

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155510	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/12/2024
NAME OF PROVIDER OR SUPPLIER Century Villa Health Care		STREET ADDRESS, CITY, STATE, ZIP CODE 705 N Meridian St Greentown, IN 46936	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>32842</p> <p>Based on interview and record review, the facility failed to ensure a staff member treated residents with respect and dignity while providing Activities of Daily Living (ADL) care for 3 of 5 residents being reviewed for ADL care. (Resident B, G and H) The deficient practice was corrected on 12/28/23, prior to the start of the survey, and was therefore past noncompliance.</p> <p>Finding includes:</p> <p>A document, titled Indiana State Department of Health Survey Report System, dated 12/22/23 at 7:30 a.m., indicated CNA 1 was being very abrupt and trying to hurry Resident B during ADL care, to the point, she was in tears. CNA 1 acted as if she had no patience for her. The incident was witnessed by the resident's daughter and other staff members. After the incident investigation was completed, it was determined CNA 1 acted abruptly and, in a haste, to do Resident B's ADL care. The resident felt tearful, since she was hurried to do her morning tasks. After interviews with other residents on the date in question and careful consideration, CNA 1 was relieved of her employment at the facility.</p> <p>A facility document, titled Status Change Notice, dated 12/22/23, indicated CNA 1 was involuntarily terminated from the facility, on 12/22/24, for providing abrupt care with a resident, which was witnessed by a family and staff member.</p> <p>A handwritten statement from CNA 2, dated 12/22/23, indicated the day started out bad. She witnessed CNA 1 being very rushed + [and] abrupt and she came off as she was agitated with a resident.</p> <p>The clinical record for Resident B was reviewed on 7/11/24 at 12:10 p.m. Diagnoses included, but were not limited to, dementia, anxiety, acute respiratory failure with hypoxia, and chronic kidney disease stage 5.</p> <p>A quarterly Minimum Data Set (MDS) assessment, completed on 12/14/23, indicated Resident B had a moderate cognitive impairment. She was totally dependent on the facility staff for mobility.</p> <p>(continued on next page)</p>

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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A care plan, dated as initiated on 12/15/23, with a revised date of 6/20/24, addressed the problem the resident required assistance with ADL's related to debility, self-care deficit, respiratory failure, chronic obstructive pulmonary disease, congestive heart failure, and diabetes mellitus. Interventions included, but were not limited to, 12/15/23, monitor for fatigue and provide rest periods as needed. 12/15/23, provide adaptive equipment: wheelchair. 12/15/23, total dependence with two assist using sit to stand lift. 12/15/23, use mechanical sit to stand lift with two staff member's assistance for transfers.</p> <p>A Social Service Director (SSD) progress note, dated 12/22/23 at 9:08 a.m., indicated Resident B's daughter came to the Social Service Director and indicated her mother's aide had been verbally mean to her that morning and physically rough. This same CNA had treated her mother like this before, but she had let it go. She was not going to let it happen anymore. The SSD spoke to the resident, who was crying, and she confirmed with the resident the same aide had been mean to her before and the resident pleaded she did not want that CNA to care for her any longer.</p> <p>A SSD progress note, dated 12/22/23 at 9:14 a.m., Resident G indicated he got along with CNA 1, but she could be a bit rough around the edges when she was in a bad mood. When the resident was asked when the last time CNA 1 was in a bad mood, he indicated that morning. The resident indicated CNA 1 was not mean, but she was rough while getting him out of the bed.</p> <p>A SSD progress note, dated 12/22/23 at 9:21 a.m., the SSD spoke with Resident H to see how his morning had been, and he indicated it could have been better. When asked what happened, he indicated CNA 1 was very grouchy and was not nice while providing care that morning. The resident indicated CNA 1 got a little rough sometimes, which was normal for that CNA to act that way.</p> <p>During a phone interview, on 7/11/24 at 12:30 p.m., Resident B's daughter indicated her mother called her on 12/22/23 and was crying because CNA 1 had gotten her up for lunch, abruptly and quickly with the stand-up lift, while yelling at her. She was afraid she was going to fall out of the stand-up lift because she was shaking as she stood in the stand-up lift, due to the fast pace which CNA 1 was pushing the stand-up lift. When she arrived at the facility, her mother was in the dining room, crying because she did not believe someone would treat her like that. Her daughter indicated her mother deserved to be treated with respect and dignity. Resident B was still upset about the incident with the stand up lift a few days later. She did not want CNA 1 to care for her anymore and she relayed that information to the management staff.</p> <p>During an interview, on 7/11/24 at 11:30 a.m., the Director of Nursing (DON) indicated CNA 1 was terminated for poor customer service due to providing abrupt care with Resident B.</p> <p>A facility document, titled Resident Rights, dated 12/2016 and provided by the DON on 7/12/24 at 3:06 p.m., indicated .Employees shall treat all residents with kindness, respect and dignity. Policy Interpretation and Implementation: 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to .be treated with respect, kindness, and dignity .</p> <p>The deficient practice was corrected by 12/28/23, after the facility implemented a systemic plan that included the following actions: all the residents on the hallway with Resident B were interviewed, all facility staff were re-educated regarding abuse and neglect, Resident B's care plan was updated, SSD monitored the residents' psychosocial status, and CNA 1 was terminated.</p> <p>(continued on next page)</p>		

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