| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155210 | A. BUILDING 00<br>B. WING | 05/30/2024 |

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| WILLOWS OF GREENSBURG | 410 PARK RD<br>GREENSBURG, IN 47240 |

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| F 0000<br><br>Bldg. 00 | This visit was for a Recertification and State licensure survey.<br><br>Survey dates: May 23, 24, 25, 26, 27, 28, 29, and 30, 2024.<br><br>Facility number: 000117<br>Provider number: 155210<br>AIM number: 100266460<br><br>Census Bed Type:<br>SNF/NF: 56<br>Total: 56<br><br>Census Payor Type:<br>Medicare: 4<br>Medicaid: 28<br>Other: 24<br>Total: 56<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed on June 7, 2024. | F 0000 | **Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because is required by the provisions of Federal and State Law.**<br>**Willows of Greensburg requests this Plan of Correction to be considered the Facilities Allegation of Compliance.Compliance effective date is 6-15-2024. We kindly request paper compliance for this annual survey.** | |
| F 0684<br>SS=D<br>Bldg. 00 | 483.25<br>Quality of Care<br>§ 483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. | | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Michael Meadows | HFA | 06/19/2024 |

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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| | Based on observation, interview, and record review, the facility failed to follow manufacturer's guidelines related to insulin pen usage (Residents 35), and failed to follow physician's orders related to hold parameters for a blood pressure medication (Resident 52) for 2 of 7 residents reviewed for quality of care.<br><br>Findings include:<br><br>1. Medication administration was observed on 05/29/24 at 9:03 A.M., with RN 3. The RN retrieved an Insulin Aspart pen and a Basalgar insulin pen from a plastic bag and indicated Resident 35 was to receive 15 units of the Aspart (a short-acting insulin) and 30 units of Basalgar (a long-acting insulin). The nurse applied needles to both pens but did not cleanse the rubber seals with an alcohol wipe before attaching the needles. She turned the dials at the end of the pens to the appropriate doses and then dialed up an additional 3 units per pen to prime the pens. The RN held the pens sideways and primed both pens, cleansed the resident's skin and administered the insulin. During an interview following the medication administration, the RN indicated she should have cleansed the pens with alcohol before attaching the needles. She usually held the insulin pens sideways when she primed them.<br><br>The clinical record for Resident 35 was reviewed on 05/29/24 at 9:45 A.M. A Quarterly MDS (Minimum Data Set) assessment, dated 03/18/24, indicated the resident was moderately cognitively impaired. The resident's diagnoses included, but were not limited to, diabetes and stroke.<br><br>The current facility policy, titled "Insulin Pen", and dated 07/23, was provided by the DON (Director of Nursing) on 05/30/24 at 10:40 A.M. | F 0684 | **F684 Quality of Care**<br>**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;**<br>Resident #35 was assessed per licensed nurse with no negative outcomes.<br>Resident #52 was assessed per licensed nurse with no negative outcomes. Supplemental documentation added for blood pressure in MD orders.<br>**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;**<br>All residents that reside in the facility have the potential to be affected by the alleged deficient practice.<br>RN #3 was educated on insulin pen administration by Director of Nursing/designee and performed return demonstration on or by 06/15/2024.<br>Medication administration records were audited for all residents that receive blood pressure medication that require vital signs. Supplementary documentation was added for blood pressure per MD orders by Director of Nursing/designee.<br>**What measures will be put into place and what systemic changes will be made to ensure that the deficient** | 06/15/2024 |

