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	07/23/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review and interview, the facility failed to document a fall and start neurological assessments in a timely manner for 1 of 3 residents reviewed for quality of care. (Resident C)Findings include:The clinical record for Resident C was reviewed on 07/22/25 at 9:55 A.M. A Quarterly Minimum Data Set (MDS) assessment, dated 05/21/25, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, stroke, heart failure, hypertension, dementia, anxiety, and depression. The resident used a walker for mobility and required partial to moderate staff assistance for Activities of Daily Living (ADLs). During an interview, on 07/23/25 at 10:53 A.M., the Director of Nursing (DON) indicated she was made aware Resident C had a fall through a text message from RN 2 on 06/09/25 at 11:12 P.M. RN 2 sent a second text message on 06/09/25 at 11:47 P.M. that the resident was having hip pain. She sent a text back advising RN 2 to make the Nurse Practitioner (NP) aware. RN 2 sent a third text message on 06/10/25 at 7:19 A.M., that the NP wanted the resident to have an x-ray of her left hip. The x-ray report indicated the resident had a left hip fracture. RN 2 did not complete a risk management for the unwitnessed fall; she had completed the form the next day. During an interview, on 07/23/25 at 11:12 A.M., Certified Nurse Aide (CNA) 3, indicated on 06/09/25 she started her shift at 10:00 P.M. Shortly after she arrived on the unit, she heard a loud thud. She went to Resident C's room and saw she had fallen. She went to the nurse's station and alerted RN 2 that the resident was on the floor. He went to the resident's room, checked her vital signs, and assisted the resident back to bed. A few minutes later the resident turned her call light on and complained of pain. CNA 3 told RN 2 and he went to the resident's room, checked her vital signs, and indicated to her the resident was fine. Around midnight the resident turned her call light on again and complained of pain and said she wanted to go to the local hospital. CNA 3 said she informed RN 2 who went to the medication cart and took something to the resident. The resident slept for the rest of her shift. During an interview, on 07/23/2025 at 11:37 A.M., Licensed Practical Nurse (LPN) 4 indicated when a resident had a fall, she would complete a head-to-toe assessment, check vital signs, range of motion of arms and legs, and if everything checked out fine, she would assist them back to bed or a chair. She would notify the DON, NP, and the resident's representative to alert them of the fall. The NP would either be called or sent a text message for them to call back. Any new orders from the NP were given verbally to the nurse. A risk management fall assessment should be completed in the resident's clinical record and neurological (neuros) assessment were completed on paper. Neurological assessments were completed at the time of the fall, every 15 minutes for the first hour, every 30 minutes for the next two hours, every four hours for five times, and every eight hours for six times. A progress note should also be documented about the fall. An unwitnessed fall assessment form was completed by the DON on 06/09/25 at 11:20 P.M.A Neuro Assessment form was started for Resident C on 06/10/25. The first set of neuros were completed and documented at 12:30 A.M. A current facility policy titled Fall Management, was provided by the DON on 7/23/25 at 11:20 A.M., with a date of 08/01/2023 , indicated .Post Fall 1. Any resident experiencing a fall will be assessed immediately by the charge nurse for possible injuries and necessary treatment will be provided. 6. The nurse will document the fall, resident and nurse statement, MD/family notification, pain assessment, potential root cause of fall, and immediate intervention.This citation relates to complaint 1294215.3.1-37(a)