STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155535	A. BUILDING 00 B. WING	10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLOW CROSSING HEALTH & REHABILITATION CENTER	3550 CENTRAL AVE COLUMBUS, IN 47203

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00418177. Complaint IN00418177 - Federal/State deficiency related to the allegations is cited at F686. Survey dates: October 5 and 6, 2023 Facility number: 000572 Provider number: 155535 AIM number: 100267710 Census Bed Type: SNF/NF: 105 Total: 105 Census Payor Type: Medicare: 9 Medicaid: 89 Other: 7 Total: 105 This deficiency reflects State Finding cited in accordance with 410 IAC 16.2-3.1. Quality review completed on October 10, 2023.	F 0000	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under and state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey. Due to the low scope and severity of the survey finding, please find the sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance. Should additional information be necessary to confirm said compliance, feel free to contact me.	
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Alisha Miller	Administrator	10/26/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

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	professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to provide appropriate wound care related to infection control procedures for 2 of 3 residents reviewed for pressure ulcers. (Resident B and C) Findings include: 1. The clinical record for Resident C was reviewed on 10/5/23 at 11:24 a.m. A Quarterly MDS (Minimum Data Set) assessment, dated 8/31/23, indicated the resident only required supervision for mobility and transfers, and was always continent of bladder and bowel. No skin issues were noted. Her diagnoses included, but were not limited to, cellulitis of the left great toe, osteomyelitis, surgical amputation of the left great toe, and diabetes myelitis type 2 with hyperglycemia and chronic kidney disease. A Physician's Order, dated 9/20/23, indicated the wound location was the left great toe and it was a surgical wound. Nursing staff were to cleanse the open area with normal saline (may use wound cleanser if normal saline was contraindicated) dry, paint the toe with betadine, cover with a Telfa (a non-adherent dressing), wrap with kerlix (rolled gauze) and an ace bandage every day and as needed.	F 0686	F157 Requires the facility to provide appropriate wound care related to infection control procedures. 1 Resident B and C had their wound care completed again with proper infection control procedures. 2 All residents have the potential to be affected. LPN 2 and 3 were immediately inserviced regarding the policy and procedures on wound care and maintaining proper infection control. No concerns were noted. See below for corrective measures. 3 The dressing-clean technique policy and procedure was reviewed with no changes made. (See attachment A) The staff was inserviced on the above procedure. 4 The DON or her designee will observe 3 wound care procedures daily to ensure proper infection control procedures are being conducted per policy. The DON or her designee will utilize the nursing monitoring tool daily	10/18/2023

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	During an observation on 10/6/23 at 9:51 a.m., Licensed Practical Nurse (LPN) 2 and LPN 3 indicated they were preparing to perform a dressing change for Resident C. LPN 2 gathered supplies, entered the room, and removed the boot from Resident C's left foot. LPN 2 donned gloves, and no hand washing was observed. She retrieved a pair of scissors from her right pocket, used them to remove the old dressing that was dated 10/6/23, and put the scissors back into her left pocket. She indicated the dressing had been changed that morning, but they were doing the dressing change again. Then wearing the same gloves, she used wound cleanser and gauze to clean the toe, used the betadine to paint the toe, covered the toe with a Telfa dressing, and then wrapped the toe and foot with kerlix. LPN 2 then replaced the resident's sock and boot, gathered the trash, and doffed her gloves. Both LPNs left the room with no hand hygiene observed. Both LPNs then proceeded down the hall to a second wound care cart and opened drawers, moved items around, and removed additional wound care supplies for the next wound care treatment with no hand hygiene observed. 2. The clinical record for Resident B was reviewed on 10/5/23 at 10:14 a.m. A Quarterly MDS assessment, dated 8/9/23, indicated the resident was moderately cognitively impaired, was totally dependent on two staff members for bed mobility and transfers, had a urinary catheter, and was always incontinent of bowel. He had three Stage 3 pressure ulcers on his coccyx. His diagnoses included, but were not limited to, paraplegia, vascular dementia with agitation, and protein calorie malnutrition. A Wound Care Report, dated 10/5/23 at 2:15 p.m.,		times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100 % compliance is obtained and maintained. (See attachment B) If the nurse fails to provide wound care per proper infection control procedures then the nurse will have to complete 1:1 inservice training and complete dressing changes with a supervisor until nurse obtains 100% competency. The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly if warranted. 5 The above corrective measures will be completed on or before Oct 18, 2023.	

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indicated Resident B had three open wounds on his coccyx:

A Physician's Order, dated 10/2/23, indicated the wound location was on the right gluteus (per the wound center). Nursing staff were to cleanse the open area with normal saline (may use wound cleanser if normal saline was contraindicated), pat dry, and apply border gauze daily on Monday, Wednesday, and Friday.

