STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155158		A. BUII B. WIN	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 01/03/2024	
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 1000 ELIZABETH DR VALPARAISO, IN 46383				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			ID REFIX TAG	CROSS-REFERENCED TO THE APPROPRI		(X5) COMPLETION DATE
F 0000							
Bldg. 00	Licensure Survey. Investigation of Co Complaint IN0042 related to the allegate F689. Survey dates: Deceded January 2 and 3, 20 Facility number: 00 Provider number: 1 AIM number: 100 Census Bed Type: SNF/NF: 52 Total: 52 Census Payor Type Medicare: 4 Medicaid: 44 Other: 4 Total: 52	onoor8 55158 289310 :: reflect State Findings cited in 0 IAC 16.2-3.1.	F 000	0	The facility requests that this pof correction be considered its credible allegations of compliance. Submission of this response and Plan of Corrections is not a legal admission that a deficiency exits or that this statement of deficiency was correctly cited and is also not a be construed as an admission interest against the facility, the Administrator, or any employe agents, or other individuals who draft or may be discussed in the response and Plan of Correction addition, preparation and submission of the Plan of Correction does not constitute admission or agreement of any kind by the facility of the truth of any facts alleged or the corrections of a conclusion set forth in this allegation by the survey agency. Accordingly, the facility has prepared and submitted this Plan of Correction to the resolution of Appear this matter solely because of the requirements under State and Federal law that mandates submission of the Plan of Corrections a condition to participate in the Title 18 and 19 programs. The submission Plan of Correction within this timeframe should in no way be non-compliance or admission	s on to of e, no e on al of he Title of e of	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Tami Adams

TITLE

If continuation sheet

(X6) DATE 01/18/2024

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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Executive Director

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		155158	B. W	ING		01/03/	/2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	₹			LIZABETH DR		
LIFE CAF	RE CENTER OF TH	HE WILLOWS		VALPAI	RAISO, IN 46383		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX	•	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	·TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					the facility. This facility		
					respectfully requests consideration of paper		
					compliance for the cited		
				deficiencies			
					a distriction		
F 0561	483.10(f)(1)-(3)(8))					
SS=D	Self-Determination	n					
Bldg. 00	§483.10(f) Self-de						
		the right to and the facility					
		d facilitate resident					
		through support of resident					
	choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of						
	this section.	raphs (i)(1) through (11) or					
	and dodaon.						
	§483.10(f)(1) The	resident has a right to					
	- ,,,,	schedules (including					
	sleeping and waki	ing times), health care and					
	•	h care services consistent					
		erests, assessments, and					
		other applicable provisions of					
	this part.						
	§483.10(f)(2) The	resident has a right to make					
	- ,,,,	pects of his or her life in the					
	facility that are sig	nificant to the resident.					
	\$400.40(\$\(0\) T'						
	- ,,,,	resident has a right to					
		bers of the community and munity activities both inside					
	and outside the fa	•					
	and oddide the la	ionity.					
	§483.10(f)(8) The	resident has a right to					
	. , , ,	r activities, including social,					
	-	nmunity activities that do					
		the rights of other residents					
	in the facility.		1_				
		on, record review, and	F 0:	561	What Corrective Action will be		02/01/2024
	mierview, the facili	ty failed to honor a resident's	I		accomplished for those reside	riis	I

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Event ID:

