STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155770	A. BUILDING 00 B. WING	03/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VILLAS OF GUERIN WOODS	1002 SISTER BARBARA WAY 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 Bldg. 00	This visit was for the Investigation of Complaint IN00402082. Complaint IN00402082 - Federal/State deficiency related to the allegation is cited at F689. Survey date: March 6, 2023 Facility number: 011509 Provider number: 155770 AIM number: 200909280 Census Bed Type: SNF/NF: 62 Residential: 7 Total: 69 Census Payor Type: Medicare: 3 Medicaid: 47 Other: 12 Total: 62 This deficiency reflects State Finding cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 8, 2023.	F 0000	**Plan of Correction for the Villas of Guerin Woods from the March 6, 2023, Complaint Survey** The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Certification Desk Review in lieu of the Post Survey Revisit.	
F 0689 SS=E Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Eric Will	Administrator	03/23/2023

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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	§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed implement increased supervision on a resident after two attempts to exit the facility; failed to ensure staff documented placement and functionality of wander guards (security bracelets); and failed to ensure a physician's order was in place timely for a wander guard for 4 of 4 residents reviewed for accident hazard, devices, and supervision. (Residents B, C, D and E) Findings include: 1. The clinical record for Resident B was reviewed on 3/6/23 at 12:13 p.m. The diagnoses included, but were not limited to, depressive disorder, dementia, anxiety and bipolar. On 3/6/23 at 10:57 a.m., the resident was observed resting in a recliner in the hearth area with her eyes closed. A wander guard was observed to her right wrist. The incident report, dated 2/19/23 at 2:20 p.m., indicated Resident B was observed outside of Villa 2 on 2/28/23 at 6:40 p.m. Resident B was returned to Villa 2, head to toe assessment completed, and the physician and family were notified. The care plan, dated 12/22/22, indicated the resident was at risk for elopement and to check the resident's whereabouts frequently. The progress note, dated 2/16/23 at 6:40 p.m., indicated the resident was agitated with being at the facility and attempted to elope out of the	F 0689	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Residents B, C, D, and E currently have wander guards in place with appropriate MD orders, updated care plans, documentation is completed on placement and function, and per physician orders. **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 the potential to be affected by the alleged deficient practice. The audit of all resident records was completed to ensures appropriate MD orders are in place for placement and function of the wander guard, care plans updated, elopement assessment completed, and that the documentation is completed on placement and function per physician orders. All identified residents were reviewed by IDT. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · The staff were educated on	03/28/2023

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	building twice. The staff had to encourage, redirect and explain to the resident that she could not leave due to the weather and safety. The progress note, dated 2/18/233 at 6:45 p.m., QMA (Qualified Medication Assistant) 3 was informed Resident B had opened the door and walked down the sidewalk. QMA 3 redirected Resident B back to the Villa without difficulty. A wander guard was then placed on the resident. The clinical record lacked documentation of any increased supervision after the resident attempted to exit the Villa on 2/16/23 at 6:40 p.m. During an interview on 3/6/23 at 2:22 p.m., QMA 3 indicated she and the aide had been assisting other residents. When she walked in the kitchen she was informed that a resident had gone out the door. She ran out the door and found Resident B on the sidewalk between Villa 2 and Villa 4. She redirected the resident back into Villa 2 without any issues. During an interview on 3/6/23 at 2:26 p.m., UM (Unit Manager) 4 indicated typically when a resident would exit seek, they would initiate Q (every) 15 minute checks or Q 30 minute checks, depending on how eager the resident had tried to get out. The revision of the elopement care plan, dated 2/21/23, indicated the resident was to have a wander guard and to check placement every shift and function daily. The physician's order, dated 2/23/23, indicated the resident was to have a wander guard in place to the right wrist and to check placement every shift.		the elopement policy, identifying residents at risk for elopement, documentation of placement and function of a wander guard and notification to the Administrator or DON/designee if a resident exhibits or shows behaviors related to wondering or potential elopement. In addition, the IDT will be reviewing changes of condition to ensure interventions are in place for those residents at risk for elopement. **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?** · The Administrator or DNS/designee will audit nurses notes on all residents 7 days a week to identify residents that have non-characteristic behaviors or actions related to elopement, ensure assessment was completed, and MD orders for using a wanderguard, placement, and function if it is determined the wanderguard is an appropriate intervention. · A performance improvement tool has been initiated that will be utilized to review 5 residents at risk for elopement to ensure appropriate interventions are in place The Administrator or DON/designee will complete this audit daily x 4 weeks then weekly x 8 weeks and then monthly x 3	