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| | The policy indicated, "...Insulin pens will be primed prior to each use to avoid collection of air in the insulin reservoir...wipe the rubber seal with an alcohol pad...With the needle pointing up, push the plunger, and watch to see that at least one drop of insulin appears on the tip of the needle..."<br><br>2. The clinical record for Resident 52 was reviewed on 05/28/24 at 10:53 A.M. An Admission MDS assessment, dated 03/19/24, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, stroke, hypertension, and diabetes.<br><br>The resident's current physician's orders included an opened-ended order, with a start date of 03/22/24, for lisinopril (a blood pressure medication), 10 mg (milligrams) once a day. The medication was to be held if the resident's SBP (Systolic Blood Pressure) was less than 110.<br><br>The March, April, and May 2024 EMARs (Electronic Medication Administration Records) were reviewed and indicated the medication was administered daily. The resident's record lacked documentation of the resident's blood pressure prior to the medication administration for 52 of 69 days reviewed:<br><br>- 03/22/24,<br>- 03/25/24 through 04/01/24,<br>- 04/05/24 through 04/07/24,<br>- 04/10/24,<br>- 04/12/24 through 04/14/24,<br>- 04/16/24,<br>- 04/19/24 through 05/01/24,<br>- 05/03/24 through 05/08/24,<br>- 05/10/24 through 05/13/24,<br>- 05/15/24, | | **practice does not recur;**<br>All nurses were educated on insulin pen medication administration by Director of Nursing/designee on or by 06/15/24<br>All nurses were educated on obtaining blood pressure with parameter orders prior to administration of blood pressure medication on or by 06/15/2024 by Director of Nursing/designee.<br>**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;**<br>QAPI tool for Insulin administration with pen and BP medication administration will be completed weekly X 4 weeks, bi-monthly X 2 and monthly X 4 months by DNS/Designee If 100% threshold is not achieved an action plan will be developed. This information will be presented to the QAPI committee during the monthly meeting. | |

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| | - 05/17/24 through 05/22/24, and<br>- 05/24/24 through 05/29/24.<br><br>During an interview on 05/30/24 at 8:36 A.M., QMA (Qualified Medication Aide) 4 indicated if a resident had a hold parameter ordered for a medication, they were to check the resident's blood pressure or heart rate before they gave the medication. If the blood pressure or heart rate was too low, they were to hold the medication and document it in the EMAR.<br><br>The current facility policy, titled "Medication Administration", dated 07/2023, was provided by the DON on 05/30/24 at 2:04 P.M. The policy indicated, "...Obtain and record vital signs, when applicable or per physician's orders. When applicable, hold the medication for those vital signs outside the physician's prescribed parameters..."<br><br>3.1-37(a)<br>3.1-48(a)(3) | | | |
| F 0690 SS=D Bldg. 00 | 483.25(e)(1)-(3)<br>Bowel/Bladder Incontinence, Catheter, UTI<br>§483.25(e) Incontinence.<br>§483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.<br><br>§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-<br>(i) A resident who enters the facility without an indwelling catheter is not catheterized | | | |

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| | unless the resident's clinical condition demonstrates that catheterization was necessary;<br>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and<br>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.<br><br>§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.<br>Based on observation, interview, and record review, the facility failed to provide resident education related to urinary catheter care related to risk of placement for 1 of 2 residents reviewed for urinary catheters. (Resident 29)<br><br>Findings include:<br><br>During an observation on 05/29/24 at 12:48 P.M., Resident 29 was self-transferring to their wheelchair in their room. The urinary catheter bag was hanging on the right side of the wheelchair under the arm rest above the resident's waist.<br><br>During an observation on 05/29/24 at 1:14 P.M., the resident was sitting in her wheelchair with her urinary catheter bag hanging off the right side of the wheelchair under the arm rest above the resident's waist in the main dining room. | F 0690 | **F690 Bowel/Bladder Incontinence, Catheter, UTI**<br>**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;**<br>Resident #29 was assessed per licensed nurse with no negative outcomes.<br>Director of Nursing/Designee completed education/return demonstration with resident #29 on catheter care and placement of catheter bag.<br>Care plan updated to reflect self-catheter placement and self-catheter care.<br>**How other residents having** | 06/15/2024 |