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Facility ID: 000078

If c

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CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES				OM	IB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		155158	B. WI	NG		01/03	/2024
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP COD		
LIEE CAI		IE WILLOWS			LIZABETH DR		
LIFE CA	RE CENTER OF TH	1E WILLOWS		VALPA	.RAISO, IN 46383		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	preference related t	o dressing for 1 of 1 residents			found to have been affected b	y this	
	reviewed for choice	es. (Resident 21)			deficient practice:		
					1. Resident 21 had no negativ	e	
	Finding includes:				outcomes. He was offered cho	oices	
					immediately in r/t dressing and	d	
	During an interview	v on 12/27/23 at 10:37 a.m.,			facility honored his wishes.		
	Resident 21 indicat	ed he would like to wear			How other residents having th	е	
	regular day clothes	and not a hospital gown.			potential to be affected by the		
					same deficient practice will be	!	
	The record for Resi	dent 21 was reviewed on			identified and what corrective		
	12/28/23 at 2:37 p.i	m. Diagnoses included, but			action will be taken:		
	were not limited to,	, paranoid personality disorder,			1. Other resident have the		
	adult failure to thriv	ve, and bipolar disorder.			potential to be affected by the		
					alleged deficient practice there	efore	
	A Significant Chan	ge in Status Minimum Data Set			an in house audit will be		
	(MDS) assessment,	dated 8/1/23, indicated the			completed by SSD/		
	resident was moder	ately impaired for daily			Nursing/Designee to obtain		
	decision making. H	e required extensive assistance			residents preferences with		
	with two persons pl	hysical assist for dressing. The			dressing. Care plans and Kard	dex	
	daily and activity p	references section indicated it			will be updated by date of		
		to the resident to choose what			compliance.		
	clothes to wear.				What measures and what		
					systemic changes will be mad	e to	
	A Care Plan, dated	12/28/22, indicated he liked to			ensure that the deficient pract		
	wear a facility/hosp	pital gown for comfort and ease.			doesn't recur:		
	Interventions include	ded, but were not limited to,			1. Education will be provided b	ру	
	staff will dress the	resident in accordance with his			ED to SSD Activities and IDT	•	
	preferences.				team that choices and prefere	nces	
					need to be reviewed at least		
	During an interview	v on 12/29/23 at 3:45 p.m., the			quarterly per care plan schedu	ıle	
		ector (SSD) indicated that the			and as needed to ensure		
	care plan was not u	pdated to reflect the MDS and			compliance. No departments		
		ight. It should have been			involved in choices or preferer	nces	
	updated.				will work past date of complian		
					without education completed a		
	On 12/29/23 at 3:50	p.m., the Administrator was			this will be offered upon hire, a		
		with Resident 21. At this time,			least annually and as needed.		
		ed he was sick of wearing the			How the corrective action will		

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hospital gowns every day and he would like to get

dressed each morning in regular day clothes. The

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monitored to ensure the deficient

practice will not recur, i.e., what

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CENTERS FOI	R MEDICARE & MEDIC				OMB NO. 0938-039	
	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155158	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/03/2024	
	PROVIDER OR SUPPLIEF		1000 E	ADDRESS, CITY, STATE, ZIP COD LIZABETH DR .RAISO, IN 46383		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
		ated that she would have the p get him dressed each		quality assurance program win put in place: 1. SSD will review 3 charts were 3 months to ensure compliance ED will review 2 charts weekly months to ensure compliance 2. The results of these review be discussed at the monthly facility Quality Assurance Committee meeting monthly fould of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of rewill be increased as needed, compliance is below 100%. Compliance date: 02/01/2024 Administrator at Life Care cer of the Willows is responsible in ensuring compliance in this P of Correction.	eekly kkly x cce. y x 6 es will for a views if The nter in	
F 0641 SS=A Bldg. 00	The assessment resident's status. Based on record reviging failed to ensure a Massessment was accurately weight loss coded in assessments review Finding includes: Record review for I 12/28/23 at 2:26 p.1	riew and interview, the facility linimum Data Set (MDS) urately completed related to ncorrectly for 1 of of 21 MDS	F 0641	How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: 1. Other residents have the potential to be affected theref MDS has completed an in how audit on the last MDS submitt per resident to assure weights coded accurately. If any issue	ore use eed s are	

disease, and atrial fibrillation.

