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	04/16/2024

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00431206 and IN00431392. Complaint IN00431206 - No deficiencies related to the allegation is cited. Complaint IN00431392 - Federal/State deficiency related to the allegation is cited at F657. Survey date: April 15 and 16, 2024 Facility number: 011509 Provider number: 155770 AIM number: 200909280 Census Bed Type: SNF/NF: 62 Residential: 8 Total: 71 Census Payor Type: Medicare: 12 Medicaid: 28 Other: 22 Total: 62 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on April 23, 2024.	F 0000	This plan of correction is prepared and executed because the provisions of state and federal law require it and not because riverbend Nursing and Rehabilitation Center agrees with the allegations and citations listed. The Villas of Geurin Woods maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor is it of such character to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions set forth in this plan of correction. We respectfully request a desk review for this plan of correction.	
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Eric WIll	Administrator	05/03/2024

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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	of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.			
	Based on observation, interview and record review, the facility failed to ensure a resident's (Resident B) plan of care was updated for 1 of 3 residents reviewed for care plans. Findings include: The clinical record for Resident B was reviewed on 4/15/24 at 2:30 p.m. The resident's diagnoses included, but were not limited to, dementia, depression and anxiety. On 4/15/24 at 11:30 a.m., during an observation the resident was observed resting in bed with her eyes closed. She was covered with 4 blankets and	F 0657	**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident B had no negative outcome due to not having a noncompliance C/P for refusal to remove numerous blankets to assist in healing of heat rash. The plan of care has been updated to reflect this non- compliance. DON/designee notified Resident B physician and responsible party of her	05/03/2024

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	a sheet. The care plan, originally dated 6/17/22 with a revision on 1/29/24, indicated the resident had an actual skin impairment of a rash to the lower back. The interventions included, but were not limited to, for staff to assist the resident to turn and reposition every 2 hours, educate resident/family/caregivers of causative factors and measurements to prevent skin injury, provide good nutrition and hydration and complete treatments as ordered. The progress note, dated 2/19/24 at 12:54 a.m., indicated the resident had a rash to both sides of her lower back and the nurse practitioner would assess the resident in the morning. The progress note, dated 2/21/24 at 10:38 a.m., indicated the nurse practitioner assessed the resident's rash. The rash was a possible heat rash due to the resident being covered with 5 blankets and the room was extremely warm. Staff were to try and keep the room at 72 degrees. The progress note, dated 3/13/24 at 11:00 a.m., indicated the resident declined to remove her blankets and to get up out of bed. The care plan lacked documentation of a revision for the residents' refusal to remove her blankets. During an interview on 4/16/24 at 12:57 p.m., NP (Nurse Practitioner) 11 indicated she had seen the resident on 2/21/24 for a rash. The resident kept her room warm and had multiple blankets on her bed which caused her to perspire resulting in the heat rash on her lower back. The resident would not let the staff remove the blankets.		non-compliance with not removing multiple blankets to assist with heat rash healing as was recommended by the medical provider. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be** taken? Other residents who are non-compliant with MD/NP recommendations to assist in the healing of skin concerns have the potential to be affected. The DON/designee will identify residents who are non-compliant with recommendations to heal skin concerns. MD and responsible parties will be notified. C/Ps will be updated to reflect that non-compliance. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The DON/designee will provide education to licensed nursing staff on the requirement to C/P residents who are non-compliant with measures to assist with skin healing as recommended by the MD/NP. The MD and RP will be notified of the non-compliance. Routine auditing to be	

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	The policy titled "Care Plans, Comprehensive Person-Centered" dated December 2016, 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 Citation relates to Complaint IN00431392 3.1-35(d)(B)		completed by the DON/designee as noted below to ensure the C/Ps have been updated to reflect residents who are non-compliant with skin healing measures and the MD/NP/RP have been notified of the non-compliance. **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The DON/designee will identify residents who are non-compliant with measures to assist with healing of skin issues and will update their C/Ps to reflect. The DON/designee will complete auditing to ensure newly identified non-compliance with skin healing measures have a C/P to reflect the non-compliance. Auditing to occur weekly x's 4 weeks, monthly x's 5 months for a total of 6 months of monitoring. Any findings will be addressed. The results of these reviews will be discussed at the facility Quality Assurance Committee monthly meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Re-education, frequency and/or duration of reviews will be increased as needed, if areas of noncompliance are identified through the auditing	

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			process.	