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 10/02/2024
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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 46961 Based on record review and interview, the facility failed to ensure the physician was notified timely of a choking episode for 1 of 1 resident reviewed for respiratory infection. (Resident 12) Finding includes: The clinical record for Resident 12 was reviewed on 9/26/24 at 3:59 p.m. The diagnoses included, but were not limited to, chronic kidney disease stage 3, psychotic and mood disturbance, anxiety, and vascular dementia with psychotic behavior. A progress note, dated 9/20/24 at 11:07 p.m., indicated the resident choked on hamburger meat during dinner. The resident was breathing but coughing. The resident was unable to bring the food up. The resident was suctioned to remove phlegm and mucus. The resident continued to cough and when she spoke, she made a gurgling sound. The resident's daughter was notified. A triage form, dated 9/20/24 at 7:00 p.m., indicated the resident had a possible aspiration and requested the nurse practitioner (NP) to assess the resident's lung sounds on Monday (9/23/24). A nurse practitioner's progress note, dated 9/23/24, indicated the resident was seen for an acute visit for a recent coughing episode. The resident experienced an episode over the weekend, during which she required suctioning. The nursing staff reported changes in breath sounds following the episode. During the examination, wheezing was noted throughout the resident's lungs. The choking episode and wheezing raised concern for a possible respiratory issue. The plan was to obtain a 2-view chest x-ray to evaluate for potential pneumonia. Oxygen saturation (percentage of oxygen in the blood) and changes in respiratory exam would be continuously monitored. Follow-up would be scheduled when results were returned or sooner if necessary. A progress note, dated 9/24/24 at 3:04 p.m., indicated the NP reviewed the chest x-ray results. New orders were received for Augmentin (an antibiotic) 800/125 milligrams (mg) for 5 days and to monitor oxygen saturation twice daily for a cough. A physician's order, dated 9/24/24, indicated Ipratropium-Albuterol solution (a medication used to treat lung conditions) 0.5-2.5 mg /3 milliliters (ml) 1 vial inhale orally twice daily for shortness of breath for 10 days. (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: 155510	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Century Villa Health Care	705 N Meridian St Greentown, IN 46936

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A care plan, dated 9/24/24, indicated the resident had pneumonia. The approaches included, but were not limited to, auscultate lung sounds, listen for crackle and breath sounds due to atelectasis (in aspiration pneumonia rhonchi and wheezing are also present), and monitor and document for mental changes, in the elderly, pneumonia may initially present as mental changes and cough only. During an interview, on 10/01/24 at 2:40 p.m., the Nurse Practitioner indicated she was notified of the episode by the triage note on Monday (9/23/24). A current policy, titled Acute Condition Changes, dated as revised 2017 and received from the Assistant Director of Nursing (ADON) on 10/1/24 at 2:08 p.m., indicated .the facility shall use defined protocol to evaluate and report changes in condition of its residents/patients .physicians shall help identify and manage causes of acute changes of condition (ACOC) .acute changes of condition will be identified and managed properly .residents/patients with acute changes of condition will not experience preventable decline in condition while being treated in the facility .the nursing staff will contact the physician based on the urgency of the situation .for emergencies, they will call or page the physician and request a prompt response (within approximately one-half hour or less) 3.1-5(a)(1) 3.1-5(a)(2) 3.1-5(a)(3)

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 44598 Based on observation, interview and record review, the facility failed to ensure the correct amount of oxygen was administered as ordered by the physician for 1 of 1 resident reviewed for respiratory care. (Resident 54) Finding includes: During an observation, on 9/25/24 at 2:23 p.m., Resident 54's oxygen concentrator (a device used to provide supplemental oxygen therapy) was set on 2.5 liters per minute (L). During an observation, on 9/26/24 at 12:20 p.m., the resident was sitting in the common area and his portable oxygen tank was set on 4L. The clinical record for Resident 54 was reviewed on 9/27/24 at 10:22 a.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease, hypertension, and chronic kidney disease. A care plan, dated 6/18/24, indicated the resident was on oxygen therapy. Interventions included, but were not limited to, monitor oxygen saturation, monitor for signs and symptoms of respiratory distress, and administer oxygen by nasal cannula as ordered. A physician's order, dated 7/12/24, indicated the resident was to receive 2L of oxygen continuously. During an interview, on 9/25/24 at 12:24 a.m., LPN 4 indicated the resident's oxygen concentrator was on 2. 5L. The resident's order was for 2 to 4L depending on the resident. During an interview, on 9/26/24 at 12:25 p.m., the Director of Nursing (DON) indicated the resident oxygen was set on 4L and she was not sure of the resident's order. During an interview, on 9/26/24 at 1:17 p.m., the DON indicated the resident's order was for 2L and the resident was on 4L. The staff should follow the physician's order. A current policy, titled Oxygen Administration, revised 10/2010 and received from the DON on 9/26/24 at 10:40 a.m., indicated .The purpose of this procedure is to provide guidelines for safe oxygen administration . Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration 3.1-47(a)(6)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44598 Based on observation, interview and record review, the facility failed to ensure the correct personal protective equipment (PPE) for contact precautions was used, to perform hand hygiene after resident contact, to utilize enhanced barrier precautions (EBP) when required, to protect clean laundry from contamination, to perform hand hygiene and change gloves while performing wound care, and to keep the indwelling catheter tubing from touching the floor for 7 of 7 residents reviewed for infection control. (Resident 19, 33, 47, 18, 20, 38 and 48) Findings include: 1. During an observation, on 9/27/24 at 8:54 a.m., QMA 5 was giving medications to Resident 28. After finishing with Resident 28, she walked over to Resident 19 and touched the resident's blanket without wearing a gown or gloves as she asked if the resident needed anything. Resident 19 had an order for contact precautions with a sign on the door. QMA 5 exited the room and walked directly to her medication cart outside the dining room. No hand hygiene was observed while she was in the room, walking down the hall, or at the medication cart. She then wrote on her resident information paper, accessed her computer screen, and prepared Resident 18's morning medications. During an observation, on 9/30/24 at 9:23 a.m., LPN 4 was giving medications to Resident 19 who remained on contact precautions with no gown or gloves on while she was in the room. The clinical record for Resident 19 was reviewed on 9/27/24 at 9:32 a.m. The diagnoses included, but were not limited to, chronic kidney disease stage 3, personal history of malignant neoplasm of bronchus and lung, personal history of malignant neoplasm of brain, and history of Escherichia coli extended-spectrum beta-lactamases producing organism (ESBL) with current infection. A physician's order, dated 9/25/24, indicated contact isolation precautions for ESBL in urine culture every shift until 10/1/24. A care plan intervention, initiated 9/25/24, indicated contact isolation precautions for ESBL for Resident 19. A nurse's note, dated 9/25/24 at 12:57 p.m., indicated the Nurse Practitioner (NP) ordered contact precautions. During an interview, on 9/30/24 at 1:35 p.m., LPN 4 indicated for enhanced barrier precautions, staff should wear a gown and gloves when giving direct care or touching a resident, and contact isolation was basically the same thing. She indicated they had to wear gowns and gloves when they were going to be in contact with an area where the infection was but not every time you went into the room. During an interview, on 10/01/24 at 2:26 p.m., the Assistant Director of Nursing (ADON) indicated that all staff had been educated on hand hygiene and the correct use of PPE, including requirements for wearing gowns and gloves every time they enter a room under contact precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The clinical record for Resident 47 was reviewed on 9/30/24 at 9:25 a.m. The diagnoses included, but were not limited to, disorder of kidney and bladder and neuromuscular dysfunction of the bladder. A physician's order, dated 7/26/24, indicated foley catheter (indwelling urethral catheter) care every shift. A nurse's note, dated 9/12/24 at 11:59 a.m., indicated the resident's indwelling urethral catheter was draining clear yellow urine. A MDS quarterly assessment, dated 9/6/24, indicated the resident had an indwelling urethral catheter. A care plan, initiated 7/25/24, indicated the resident had a foley catheter related to neurogenic bladder. The clinical record did not include an order for enhanced barrier precautions. During an interview, on 10/01/24 at 3:25 p.m., the Director of Nursing (DON) indicated the resident had an indwelling urethral catheter present and should be on EBP. She did not know why there was no signage on the door or an order. A Centers for Medicare and Medicaid Services (CMS) memorandum QSO-24-08-NH, titled Enhanced Barrier Precautions in Nursing Homes, dated 3/20/24, indicated EBP are indicated for residents with any of the following .indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO .Indwelling medical device examples include .urinary catheters 4. During an observation, on 10/01/24 at 11:02 a.m., there were three pairs of pants and one shirt hanging on the handrail outside of room [ROOM NUMBER]. Resident 18 and Resident 20 were in room [ROOM NUMBER] with contact droplet isolation for Covid. During an interview, on 10/01/24 at 11:04 a.m., CNA 7 indicated the clothes were not supposed to be hanging on the hand railing outside. During an interview, on 10/01/24 at 11:32 a.m., the Housekeeping Manager indicated she told the staff to hang the clothes on the outside of the door so the nursing staff would take it in. Clothes should not be hung on the rails outside the rooms. 49891 5. During a wound care observation, on 10/2/24 at 9:58 a.m., LPN 2 did not change her gloves and did not perform hand hygiene after removing Resident 38's shoe and dirty dressing before cleansing the wound with saline and gauze. She did not change gloves and perform hand hygiene after putting Resident 38's shoe back on and before re-capping the Santyl ointment. The clinical record for Resident 38 was reviewed on 9/26/24 at 3:25 p.m. The diagnoses included, but were not limited to, Parkinson's disease, dementia, muscle weakness, and abnormalities of gait and mobility. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A current facility policy, titled Isolation- Categories of Transmission-Based Precautions, dated 4/2/24 and received from Clinical Support on 9/27/24 at 1:50 p.m., indicated .Contact precautions are implemented for residents .infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces .Staff .wear gloves .when entering the room .Gloves are removed, and hand hygiene performed before leaving the room .Staff .wear a disposable gown upon entering the room 3.1-18(b) 3.1-18(l)