noted modifications will be

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	
		155158	B. W	ING		01/03/	2024
NAME OF F	AN OLUBER OR GURRI IER		-	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	<u>:</u>		1000 E	LIZABETH DR		
LIFE CAF	RE CENTER OF TH	IE WILLOWS		VALPA	RAISO, IN 46383		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					completed and resubmitted pr	ior	
	The Quarterly MDS assessment, dated 10/11/23,				to date of compliance.		
	indicated the resident was cognitively impaired.				What measures and what		
	The resident required setup assistance for eating				systemic changes will be mad		
	meals. His weight was 138 lbs (pounds), which				ensure that the deficient pract	ice	
		ignificant weight loss and was			doesn't recur:		
	not on a prescribed	weight-loss regimen.			MDS will be in serviced by the serviced b		
					Regional CRS on the accurac	y of	
	_	cord indicated weights on the			assessments by date of		
	following dates:				compliance.		
	- /27/23; 141 lbs				How the corrective action will		
	- 4/27/23: 139 lbs				monitored to ensure the defici		
	- 6/9/23: 138 lbs				practice will not recur, i.e., wh		
	- 7/12/23: 136 lbs				quality assurance program wil	l be	
		weight marked out on 7/12/23,			put in place:		
	indicated error				DON/Designee will validate		
		weight marked out on 9/12/23,			weight accuracy of 3 MDS we	-	
	indicated error				x 3 months then 2 times week	-	
		, weight marked out on 10/19/23,			3 months to ensure compliance		
	indicated error				The results of these reviews	s will	
	- 10/3/23: 138.1 lbs				be discussed at the monthly		
					facility Quality Assurance		
		e documented weights since			Committee meeting monthly for	or a	
	10/3/23.				total of 3 months and then		
					quarterly thereafter once		
	_	on 12/28/23 at 3:30 p.m., the			compliance is at 100%.		
		ndicated the Quarterly MDS			Frequency and duration of rev		
	was coded incorrect	tly and the resident had not			will be increased as needed, i	f	
	had a weight loss.				compliance is below 100%.		
					Compliance date:02/01/2024.		
	_	on 12/29/23 at 10:29 a.m., the			Administrator at Life Care Cer		
		of Nursing (ADON) indicated			of the Willows is responsible in		
		had a weight loss and the			ensuring compliance in this Pl	an	
	_	October was incorrect. She			of Correction.		
	_	ocumentation that any					
	_	ompleted on the resident from					
		23. She indicated making sure					
	residents were weig	hed monthly had been an					
	ongoing issue at the	facility which she was trying					
	to improve.						

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							FORM APPROVED OMB NO. 0938-039	
		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155158	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 01/03/2024	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155158 NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF THE WILLOWS (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION 3.1-31(d)(3)			STREET ADDRESS, CITY, STATE, ZIP COD 1000 ELIZABETH DR VALPARAISO, IN 46383					
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	483.21(a)(1)-(3) Baseline Care Pla §483.21 Compreh Care Planning §483.21(a) Baselii §483.21(a) Baselii §483.21(a)(1) The implement a base resident that inclu- to provide effective of the resident that standards of quali plan must- (i) Be developed v resident's admissi (ii) Include the mir information neces resident including (A) Initial goals ba (B) Physician order (C) Dietary orders (D) Therapy service (E) Social services (F) PASARR reco	ensive Person-Centered ne Care Plans facility must develop and line care plan for each des the instructions needed e and person-centered care t meet professional ty care. The baseline care within 48 hours of a on. nimum healthcare sary to properly care for a but not limited to- sed on admission orders. ers. ces. s.						

