STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155210	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willows of Greensburg	410 Park Rd Greensburg, IN 47240

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 38239 Based on interview and record review, the facility failed to ensure a resident received appropriate care and treatment in a timely manner after experiencing an unwitnessed fall for 1 of 3 residents reviewed for falls. (Resident E) Findings include: During an interview on 12/18/24 at 1:20 P.M., Certified Nurse Aide (CNA) 2 indicated Resident E fell on the morning of 12/11/24. She was standing at the nurses' station, and the resident was in his room and his door was open. She saw the resident stand up from his recliner. She told him to, Hold on, and as she rounded the corner of the counter heading to his room he must have fallen because he was on the floor laying on his left side by the time she had gotten to him. Licensed Practical Nurse (LPN) 3 came in, assessed the resident, and then they both assisted him up from the floor and into his bed. The resident walked with assistance to the bed and did not indicate he was in any pain. A short time later, as CNA 2 was providing personal hygiene care, she noticed the resident was rubbing his right thigh. He did not verbalize he was in pain. The resident was not acting like himself, but he hadn't been for the last couple of days. He had COVID-19 and a possible urinary tract infection. CNA 2 told LPN 3 about the resident rubbing his thigh and LPN 3 said they would continue to monitor him or keep an eye on him. CNA 2 checked on him at lunch and she brought him his meal tray, but he didn't eat anything. He didn't get out of bed the rest of the shift. She provided personal hygiene care again sometime after lunch but before the end of her shift (her shift ended at 2:00 P.M.). He was holding his right thigh, but he didn't say anything about being in pain. CNA 2 didn't work the next day, when she came back on 12/13/24 staff told her the resident had been sent out to the hospital. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/19/24 at 1:28 P.M., the Director of Nursing (DON) indicated the night shift nurse noticed the resident's leg was swollen on the evening of 12/11/24. The Nurse Practitioner (NP) was in the facility on 12/12/24, and had assessed the resident. The NP indicated staff were to monitor his leg and encourage the resident to elevate the leg. That evening, the nurse on duty was concerned about the resident's right hip as it was swollen, and she noticed shortening of the leg. They called the NP who ordered a STAT (immediate) X-ray. At that time, they still were unaware that the resident had fallen on 12/11/24. The resident had COVID-19, and while they were waiting for the X-ray to be obtained, the resident's respiratory status was worsening. They sent him to the local hospital before the mobile X-ray company arrived. An X-ray was obtained at the hospital, and it was determined the resident had fractured his right hip. At that time, the DON had started to investigate the injury and CNA 2 told her the resident had fallen on 12/11/24 and that LPN 3 knew about the fall. The LPN had assisted her with getting the resident up from the fall and back into bed. The DON reviewed the resident's record, and the nurse had not documented anything about the fall, and she had not reported the fall to any other staff members. The DON asked LPN 3 about the resident and if he had fallen. The nurse denied any knowledge of the resident falling and suggested another staff member may have dropped the resident and didn't say anything. The DON indicated the LPN was no longer an employee. During an interview on 12/19/24 at 1:35 P.M., the DON indicated when a resident experienced a fall nursing staff were to assess the resident immediately for any injury and obtain their vital signs. If the resident's range of motion was good, they would assist the resident up from the floor, if there was an injury they would call Emergency Medical Services (EMS). If the fall was not witnessed or if the resident hit their head, they would begin neurological assessments. They would put an immediate intervention in place. They would notify the MD or Nurse Practitioner (NP), Administrator, DON, and the resident's family, They would document the fall in the computer. There would be progress notes and assessments. The Interdisciplinary team would review the fall and determine the cause. Care plans would be updated to reflect interventions put into place related to the fall. Resident E's clinical record was reviewed on 12/18/24 at 12:55 P.M. A Quarterly Minimum Data Set assessment, dated 