| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155770 | A. BUILDING 00<br>B. WING | 02/15/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| VILLAS OF GUERIN WOODS | 1002 SISTER BARBARA WAY<br>GEORGETOWN, IN 47122 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 0000<br><br>Bldg. 00 | This visit was for the Investigation of Nursing Home Complaints IN00397564, IN00398712, IN00399005 and IN00400688.<br><br>Complaint IN00397564 - Unsubstantiated due to lack of sufficient evidence.<br><br>Complaint IN00398712 - Substantiated. No deficiencies related to the allegations are cited.<br><br>Complaint IN00399005 - Substantiated. No deficiencies related to the allegations are cited.<br><br>Complaint IN00400688 - Substantiated. No deficiencies related to the allegations are cited<br><br>Unrelated deficiency cited.<br><br>Survey dates: February 13, 14 and 15, 2023<br><br>Facility number: 011509<br>Provider number: 155770<br>AIM number: 200909280<br><br>Census Bed Type:<br>SNF/NF: 63<br>Residential: 8<br>Total: 71<br><br>Census Payor Type:<br>Medicare: 9<br>Medicaid: 38<br>Other: 16<br>Total: 63<br><br>This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. | F 0000 | By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective March 13, 2023 to the complaint survey completed February 15, 2023 | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Eric Will | Administrator | 03/03/2023 |

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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155770 | A. BUILDING 00<br>B. WING | 02/15/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| VILLAS OF GUERIN WOODS | 1002 SISTER BARBARA WAY<br>GEORGETOWN, IN 47122 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | Quality review completed on February 17, 2023. | | | |
| F 0684<br>SS=D<br>Bldg. 00 | 483.25<br>Quality of Care<br>§ 483.25 Quality of care<br>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, and the residents' choices.<br>Based on interview and record review, the facility failed to ensure a resident (Resident G) was assessed by a licensed nurse, prior to moving after an unwitnessed fall, for 1 of 3 residents reviewed for resident assessment.<br><br>Finding included:<br><br>The clinical record for Resident G was reviewed on 2/13/23 at 3:02 p.m. The diagnoses included, but were not limited to, dementia and anxiety.<br><br>The care plan, dated 11/8/22, indicated the resident was at risk for falls due to cognitive impairment.<br><br>The progress note, dated 1/3/23 at 1:02 a.m., indicated CNA (Certified Nursing Aide) 3 notified the nurse in another Villa that Resident G had gotten up out of bed and went to the bathroom. CNA 3 found the resident sitting on the floor on her buttocks with her leg wrapped around her walker. CNA 3 reported the resident had a bruise to her lower left leg and a skin tear on her arm and had gotten the resident up off the floor because | F 0684 | F684<br>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?Resident G has been assessed by a licensed nurse. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?All residents have been reviewed to assure those with falls were assessed by a licensed nurse prior to being moved post fall. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?All staff have been in-service on the necessity of all residents being assessed by a licensed nurse prior to being moved post fall. How will the corrective action (s) be monitored to ensure the deficient | 03/13/2023 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155770 | A. BUILDING 00<br>B. WING | 02/15/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| VILLAS OF GUERIN WOODS | 1002 SISTER BARBARA WAY<br>GEORGETOWN, IN 47122 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | she was care planned for falls and helped her back to her bed.<br><br>The written statement from CNA 3, dated 1/2/23 and untimed indicated he found Resident G in the bathroom on the floor and she asked for help to get up. CNA 3 believed the resident was care planned for falls and he assisted her up off the floor, into her bed, and then exited the room. Resident G came out of her room and complained about her arm and leg being hurt. CNA 3 then called LPN (Licensed Practical Nurse) 4 in another Villa and reported the resident's fall and complaints.<br><br>The clinical record lacked documentation of any assessment by a licensed nurse prior to CNA 3 moving the resident.<br><br>During an interview on 2/15/23 at 1:00 p.m., the Unit Manager indicated the residents should not be moved after a fall until the nurse assessed them for injury.<br><br>On 2/14/23 at 12:30 p.m., a copy of the document titled "Falls Management System" dated 2016 was provided. It included, but was not limited to, "Policy...It is the policy of this center to provide each resident with appropriate evaluation and interventions to prevent falls and to minimize complications if a fall occurs...When a resident sustains a fall...The investigation and appropriate interventions will be evaluated at the time of the fall...When a resident sustains a fall, an evaluation for injury by a licensed nurse is completed...."<br><br>3.1-37 | | practice will not recur, i.e., what quality assurance program will be put into place?A Performance Improvement Tool has been initiated that randomly reviews 5 residents, if applicable, that have had falls, to assure a licensed nurse assessed the resident prior to being moved. The DON, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools. The Quality Assurance Committee will review the Performance improvement Tool as indicated above and will increase to weekly monitoring if < 90% of residents reviewed show compliance. The Quality Assurance Committee will continue to review the Performance Improvement Tool until auditing tools are showing 100% compliance, at which time the Quality Assurance Committee may decrease the monitoring increments. Deficencies in this practice will result in disciplinary action up to including termination. . The date the systemic changes will be completed: March 13, 2023 | |