetic and orthotic devices..."			

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	3.1-42(a)(2)			