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plan-

comprehensive care plan in place of the baseline care plan if the comprehensive care

(i) Is developed within 48 hours of the

(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that

resident's admission.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 01/03/2024 155158 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1000 ELIZABETH DR LIFE CARE CENTER OF THE WILLOWS VALPARAISO, IN 46383 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. Based on record review and interview, the facility F 0655 F 655 Base Line Care Plan 02/01/2024 failed to develop an initial plan of care within 48 What Corrective Action will be hours of admission related to Activities of Daily accomplished for those residents Living (ADL) for 1 of 19 residents whose care found to have been affected by this plans were reviewed. (Resident B). deficient practice: 1. Resident B had no negative Finding includes: outcomes. Base line care plan was completed immediately. The record for Resident B was reviewed on How other residents having the 3/26/19 at 9:03 p.m. The resident was admitted on potential to be affected by the 3/1/23. Diagnoses included, but were not limited same deficient practice will be to bipolar disorder, respiratory failure, and identified and what corrective dementia. action will be taken: 1. An in house audit on residents The baseline care plan was initiated on 3/13/23 will be completed by MDS to which included ADL status, discharge plan, pain, validate residents have Base line skin integrity, and risk for change in mood or care plans in place and they are behavior due to a medical condition. timely by date of compliance. What measures and what During an interview on 1/2/24 at 3:45 p.m., the systemic changes will be made to Assistant Director of Nursing indicated the ensure that the deficient practice baseline care plan should have been created doesn't recur: within 48 hours after admission regarding his ADL 1. DON/Designee will educate status. MDS, Clinical management team, IDT team and licensed nursing on 3.1-30(a) completing a base line care plan timely on new admission by date

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of compliance. MDS, Clinical management team. IDT team and licensed nursing will not work past

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/30/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155158		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/03/2024		
	PROVIDER OR SUPPLIER		1000 E	STREET ADDRESS, CITY, STATE, ZIP COD 1000 ELIZABETH DR VALPARAISO, IN 46383		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
				date of compliance without the education being completed. The education will be presented under hire, at least annually as need thow the corrective action will monitored to ensure the deficion practice will not recur, i.e., who quality assurance program with put in place: 1. MDS will validate any new admissions within 48 hours to ensure compliance. The clinic management team will complich chart audits daily Monday through the friday in morning meeting/climing and validate base linicate plan in place and timely ongoing. 2. The results of these review be discussed at the monthly facility Quality Assurance Committee meeting monthly for total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of rewill be increased as needed, incompliance is below 100%. Compliance date: 02/01/2024 Administrator at Life Care Celeof the Willows is responsible in ensuring compliance in this P of Correction.	rhis pon ded. be ded. be deient dat ll be deal ete bugh nical e s will for a views if . The nter n	
F 0656 SS=D Bldg. 00	§483.21(b) Compi §483.21(b)(1) The implement a comp	nt Comprehensive Care Plan rehensive Care Plans facility must develop and prehensive person-centered resident, consistent with				

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		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155158	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	COM	(X3) DATE SURVEY COMPLETED 01/03/2024			
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 1000 ELIZABETH DR VALPARAISO, IN 46383						
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP		(X5) COMPLETION			
TAG	1	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	PROPRIATE	DATE			
TAG	the resident rights and §483.10(c)(3) objectives and time resident's medical psychosocial need comprehensive as the attain or maintain practicable physicipsychosocial well-§483.24, §483.25 (ii) Any services the required under §4 but are not provide exercise of rights the right to refuse (6). (iii) Any specialized rehabilitative services provide as a result recommendations the findings of the its rationale in the (iv)In consultation resident's represe (A) The resident's desired outcomes (B) The resident's future discharge. Whether the resident community was as to local contact agaptropriate entities (C) Discharge plan, as appreted the requirements.	s set forth at §483.10(c)(2)), that includes measurable neframes to meet a I, nursing, and mental and ds that are identified in the ssessment. The are plan must describe the nat are to be furnished to the resident's highest cal, mental, and -being as required under or §483.40; and nat would otherwise be 83.24, §483.25 or §483.40 ed due to the resident's under §483.10, including treatment under §483.10(c) ed services or specialized ices the nursing facility will at of PASARR s. If a facility disagrees with PASARR, it must indicate resident's medical record. with the resident and the entative(s)- goals for admission and	TAG	DEFICIENCY)		DATE			
l	this section.			1					

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\$483.21(b)(3) The services provided or