During a continuous observation on 10/6/23 at 10:03 a.m., with no hand hygiene observed and with bare hands, LPN 2 gathered border foam dressings and wound cleanser from a second treatment cart and held them against her right chest with her right arm. She then stopped at a medication cart and checked the physician's orders for Resident B. No hand hygiene was observed. LPN 2 and LPN 3 entered Resident B's room. LPN 2 placed the dressing supplies on the resident's bed side tray table without cleaning the table. Resident B was observed lying on his back with a pillow under his right shoulder. Both LPNs donned gloves without washing their hands. LPN 2 used the bed remote to lower the head of the bed. LPN 3 assisted the resident to roll to his left side. LPN 2 then removed the old dressing. She doffed her gloves, and with no hand hygiene observed, donned new gloves. She used the wound cleanser to clean all three wounds. She doffed her left glove and laid the soiled glove on the tray table, moved the supplies around with her left hand, picked up the soiled glove, and put it in the trash. She used her left bare hand and gloved right hand to roll an absorbent pad under the resident's buttock area. She opened the border foam dressing and donned a left glove with no hand hygiene observed. She used her right gloved hand to reach into her right front pocket

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	and retrieved a black marker, dated all three foam border dressings, and placed the marker back into her pocket. She doffed her left glove, searched her pockets, and retrieved the scissors she used from the first dressing change to trim all three foam dressings then donned a left glove. She placed the first dressing. When she attempted to place the second dressing, the lower part of the dressing was folded under, so she retrieved the used scissors from her pocket to trim the sticky part from the foam dressing. She doffed her left glove, opened another foam dressing, retrieved the marker from her right pocket with her gloved right hand, and dated and initialed that dressing. She then placed the fourth foam dressing, picked up the left dirty glove and disposed of it. LPN 3 tapped LPN 2's left hand to indicate she needed to put on a glove. With no hand hygiene observed, LPN 2 doffed the right glove and went to the treatment cart in the doorway to the room to retrieve more tape to secure the four dressings. Both LPNs doffed their gloves and washed their hands. During an observation and interview on 10/6/23 at 10:31 a.m., LPN 3 indicated she did not like the look of the multiple border foam dressings and was going to redo the dressing change. She went to the treatment cart and retrieved four Optifoam basic dressings and retention tape. She placed a towel on the resident's bed side tray table and placed the supplies on the towel. With no hand hygiene observed, she donned gloves. LPN 2 had donned gloves and was feeling around in her pockets looking for the scissors. LPN 3 found the marker on the tray table and dated the Optifoam dressings. She then removed the border foam dressings, doffed her gloves, and donned clean gloves with no hand hygiene observed. She placed three foam dressings on Resident B's			

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coccyx area. LPN 2 touched the third foam dressing to hold the dressings in place while LPN 3 covered the dressings with retention tape. LPN 2 asked Resident B if he was comfortable on his left side and the resident indicated he was. Both LPNs doffed their gloves. LPN 3 washed her hands and LPN 2 gathered the trash and washed her hand.

During an interview on 10/6/23 at 10:43 a.m., LPN 2 indicated hand hygiene should take place before donning gloves, after the old dressing was removed, and after the treatment was completed. She did not wash her hands after the first treatment and before the second treatment.

During an interview on 10/6/23 at 10:44 a.m., LPN 3 indicated staff should wash their hands before and after each resident contact. She stated, when doing a dressing change, she should have hand washed during the procedure after removing the old dressing.

The current facility policy titled "DRESSING - CLEAN TECHNIQUE" and dated 10/2014, was provided by the Assistant Director of Nursing (ADON) on 10/6/23 at 10:57 a.m. The policy indicated, " ...Purpose: A clean dressing techniques is used to provide an appropriate environment conducive to wound healing ...Procedure: 1. Perform necessary initial steps (See STEPS, INITIAL AND FINAL - PROVISION OF CARE for a complete list of steps.) ...2. Remove soiled dressing ...3. Remove gloves, wash hands, and put on a pair of clean gloves ...5. Apply dressing ...remove gloves ....6. Perform necessary final steps ..."

The current facility policy titled "STEPS, INITIAL AND FINAL - PROVISION OF CARE" and dated 10/2014, was provided by the ADON on 10/6/23 at

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	10:57 a.m. The policy indicated, " ...Purpose: To provide resident with care that ensures ...infection control ... Procedure: INITIAL STEPS: ...8. Wash hands ...9. Wear gloves ...FINAL STEPS: ...1. Remove gloves ...and wash your hands ... This citation relates to Complaint IN00418177. 3.1-40(2)			