STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155510	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Century Villa Health Care	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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review, the facility failed to ensure a resident's representative received notification in writing of the facility's bed hold policy, the Ombudsman was notified when a resident's was transferred and discharged to the hospital, and discharge paperwork provided to a resident's caregiver did not contain another resident's information for 2 of 3 residents reviewed for discharge. (Resident 37 and C)Findings include:1. The clinical record for Resident 37 was reviewed on 12/12/25 at 2:38 p.m. The diagnoses included, but were not limited to, muscle weakness, Alzheimer's disease, major depressive disorder, hypertension, osteoporosis, chronic kidney disease, and pain. A facility reported incident, dated 11/23/25 at 5:01 p.m., indicated Resident 37 had a fall, was sent to the hospital, and was hospitalized . The clinical record did not include documentation to indicate the bed hold policy was provided to the resident's representative in writing or the Ombudsman was notified of the transfer to the hospital. During an interview, on 12/16/25 at 10:30 a.m., the Clinical Support Nurse indicated the resident was not on the Ombudsman notification list and the Ombudsman should have been notified. During an interview, on 12/16/25 at 10:45 a.m., the Director of Nursing (DON) indicated there was no documentation the bed hold policy was provided to the resident's representative in writing or the Ombudsman was notified of the transfer to the hospital. 2. The clinical record for Resident C was reviewed on 12/16/25 at 2:09 p.m. The diagnoses included, but were not limited to, muscle weakness, diabetes mellitus, anemia, chronic kidney disease, and hypertension. Resident C was discharged from the facility to home on 8/30/25. During an interview, on 12/17/25 at 10:35 a.m., Resident C's caregiver indicated she received another resident's paperwork with personal health information on it, along with Resident C's discharge paperwork. During an interview, on 12/17/25 at 2:31 p.m., Registered Nurse 7 indicated when a resident was close to discharge, social services would print and prepare the discharge paperwork in a folder. During the discharge, an RN would go over the paperwork with the resident and/or a family member before sending them home. (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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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 12/17/25 at 2:55 p.m., the DON indicated when a resident was discharged , the nurse would go over paperwork with the resident and family or caregiver. The paperwork went into a folder and went with the resident. If someone else's paperwork was mixed in, it should be noticed and caught before discharge. A current facility policy, titled Protected Health Information (PHI), Management and Protection of, undated and received from Clinical Support on 12/17/25 at 3:43 p.m., indicated .it is the responsibility of all personnel who have access to resident and facility information to ensure that such information is managed and protected to prevent unauthorized release or disclosure A current facility policy, titled Bed Hold and Return to Center Policy, revised on 4/20/18 and received from the Clinical Support Nurse on 12/16/25 at 11:26 p.m., indicated .A copy of the facility Bed Hold Policy Review and Notice will be provided to the resident and/or resident representative upon admission by the Admissions Coordinator or designee .A copy of the facility Bed Hold Policy Review and Notice will be provided to the resident and/or resident representative at the time of transfer or in cases of emergency transfer, within 24 hours. Multiple attempts to notify the resident representative will be documented in the progress notes in cases where the facility was unable to notify the representative A current facility policy, titled Transfer or Discharge, Facility-Initiated, revised on 10/2022 and received from the Clinical Support Nurse on 12/16/25 at 11:26 p.m., indicated .Facility-initiated transfers and discharges, when necessary, must meet specific criteria and require/representative notification and orientation, and documentation as specified in this policy .The facility will send a copy of the discharge notice to a representative of the Office of the State LTC Ombudsman .Notice to the Office of the State LTC Ombudsman will occur at the same time the notice of discharge is provided to the resident and resident representative . When a resident is transferred or discharged from the facility, the following information is documented in the medical record .A summary of the resident's overall medical, physical, and mental condition .Disposition of personal effects .Disposition of medication .The signature of the person recording the data in the medical record This citation relates to Intake 2617173. 3.1-12(a)(6)(A)(i) 3.1-12(a)(6)(A)(ii) 3.1-12(a)(6)(A)(iii)