10/03/24, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, dementia, anemia, hypertension, heart failure, anxiety, depression, seizure disorder, and Chronic Obstructive Pulmonary Disease. The resident had experienced two falls since the last assessment. A Progress Note, dated 12/12/24 at 7:18 A.M., indicated the resident's right leg was swollen from his knee to his hip. There was no rotation of the hip joint. There were no bruises or discoloration of the right hip. There was no grimacing or crying out. A Progress Note, dated 12/12/24 at 10:10 A.M., indicated the resident's right hip and leg were swollen. The NP was made aware, and she assessed the resident. A Progress Note, dated 12/12/24 at 10:10 P.M., indicated the resident was moaning and crying out during care. The NP was made aware and ordered an x-ray of the resident's right hip. A Progress Note, dated 12/13/24 at 3:40 A.M., indicated the resident was experiencing shortness of breath and a decrease in his oxygen saturation rate. The resident was sent out to the local hospital. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident's record lacked any indication the resident had experienced a fall on 12/11/24. An X-ray of the resident's right hip was obtained at the local hospital on 12/13/24 at 11:11 A.M. The clinical indication for the X-ray was swelling and deformity. The findings indicated the resident had a previous right hip replacement. There was now a displacement of the femoral stem with the fracture abnormality involving the intertrochanteric and subtrochanteric aspect of the right hip/femur. The current facility policy, titled Fall Management, dated, 08/01/23, was provided by the Administrator on 12/19/24 at 1:52 P.M. The policy indicated, .Any resident experiencing a fall will be assessed immediately by the charge nurse for possible injuries and necessary treatment will be provided .A neurological assessment will be initiated on all un-witnessed falls .the physician will be contacted immediately if there are injuries .the family will be notified .falls will be discussed by the interdisciplinary team .Fall follow up assessment will be completed and documented by licensed nurse every shift x 72 hours .nurse will document the fall in the medical record to include description of fall, resident and nurse statement, MD/family notification, pain assessment, potential root cause of fall, and immediate intervention .Notify DON . This citation relates to Complaint IN00449496.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 38239 Based on interview and record review, the facility failed to document and report forward of a resident's fall to ensure a resident received appropriate care and treatment in a timely manner for 1 of 3 residents reviewed for Resident Records. (Resident E) Findings include: During an interview on 12/18/24 at 1:20 P.M., Certified Nurse Aide (CNA) 2 indicated Resident E fell on the morning of 12/11/24. She was standing at the nurses' station, and the resident was in his room and his door was open. She saw the resident stand up from his recliner. She told him to, Hold on, and as she rounded the corner of the counter heading to his room he must have fallen because he was on the floor laying on his left side by the time she had gotten to him. Licensed Practical Nurse (LPN) 3 came in, assessed the resident, and then they both assisted him up from the floor and into his bed. The resident walked with assistance to the bed and did not indicate he was in any pain. A short time later, as CNA 2 was providing personal hygiene care, she noticed the resident was rubbing his right thigh. He did not verbalize he was in pain. The resident was not acting like himself, but he hadn't been for the last couple of days. He had COVID-19 and a possible urinary tract infection. CNA 2 told LPN 3 about the resident rubbing his thigh and LPN 3 said they would continue to monitor him or keep an eye on him. CNA 2 checked on him at lunch and she brought him his meal tray, but he didn't eat anything. He didn't get out of bed the rest of the shift. She provided personal hygiene care again sometime after lunch but before the end of her shift (her shift ended at 2:00 P.M.). He was holding his right thigh, but he didn't say anything about being in pain. CNA 2 didn't work the next day, when she came back on 12/13/24 staff told her the resident had been sent out to the hospital. During an interview on 12/19/24 at 1:28 P.M., the Director of Nursing (DON) indicated the night shift nurse noticed the resident's leg was swollen on the evening of 12/11/24. The Nurse Practitioner (NP) was in the facility on 12/12/24, and had assessed the resident. The NP indicated staff were to monitor his leg and encourage the resident to elevate the leg. That evening, the