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| | During an observation 05/29/24 at 3:35 P.M., the resident was in the public bathroom by the main entrance doors, emptying her urinary catheter bag into the toilet while she was sitting in her wheelchair.<br><br>During an observation on 05/30/24 at 10:08 A.M., the resident was sitting at the nurse's station in their wheelchair with their urinary catheter bag under the right-side arm rest of the wheelchair.<br><br>During an interview on 05/23/24 at 2:04 P.M., the resident indicated she had a urinary catheter. The urinary catheter bag was usually placed on the side of wheelchair under the right-side handle.<br><br>During an interview on 05/30/24 at 3:18 P.M., the resident indicated she did their own urinary catheter care.<br><br>During an interview with CNA (Certified Nurse Aide) 2 on 05/30/24 at 2:40 P.M., she indicated Resident 29 usually provided her own urinary catheter care and would call for assistance with getting dressed as needed. The resident usually needed help to complete her shower. Usually, the staff would ask the resident if she needed help with catheter care and the resident had already done it. The staff had gone in the resident's room today to empty the urinary catheter bag and she had already emptied it herself. The CNA indicated the typical placement of the resident's urinary catheter bag was clipped onto the side under her armrest. The urinary catheter bags were supposed to be hung underneath the wheelchair, but the resident liked it on the side of her wheelchair because it was easier for her to access.<br><br>During an interview with the DON (Director Of | | **the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;**<br>All residents that reside in the facility have the potential to be affected by the alleged deficient practice.<br>Audit completed for all residents that have a urinary catheter.<br>Education/return demonstration completed for those that have the ability to perform catheter care per self by Director of Nursing/designee on or by 06/15/24.<br>**What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;**<br>Education/return demonstration completed for those residents that have the ability to perform catheter care per self by Director of Nursing/designee on or by 06/15/24.<br>**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;**<br>QAPI tool for Catheter tubing/education regarding catheter care and placement of bag will be completed weekly X 4 weeks, bi-monthly X 2 and monthly X 4 months by | |

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| | Nursing) on 05/30/24 at 2:54 P.M., she indicated therapy usually worked with the residents for providing their own urinary catheter care. They would educate the residents on admission related to the urinary catheter care and placement of the urinary catheter bag. She had not documented education with the resident related to her urinary catheter care or placement of the urinary catheter bag, it was usually something they just went over with them verbally. She was unsure if the residents would be care planned for the education and providing their own urinary catheter care. She indicated residents that provide their own catheter care should have been educated on the proper placement or risk of placement of the catheter bag.<br><br>During an interview with the DON 05/30/24 at 3:41 P.M., she indicated she could not provide any documentation for the resident's education related to urinary catheter care and urinary catheter bag placement.<br><br>The clinical record for the resident was reviewed on 05/28/24 at 9:32 P.M. The Quarterly MDS (Minimum Data Set) assessment, dated 02/26/24, indicated the resident was moderately cognitively impaired. The resident's diagnoses included, but were not limited to, neuromuscular dysfunction of bladder and diabetes. The resident required staff supervision with toileting.<br><br>The facility's Infection tracking and trending documents were reviewed on 05/30/24 at 9:36 A.M. The documents indicated the resident had a confirmed UTI on 02/12/24 and 12/06/23.<br><br>A Progress Note, dated 02/29/24 at 11:09 P.M., indicated the resident had reported a significant amount of leakage from the urinary catheter. There was a large amount of sediment in the tubing and | | DNS/Designee If 100% threshold is not achieved an action plan will be developed. This information will be presented to the QAPI committee during the monthly meeting. | |

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| | entry holes at the tip of the catheter when changed.<br><br>A current physician's order, with the start date of 12/13/23, indicated that staff were to provide Foley catheter care every shift.<br><br>A current physician's order, with the start date of 05/12/24, indicated the resident had a Foley catheter due to neuromuscular dysfunction of the bladder.<br><br>The clinical record lacked documentation that the resident was educated on proper urinary catheter bag placement related to bladder level.<br><br>The resident lacked a care plan for self-catheter bag placement and self-catheter care.<br><br>The current facility policy titled "Catheter Care" dated 07/23 was provided by DON on 5/30/24 at 2:04 P.M. The policy indicated, "...is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care...".<br><br>3.1-41(a)(2) | | | |
| F 0880 SS=D Bldg. 00 | 483.80(a)(1)(2)(4)(e)(f)<br>Infection Prevention & Control<br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program. | | | |