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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. Based on interview and record review, the facility failed to ensure Abnormal Involuntary Movement Scale (AIMS) assessments were completed and daily weights were obtained for 2 of 2 residents reviewed for quality of care. (Resident 21 and 46)Findings include: 1. The clinical record for Resident 21 was reviewed on 12/15/25 at 11:39 a.m. The diagnoses included, but were not limited to, bipolar disorder, anxiety disorder, delusional disorder, persistent mood disorder, and dementia without behavioral disturbances. A care plan, dated 8/8/23, indicated Resident 21 was at risk for adverse side effects related to the use of antipsychotic and antidepressant medication. A physician's order, dated 11/14/24, indicated to administer Invega (an atypical antipsychotic medication) extended release 1.5 milligram (mg) tablet once a day at bedtime. A physician's order, dated 10/16/25, indicated to administer Pristiq (an antidepressant medication) extended release 25 mg tablet once a day. An Abnormal Involuntary Movement Scale (AIMS) assessment, dated 2/21/24 at 12:16 p.m., indicated the involuntary movement score was zero (0). An Abnormal Involuntary Movement Scale (AIMS) assessment, dated 1/21/25 at 8:44 p.m., indicated the assessment was completed by error with no involuntary movement score. During an interview, on 12/15/25 at 2:24 p.m., the Director of Nursing (DON) indicated the AIMS assessments were to be completed every 3-6 months. During an interview, on 12/17/25 at 11:55 a.m., the DON indicated Resident 21's last AIMS assessment was performed on 1/21/25 and had been struck out in error. AIMS assessments were to be completed every six months for residents who were receiving psychotropic medications. During an interview, on 12/18/25 at 9:29 a.m., LPN 6 indicated AIMS assessments were to be completed for residents who received psychotropic medications upon admission and then quarterly. During an interview, on 12/18/25 at 9:36 a.m., LPN 5 indicated AIMS assessments were to be completed for residents who received psychotropic medications every three months. During an interview, on 12/18/25 at 12:25 p.m., the DON indicated the nursing staff were responsible for the completion of the AIMS assessments. 2. The clinical record for Resident 46 was reviewed on 12/17/25 at 9:04 a.m. The diagnoses included, but were not limited to, diabetes mellitus, congestive heart failure, and anxiety disorder. A care plan, dated 3/6/24, indicated Resident 46 had a diagnosis of congestive heart failure. The interventions included, but were not limited to, monitor weight gain unrelated to intake, obtain weights as ordered, and notify the physician of significant weight loss or gain. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician's order, dated 8/23/24, indicated to obtain a daily weight and notify the Nurse Practitioner (NP) if the resident had a 3-pound weight gain in 24 hours. The Medication Administration Record, dated 5/1/25 to 5/31/25, indicated documentation a daily weight was obtained was missing on 5/5/25, 5/8/25, 5/11/25, 5/12/25, 5/15/25, 5/16/25, 5/17/25, 5/18/25 and 5/19/25. The Medication Administration Record, dated 6/1/25 to 6/30/25, indicated documentation a daily weight was obtained was missing on 6/3/25, 6/4/25, 6/6/25, 6/10/25, 6/14/25, 6/18/25 and 6/21/25. The Medication Administration Record, dated 7/1/25 to 7/31/25, indicated documentation a daily weight was obtained was missing on 7/20/25, 7/25/25, 7/26/25 and 7/31/25. The Medication Administration Record, dated 8/1/25 to 8/31/25, indicated documentation a daily weight was obtained was missing on 8/10/25, 8/11/25, 8/12/25, 8/19/25, 8/20/25, 8/23/25 and 8/24/25. During an interview, on 12/17/25 at 9:36 a.m., the Director of Nursing (DON) indicated if the resident was supposed to be weighed daily then the nurse was expected to obtain a weight. During an interview, on 12/17/25 at 1:35 p.m., Licensed Practical Nurse (LPN) 5 indicated when a resident had an order for a daily weight, he would provide a list of the residents for the Certified Nursing Assistant (CNA) to obtain. Once the weight was obtained, it would be documented in the resident's record. During an interview, on 12/17/25 at 1:45 p.m., CNA 6 indicated any staff could obtain a resident's