nurse on duty was concerned about the resident's right hip as it was swollen, and she noticed shortening of the leg. They called the NP who ordered a STAT (immediate) X-ray. At that time, they still were unaware that the resident had fallen on 12/11/24. The resident had COVID-19, and while they were waiting for the X-ray to be obtained, the resident's respiratory status was worsening. They sent him to the local hospital before the mobile X-ray company arrived. An X-ray was obtained at the hospital, and it was determined the resident had fractured his right hip. At that time, the DON had started to investigate the injury and CNA 2 told her the resident had fallen on 12/11/24 and that LPN 3 knew about the fall. The LPN had assisted her with getting the resident up from the fall and back into bed. The DON reviewed the resident's record, and the nurse had not documented anything about the fall, and she had not reported the fall to any other staff members. The DON asked LPN 3 about the resident and if he had fallen. The nurse denied any knowledge of the resident falling and suggested another staff member may have dropped the resident and didn't say anything. The DON indicated the LPN was no longer an employee. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/19/24 at 1:35 P.M., the DON indicated when a resident experienced a fall nursing staff were to assess the resident immediately for any injury and obtain their vital signs. If the resident's range of motion was good, they would assist the resident up from the floor, if there was an injury they would call Emergency Medical Services (EMS). If the fall was not witnessed or if the resident hit their head, they would begin neurological assessments. They would put an immediate intervention in place. They would notify the MD or Nurse Practitioner (NP), Administrator, DON, and the resident's family, They would document the fall in the computer. There would be progress notes and assessments. The Interdisciplinary team would review the fall and determine the cause. Care plans would be updated to reflect interventions put into place related to the fall. Resident E's clinical record was reviewed on 12/18/24 at 12:55 P.M. A Quarterly Minimum Data Set assessment, dated 10/03/24, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, dementia, anemia, hypertension, heart failure, anxiety, depression, seizure disorder, and Chronic Obstructive Pulmonary Disease. The resident had experienced two falls since the last assessment. A Progress Note, dated 12/12/24 at 7:18 A.M., indicated the resident's right leg was swollen from his knee to his hip. There was no rotation of the hip joint. There were no bruises or discoloration of the right hip. There was no grimacing or crying out. A Progress Note, dated 12/12/24 at 10:10 A.M., indicated the resident's right hip and leg were swollen. The NP was made aware, and she assessed the resident. A Progress Note, dated 12/12/24 at 10:10 P.M., indicated the resident was moaning and crying out during care. The NP was made aware and ordered an x-ray of the resident's right hip. A Progress Note, dated 12/13/24 at 3:40 A.M., indicated the resident was experiencing shortness of breath and a decrease in his oxygen saturation rate. The resident was sent out to the local hospital. The resident's record lacked any indication the resident had experienced a fall on 12/11/24. An X-ray of the resident's right hip was obtained at the local hospital on 12/13/24 at 11:11 A.M. The clinical indication for the X-ray was swelling and deformity. The findings indicated the resident had a previous right hip replacement. There was now a displacement of the femoral stem with the fracture abnormality involving the intertrochanteric and subtrochanteric aspect of the right hip/femur. The current facility policy, titled Fall Management, dated, 08/01/23, was provided by the Administrator on 12/19/24 at 1:52 P.M. The policy indicated, .Any resident experiencing a fall will be assessed immediately by the charge nurse for possible injuries and necessary treatment will be provided .A neurological assessment will be initiated on all un-witnessed falls .the physician will be contacted immediately if there are injuries .the family will be notified .falls will be discussed by the interdisciplinary team .Fall follow up assessment will be completed and documented by licensed nurse every shift x 72 hours .nurse will document the fall in the medical record to include description of fall, resident and nurse statement, MD/family notification, pain assessment, potential root cause of fall, and immediate intervention .Notify DON . This citation relates to Complaint IN00449496. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-50(a)(2)