STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155510	A. BUILDING 00 B. WING	12/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CENTURY VILLA HEALTH CARE	705 N MERIDIAN ST GREENTOWN, IN 46936

(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 Bldg. 00	This visit was for the Investigation of Complaint IN00395942. Complaint IN00395942 - Substantiated. No deficiencies related to the allegations were cited. Unrelated deficiencies are cited at F684. Survey dates: December 7 and 8, 2022 Facility number: 000549 Provider number: 155510 AIM number: 100267470 Census bed type: SNF: 6 SNF/NF: 59 Residential: 39 Total: 104 Census payor type: Medicare: 5 Medicaid: 32 Other: 28 Total: 65 This deficiency reflects state findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on December 20, 2022.	F 0000	This Plan of Correction constitutes Century Villa Health Care and Rehabilitation's written allegation of compliance for the alleged deficiencies cited. Submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by State and Federal law. Century Villa Health Care and Rehabilitation respectfully requests a desk review for this Plan of Correction.	
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			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Michael Gerig	Executive Director	12/28/2022

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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	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. Based on observation, interview and record review, the facility failed to assess, monitor and document a bruise from an unknown origin throughout the healing process for 1 of 1 resident reviewed for non-pressure skin areas. (Resident C) Finding includes: A report, titled "Indiana State Department Health Survey Report System," undated, indicated on 11/08/22 at 10:01 a.m., a bruise was observed on Resident C's left arm with an unknown origin. After further investigation, the resident indicated CNA 1 grabbed her left arm during a bed change, but the facility did not substantiate allegations of abuse against CNA 1. A written statement by the Director of Nursing (DON), dated 11/8/22, indicated there were no visible handprints on Resident C's left arm. The record for Resident C was reviewed on 12/7/22 at 3:30 p.m. Diagnoses included, but were not limited to, encephalopathy, chronic obstructive pulmonary disease, depression, pain, and generalized muscle weakness. Resident C's quarterly MDS (Minimum Data Set) assessment, dated 10/5/22, indicated she had a BIMS (Brief Interview Mental Status) assessment score of 14, which indicated she was cognitively intact. She required extensive two-person physical assist for bed mobility, transfers, locomotion on	F 0684	· What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; - Action was taken with the resident that was found to have a deficient practice. Nursing staff and social services has followed up daily with resident C and have monitored said area daily. The area to resident C has since healed. · How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; - DON and ADON did a head to toe skin sweep with residents to find and document any new areas discovered. · What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; - Nursing staff have been reeducated on facility Policy &	12/29/2022

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	and off the unit, dressing, toilet use and personal hygiene. Bathing required extensive assist with one person. The resident's record lacked progress notes, a skin observation tool assessment, and an observation/event monitoring documentation to indicate the bruise on the resident's left arm observed, on 11/8/22, had been assessed and was being monitored throughout the healing process. The last completed "Skin Observation Tool," dated 11/4/22 at 10:27 a.m., indicated the resident had no red, open or bruise areas noted at the time. During an interview, on 12/7/22 at 3:33 p.m., the Assistant Director of Nursing (ADON) indicated she observed a bruise on Resident C's left arm. The bruise was a purple and the size of a dime when she found it on 11/8/22. She did not document an assessment of the bruise in her records, but she was sure the nurse caring for her assessed and documented it. The facility did not typically follow through with monitoring, such as measuring small bruises like the one she found on the resident. The nurses would document whether the bruise was still present or not. On 12/8/22 at 2:38 p.m., Resident C was observed lying, in her bed, with her right arm propped up on two pillows. She had a faintly yellow bruise noted just above her wrist area. When asked if she knew how she got the bruise, she indicated an unidentified CNA grabbed her arm and she demonstrated how she grabbed her arm. During an interview, on 12/8/22 at 3:00 p.m., the DON indicated the bruise on Resident C's left forearm was a small yellow bruise when the ADON observed it on 11/8/22. She would check		Procedure related to skin changes, notification and weekly documentation related to skin · How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; - A Performance Improvement Tool has been developed that will monitor compliance with notification of changes in skin and follow up. DON/Designee will complete PI tool daily Monday through Friday for 2 weeks, then weekly for 2 weeks, then monthly for 3 months. Skin is a standing agenda item at QAPI and will continue to be monitored. · By what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, the division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date; - This POC systemic changes will be completed by the 29th day of December 2022	

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	for the assessment, monitoring and documentation of the bruise. During an interview, on 12/8/22 at 5:25 p.m., the Executive Director (ED), DON and ADON was in attendance. The ED indicated they did not have the measurements for resident's bruise to her left arm. The ADON indicated she thought the dayshift nurse on 11/8/22, was going to assess and document the bruise and the dayshift nurse thought she was going to assess and document the bruise. Neither of them assessed or documented it. The DON indicated there was no documentation of an assessment or monitoring of the bruise through the healing process. A current facility policy, titled "Facility Responsibilities for Reporting Allegations," dated as revised September 2022 and provided by the DON on 12/7/22 at 12:53 p.m., indicated "The following addresses facility responsibilities for...injuries of unknown source...Injuries on Unknown Source NOT Required to Report...NOTE: Even if the injury is not one that requires a report, the facility should adequately assess and monitor the resident, notify the physician/resident representative as appropriate, and document the injury and investigation as a part of the resident's medical record...." 3.1-37(a)			