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	The clinical record lacked documentation of the wander guard placement check for 2/26/23 on day shift, and an order for the resident's wander guard between 2/18/23 at 2/22/23. During an interview on 3/6/23 at 3:32 p.m., RN (Registered Nurse) 5 indicated once placement of a wander guard was checked, staff should sign the treatment administration record. During an interview on 3/6/23 at 5:07 p.m., the interim Director of Nursing indicated there should be an order in place for a wander guard. 2. The clinical record for Resident C was reviewed on 3/6/23 at 12:48 p.m. The diagnoses included, but were not limited to, dementia with psychotic disturbance and major depressive disorder. The physician's order, dated 10/5/22, indicated the resident was to have a wander guard to his right wrist and to check placement and function of the wander guard every shift. The care plan, dated 10/5/22, indicated the resident was an elopement risk and staff were to check the resident's wander guard every shift for placement and the function daily. Review of the February 2023 and March 2023 treatment administration records lacked documentation of the placement and function of the resident's wander guard on the following dates and shifts: - On 02/02/23 - day shift - On 02/03/23 - day shift - On 02/06/23 - day shift - On 02/20/23 - day shift - On 02/23/23 - day and night shift		months and quarterly x 2. Any issues identified will be immediately corrected. The QA committee will review the tool at regularly scheduled meetings and make additional recommendations as needed based on the outcome of the tools. The review the tool as indicated above and will increase to daily monitoring if less than 90% of residents show compliance. The Quality Assurance Committee will continue to review the auditing tool until the tool is showing 100% compliance at which time the committee may decrease the monitoring increments. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee. Date of Compliance 3/28/2023	

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	- On 02/24/23 - day shift - On 02/27/23 - day shift - On 03/03/23 - day shift 3. The clinical record for Resident D was reviewed on 3/6/23 at 1:14 p.m. The diagnoses included, but were not limited to, dementia and anxiety. The progress note, dated 2/22/23 at 7:05 p.m., indicated the resident had exit seeking behavior and attempted to exit. The resident was redirected and a wander guard was placed. The care plan, dated 2/22/23, indicated the resident had the potential for elopement and staff were to check the resident's wander guard for placement and function as ordered. The physician's order, dated 3/2/23, indicated the resident was to have a wander guard and staff were to check the function every night shift and for proper placement every shift. The clinical record lacked documentation of an order for the resident's wander guard between 2/22/23 and 3/1/23. 4. The clinical record for Resident E was reviewed on 3/6/23 at 1:42 p.m. The diagnoses included, but were not limited to, unspecified head injury and major depressive disorder. On 3/6/23 at 1:58 p.m., the resident was observed with a wander guard to her right wrist. The behavior note, dated 1/7/23 at 6:36 p.m., indicated a lunch time, the resident was confused and wandered around the Villa. At dinner time, the resident was very agitated and tried to leave out the back and front door. A wander guard was			

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	placed on the resident. The care plan, dated 1/9/23, indicated the resident was an elopement risk and staff were to check the placement and function per physician's order. The clinical record lacked documentation of a physician's order for the wander guard and placement/function of the wander guard since applied on 1/7/23. On 3/6/23 at 5:07 p.m., the interim DON indicated resident should have had an order for a wander guard and there was no order for the resident's wander guard. On 3/6/23 at 4:13 p.m., the interim Director of Nursing provided a current copy of the document titled "Elopement" dated January 2019. It included, but was not limited to, "It is the policy of this facility to provide a safe and secure environment for our residents and to be proactive in preventing resident elopement ...Electronic monitoring systems may be implemented as possible interventions as appropriate. If an electronic monitoring device is utilized as an intervention they shall be checked ...for function and placement ...." This Federal tag relates to Complaint IN00402082 3.1-45(a)(2)			