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	ETED
		155158	B. W	ING		01/03	/2024
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	8			LIZABETH DR		
LIFE CAF	RE CENTER OF TH	HE WILLOWS			RAISO, IN 46383		
	T				, · · · · · · · · · · · · · · · · · · ·		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
IAG		R LSC IDENTIFYING INFORMATION	+	TAG			DATE
	comprehensive ca	acility, as outlined by the					
	•	•					
	(iii) Be culturally-competent and trauma-informed.						
		on, record review, and	F 0	656	F 656 Develop/implement		02/01/2024
		ty failed to ensure a	1 0	030	Comprehensive Care Plan		02/01/2024
		e plan was developed and in			What Corrective Action will be	<u>.</u>	
	_	with a history of dehydration			accomplished for those reside		
	_	care plans reviewed. (Resident			found to have been affected b		
	G)	r			deficient practice:	,	
	_				Resident G had care plan		
	Finding includes:				updated immediately.		
					How other residents having th	e	
	On 12/27/23 at 9:26 a.m. the Resident G was				potential to be affected by the		
	observed in her bed	l. The side rails were up, there			same deficient practice will be		
	was a mat on the flo	oor. There was no beverage to			identified and what corrective		
	drink in the room.	The resident was observed			action will be taken:		
		at 9:56 a.m., and 12:59 p.m., and			1. MDS/Designee will do an ir	1	
	1/2/24 at 8:15 a.m.	in bed with no beverage in the			house audit on residents with	dx	
	room.				of Dehydration and assure a	care	
					plan is in place by date of		
		2 a.m., staff was observed			compliance.		
	-	ent's breakfast tray from her			What measures and what		
	_	e was on the tray, full with a lid			systemic changes will be mad		
		been untouched. There was			ensure that the deficient pract	ice	
	no beverage in the i	room.			doesn't recur:		
	0 10/00/00 : 10	10.25			1. MDS, IDT team and clinical		
		15 p.m. and 2:35 p.m., the			management team will be		
		with the side rails up and a			in-serviced by the CRS on rev	_	
		nere was a beverage on the			care plans when changes occ	ur	
		vas located out of reach			immediately by date of	n d	
	beyond the foot of t	me bea.			compliance. MDS, IDT team a		
	On 1/2/24 at 9.57 a	.m., the resident was up in a			clinical management team wil	11101	
		lining room. There was no			work past date of compliance		
		le. At 1:13 p.m., the resident			without this education being	l he	
	_	ng room, she had a lunch in			completed. This education will offered upon hire, at least ann		
		s feeding herself, however,			and as needed.	iualiy	
		age present. At 1:40 p.m., the			How the corrective action will	he	
		removed. There were 3 other			monitored to ensure the defici		
	I minor may mad been		1		I monitored to endure the delici	OIIL	ı

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Event ID:

J6PQ11 Facility ID: 000078

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED		
AND FLAN	OF CORRECTION	155158	B. W		<u>00</u>	01/03/	
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 1000 ELIZABETH DR VALPARAISO, IN 46383				
(X4) ID PREFIX TAG	(EACH DEFICIENT REGULATORY OF residents seated at resident did not have the resident's record resident	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION the table with a beverage, the ve one. rd was reviewed on 12/28/23 at es included, but were not limited		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI- DEFICIENCY) practice will not recur, i.e., wh quality assurance program wi put in place: 1. Rar committee will review residents with current dx of	nat	(X5) COMPLETION DATE
	to, metabolic encep unspecified convul The Significant Ch	chalopathy, muscle weakness, sions and diabetes mellitus. ange Minimum Data Set			dehydration weekly to ensure plans in place with appropriat interventions ongoing. 2. The results of these review	е	
	had significant cog extensive staff assi transfers and toileti	12/20/23, indicated the resident nitive impairment, and required stance for bed mobility, ng and supervision for eating.			be discussed at the monthly facility Quality Assurance Committee meeting monthly f total of 3 months and then quarterly thereafter once	or a	
	resident was dehyd intravenous (IV) fl	uid D5.45 normal saline be e resident had not taken			compliance is at 100%. Frequency and duration of rewill be increased as needed, compliance is below 100%. Compliance date: 02/01/2024 Administrator at Life Care Ce	if . The	
	resident needed to and the patient was	•			of the Willows is responsible in ensuring compliance in this Prof Correction.		
	resident's dehydrati						
	(ADON) on 1/2/24 aware of the above residents who were fluids pushed and I	Assistant Director of Nursing at 10:57 a.m., she was made observations and indicated dehydrated should have abs monitored. She indicated are plan in place related to her					
F 0677	3.1-35(a)						
SS=D Bldg. 00		ed for Dependent Residents esident who is unable to					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SI			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	LETED
		155158	B. W	NG _		01/03	/2024
		1	1	STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	R			ELIZABETH DR		
LIFF CAF	RE CENTER OF TH	HE WILLOWS		VALPARAISO, IN 46383			
	Г		1		T		1
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	1 -	s of daily living receives the					
	necessary services to maintain good						
	_	g, and personal and oral					
	hygiene;	on magaind marriage and	F 0		F C77 ADL Com- Deside Lo		02/01/2024
		on, record review, and	F 00	0//	F 677 ADL Care Provided for		02/01/2024
		ity failed to ensure residents			Dependent Residents		
		ary care for activities of daily			What Corrective Action will be		
		related to not receiving bathing			accomplished for those reside		
		I twice weekly, dirty fingernails,			found to have been affected b	y mis	
		ving a beard for 3 of 3 residents care. (Residents D, B, and C)			deficient practice:	no	
	16viewed for ADL	care. (Residents D, B, and C)			1. Residents D, B, and C had		
	Findings includes				negative outcomes. The resid	ents	
	Findings include:				cited had adl care performed immediately		
	1 On 12/27/23 of 1	0:23 a.m., Resident D was			How other residents having th		
		ed. The resident's fingernails			potential to be affected by the		
		anderneath them. The resident			same deficient practice will be		
		ot received any bathing at the			identified and what corrective	•	
	facility since she wa				action will be taken:		
	lacine, since sie w				1. An in house audit including		
	Record review for I	Resident D was completed on			observations of residents to		
		.m. Diagnoses included, but			include nails, hair, oral care,		
		, vertebral fracture, anxiety, and			shaving and bathing 2 times		
		sident was admitted to the			weekly will be completed by d	ate	
	facility on 12/21/23				of compliance by nursing		
]				management. Any issues note	ed	
	The Bathing Task r	record indicated the resident			will be addressed immediately		
	had 1 shower on 12				What measures and what		
					systemic changes will be mad	le to	
	The record lacked a	any documentation the resident			ensure that the deficient pract		
	had a shower prior	to 12/27/23 since she was			doesn't recur:		
	admitted on 12/21/2	23.			1. Education will be provided	by	
					the SDC to all nursing includir	ng	
	During an interview	v on 12/28/23 at 11:40 a.m., the			aides, QMAS, and nurses on	the	
	Assistant Director of Nursing (ADON) indicated				policy for assuring personal ADL		
	she could not provide any documentation the				care is being completed as		
	resident had received any bathing since being				expected up to and including		
	admitted on 12/1/23	3, until 12/27/23.			observing residents prior to le	aving	
	2. During an intervi	iew on 12/27/23 at 1:52 p.m.,			for hospital and or appointmen	nts.	
	Resident B's represe	entative indicated he liked to			No sides nurses or OMAS wi	П	1

