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	11/14/2022

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 Complaints IN00389635 and IN00394192. Complaint IN00389635 - Unsubstantiated due to lack of sufficient evidence. Complaint IN00394192 - Substantiated. Federal/State deficiency related to the allegation is cited at F656. Survey date: November 14, 2022 Facility number: 011509 Provider number: 155770 AIM number: 200909280 Census Bed Type: SNF/NF: 65 Residential: 6 Total: 71 Census Payor Type: Medicare: 15 Medicaid: 39 Other: 11 Total: 65 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on November 22, 2022.	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 December 15, 2022 to the complaint survey completed on November 14, 2022.	
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered			

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

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	care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.			

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	§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on interview and record review, the facility failed to ensure a plan of care was implemented timely for a resident (Resident B) with a high risk for elopement for 1 of 4 residents reviewed for comprehensive care plans Findings include: The clinical record for Resident B was reviewed on 11/14/22 at 12:26 p.m. The diagnosis included, but was not limited to, dementia. The incident report, dated 11/5/22 at 3:35 p.m., indicated Resident B was observed outside of her Villa by staff. The care plan, dated 10/13/21, indicated the resident had dementia with an intervention of a wander guard to her wrist related to impaired decision making. The elopement/wander risk evaluation, dated 8/30/22 at 5:49 p.m., indicated the resident was forgetful/short attention span, ambulated independently with a cane or walker, had early dementia, a history of wandering, and a wander guard was in place. The clinical record lacked documentation of a plan of care related to the resident's elopement risk evaluation completed on 8/30/22 until 11/5/22. During an interview on 11/14/22 at 4:07 p.m., the Executive Director indicated the wander guard itself was documented under the dementia care	F 0656	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident B care plan was revised on 11/5/2022 by the administrator to include a risk for elopement. **How other residents having the potential to be affected by the same deficient practice will be identified and corrective action(s) will be taken?** All residents identified as at risk on their elopement assessment were reviewed and care plan and interventions were updated as needed to include the risk for elopement. ="" p="">**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** IDT and Licensed Nurses will be educated by the Unit Manager, Director of Nursing and Administrator on the comprehensive care planning process. Staff will be educated on or by 12/14/2022. **How the corrective action(s) will be monitored to ensure the**	12/15/2022

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	plan. When she went to update the resident's care plan after the incident, she added the elopement care plan. On 11/14/22 at 5:16 p.m., the Executive Director provided a current copy of the document titled "Care Plans, Comprehensive Person-Centered" dated December 2016. It included, but was not limited to, "Policy Statement...A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the residents...needs is developed and implemented for each resident...The comprehensive, person-centered care plan will...Incorporate identified problem areas...Incorporate risk factors associated with identified problems...." This Federal tag relates to Complaint IN00394192 3.1-35(a) 3.1-35(c)(1)		**deficient practice will not recur, i.e. what quality assurance program will be put into place?** The MDS Coordinator, Director of Nursing and/or Unit Manager will conduct an audit to include residents who triggered as at risk for elopement have appropriate care plans and in interventions in place. The DON, UM and/or MDS coordinator will complete at least 5 resident chart audits per week for 4 weeks then 3 audits per week for 4 weeks then 1 per week for 4 weeks to ensure the sustained compliance. These audits will be conducted randomly throughout the Villas to ensure compliance with all nurses. Any areas identified via the audit will be immediately corrected. The QA committee will review the results of the audits at scheduled meetings with recommendations as needed based on the outcome until 100% compliance is achieved. If 100% compliance is not achieved at any time, the QAPI team may determine the need to continue further audit until 100% compliance is sustained for 3 months. ="" p="">	