weight. The weight list came from the nurse, the weight would be obtained, and the nurse would chart the weight in the resident's record. A current facility policy, titled Psychotropic Medication Use, dated as revised 7/2022 and received from the Clinical Support Nurse on 12/16/25 at 11:55 a.m., indicated .Residents receiving psychotropic medications are monitored for adverse consequences. A current facility policy, titled Heart Failure - Clinical Protocol, dated as revised 11/2018 and received from the Clinical Support Nurse on 12/17/25 at 1:30 p.m., indicated .The physician will help identify or clarify causes of congestive heart failure .The physician will review and make recommendations for relevant aspects of the nursing care plans; for example .weights .to monitor, when to report the findings to the physician 3.1-37(a)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a medication cart was locked when not in direct observation of staff for 1 of 4 medication carts randomly observed for medication storage. (300 hall medication cart) Findings include:During an observation, on 12/12/25 at 10:30 a.m., the 300-hall medication cart was unlocked and unattended.During an observation, on 12/12/25 at 10:32 a.m., LPN 4 came out of room [ROOM NUMBER] and went to the medication cart.During an interview, on 12/12/25 at 10:32 a.m., LPN 4 indicated the medication should not have been left unlocked when she went into room [ROOM NUMBER].During an interview, on 12/17/25 at 11:57 a.m., the Director of Nursing (DON) indicated medication carts should be locked all times when not in direct supervision of nursing staff.During an interview, on 12/18/25 at 9:21 a.m., QMA 7 indicated medication carts should be kept locked when not in direct observation of the staff member responsible for the cart.During an interview, on 12/18/25 at 9:26 a.m., LPN 6 indicated medication carts should be kept locked when not in direct observation of the staff member responsible for the cart.During an interview, on 12/18/25 at 9:37 a.m., LPN 5 indicated medication carts should be kept locked when not in direct observation of the staff member responsible for the cart.A current facility policy, titled Medication Labeling and Storage, revised on 2/2023 and received from the DON on 12/17/25 at 12:12 p.m., indicated .Compartments.containing medications and biologicals are locked when not in use, and trays or carts used to transport such items are not left unattended if open A current facility policy, titled Exceptional Living Centers Job Description Licensed Practical Nurse-605014, with no date and received from the DON on 12/17/25 at 12:12 p.m., indicated .Carries out responsibilities in compliance with federal, state, local laws and regulations, and with facility philosophy, policies and procedures 3.1-25(m)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure staff wore personal protective equipment (PPE) into an enhanced barrier precaution (EBP) room while providing care for 1 of 5 residents reviewed for enhanced barrier precautions. (Resident 46)Findings include:During an observation, on 12/16/25 at 3:59 p.m., RN 2 entered Resident 46's room to administer medication and a bolus feed. The resident had a gastrostomy tube (a tube surgically inserted into the stomach to provide medication and nutrition) and was in isolation for enhanced barrier precautions. RN 2 did not put on an isolation gown to administer the medication and bolus feed through the gastrostomy tube.The clinical record for Resident 46 was reviewed on 12/17/25 at 9:28 a.m. The diagnosesincluded, but were not limited to, gastrointestinal hemorrhage, vascular disorder ofthe intestine, gastrostomy status, and [NAME]-Danlos syndrome.A physician's order, dated 7/25/25, indicated Resident 46 was in enhanced barrier precautions due to the gastrostomy tube.During an interview, on 12/17/25 at 9:13 a.m., the Director of Nursing (DON) indicatedwhen a resident was in enhanced barrier precautions the staff were supposed to a wear a gown and gloves.During an interview, on 12/17/25 at 12:11 p.m., LPN 3 indicated she would wear a gownand gloves while administering medication or bolus tube feeds through a gastrostomy tube.A current facility policy, titled Enteral Tube Feeding via Syringe (Bolus), dated November 2018 and provided by the DON on 12/17/25 at 9:13 a.m., indicated .The following equipment and supplies will be necessary when performing this procedure.Personal protective equipment e.g., gowns, gloves, mask.A current facility policy, titled Enhanced Barrier Precautions, dated March 2024 and provided by the DON on 12/17/25 at 9:13 a.m., indicated . Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include. device care or use.feeding tube.3.1-18(b)(2)