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| | The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or | | | |

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| | their food, if direct contact will transmit the disease; and<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary. | | | |
| | Based on observation, interview, and record review, the facility failed to follow infection control guidelines related to indwelling urinary catheters for 1 of 2 residents reviewed for urinary catheters. (Resident 51)<br><br>Findings include:<br><br>On 05/23/24 at 11:43 A.M., Resident 51 was observed in his wheelchair in the main dining room. The resident's urinary catheter drainage bag was in a dignity pouch. The drainage bag and pouch were hanging from his wheelchair, with the bottom of the pouch resting on the dining room floor.<br><br>On 05/24/24 at 10:01 A.M., the resident was in his room sitting in a recliner. The resident's catheter drainage bag was hanging from his wheelchair and not in a dignity pouch. The bottom of the | F 0880 | **F880 Infection Control**<br>**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;**<br>Resident # 51 was assessed by licensed nurse with no negative outcome.<br>Catheter placed in dignity bag, under wheelchair. Tubing and bag free from floor.<br>**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;**<br>All residents that reside in the facility have the potential to be affected by the alleged deficient | 06/15/2024 |

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| | residents catheter drainage bag was resting directly on the floor. The resident indicated he had not had the urinary catheter for very long.<br><br>On 05/28/24 at 10:41 A.M., the resident was in his room in bed. The resident's catheter drainage bag was in a dignity pouch. The bag and pouch were laying in a plastic wash basin on the floor.<br><br>The resident's record was reviewed on 05/28/24 at 11:57 A.M. An Admission MDS (Minimum Data Set) assessment, dated 02/19/24, indicated the resident was moderately cognitively impaired. The resident's diagnoses included, but were not limited to, Parkinson's disease, dementia, diabetes, BPH (benign prostatic hyperplasia) and history of bladder cancer.<br><br>The resident's current physician's orders included an open ended order, with a start date of 05/12/24, for the resident to utilize an indwelling urinary catheter for obstructive uropathy.<br><br>On 05/30/24 at 10:59 A.M., the resident was observed with CNA (Certified Nurse Aide) 2. The resident was in his room in bed. The bed was in a lower position, and the catheter drainage bag and dignity pouch were hanging on the side of his bed, with the bottom of the drainage bag hanging out of the dignity pouch and resting directly on the floor mat. CNA 2 indicated the drainage bag and pouch should not touch the floor. She adjusted the bag on the bed so that it didn't touch the floor or the floor mat.<br><br>During an interview on 05/30/24 at 2:54 P.M., the DON (Director of Nursing) indicated the facility did not have a policy on catheter bag placement, but staff knew that catheter bags should be off the floor. | | practice.<br>All residents that have a catheter were reviewed for proper placement of catheter in dignity bag while in wheelchair and in bed to ensure no part of catheter touching the floor by Director of Nursing/designee on or by 06/15/2024<br>**What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;**<br>All staff was educated on proper placement of catheter in dignity bag while in wheelchair and in bed to ensure no part of catheter is touching the floor by Director of Nursing/designee on or by 06/15/2024<br>**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;**<br>QAPI tool for catheter tubing/education will be completed weekly X 4 weeks, bi-monthly X 2 and monthly X 4 months by DNS/Designee If 100% threshold is not achieved an action plan will be developed. This information will be presented to the QAPI committee during the monthly meeting. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155210 | A. BUILDING 00<br>B. WING | 05/30/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| WILLOWS OF GREENSBURG | 410 PARK RD<br>GREENSBURG, IN 47240 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | 3.1-18(b) | | | |