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		155158	B. W	ING		01/03	/2024
		<u> </u>		CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	R			LIZABETH DR		
LIEECAE	RE CENTER OF TH	JE WILLOWS			RAISO, IN 46383		
LIFE CAI	NE CENTER OF II	IE WILLOWS		VALFA			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		d it appeared he hadn't			work without this education be	eing	
	received assistance with shaving for a while.				completed and competencies		
	Resident B was observed to have facial hair at the				completed on basic adls. This		
	time.				education and competencies v	will	
					be offered upon hire, at least		
		served on 12/29/23 at 10:47			annually and as needed.		
		neelchair in the hallway with			How the corrective action will		
	facial hair noted.				monitored to ensure the defici		
					practice will not recur, i.e., who		
		ident B was reviewed on			quality assurance program wil	l be	
		.m. Diagnoses included, but			put in place:		
		bipolar disorder, respiratory			The clinical management te		
	failure, and dement	ria.			will observe 5 resident's week	-	
					3 months then 3 residents wee	•	
		imum Data Set, dated 10/9/23,			x 3 months to ensure complian		
		ent was significantly impaired			The DON/Designee will valida	ite	
	for daily decision n	naking.			showers daily with supporting		
					shower sheets ongoing.		
		3/13/23, indicated the resident			2. The results of these reviews	s will	
	-	with mobility and activities of			be discussed at the monthly		
	daily living (ADLs)) as needed.			facility Quality Assurance		
					Committee meeting monthly for	or a	
		documentation of Resident B			total of 3 months and then		
	being offered assist	tance with shaving.			quarterly thereafter once		
		1/0/04 0.15			compliance is at 100%.	_	
	-	v on 1/2/24 at 3:45 p.m., the			Frequency and duration of rev		
		of Nursing the resident should			will be increased as needed, it	t	
	be clean shaven if t	hat is his preference.			compliance is below 100%.		
					Compliance date: 02/01/2024		
	2.5	. 12/27/22 + 10 27			Administrator at Life Care Cer		
		iew on 12/27/23 at 10:37 a.m.,			of the Willows is responsible in		
		ed he did not get assistance			ensuring compliance in this Pl	an	
		His fingernails were long and			of Correction.		
	dirty. He had long i	facial hair on his chin.					
	D:44-C 1						
	Resident C was observed on 12/28/23 at 2:24 p.m.						
	He was laying in bed in a hospital gown. He had						
		his chin and his nails were still					
	long and dirty.						
1			1		1		I

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	
		155158	B. W	ING	_	01/03	/2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	R			LIZABETH DR		
	RE CENTER OF TH	HE WILLOWS	•		RAISO, IN 46383		_
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	1	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENC!)		DATE
		ident C was reviewed on m. Diagnoses included, but					
		, paranoid personality disorder,					
		ve, and bipolar disorder.					
	addit famule to till to	ve, and orporar disorder.					
	The Quarterly Mini	imum Data Set, dated 10/30/23,					
		ent was moderately cognitively					
		decision making. He had					
		n in range of motion of both					
		tremities. He required					
	assistance from stat	ff for activities of daily living.					
	l a Bi i i	0/1/10 1 12 1 11 1 11					
	•	2/1/19, indicated he had been					
		owers/bed baths, haircuts, and					
	_	nterventions included, but were r bed baths and haircuts in his					
		to offer alternate staff					
		m bed baths, haircuts, and					
	shaving.	in oca batils, nancuts, and					
	shaving.						
	The Bathing task sh	neet for December 2023					
	1	ent refused a shower/bath on					
	12/4/23, received a	sponge bath on 12/8/23,					
	refused a shower/ba	ath on 12/11/23, and received a					
	sponge bath on 12/2	22/23 and 12/25/23.					
		mentation of alternate staff					
		bed baths upon refusals or					
	documentation of sl	having offered to the resident.					
	During an interview	v on 1/2/23 at 3:45 p.m., the					
		of Nursing indicated she was					
		mentation of shaving and nail					
	care offered to the						
	This citation relates	s to Complaint IN00424101.					
	3.1-38(a)(3)(D)						
	3.1-38(a)(3)(E)						
	3.1-38(b)(2)						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		155158	B. WI	NG		01/03/	/2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	2			LIZABETH DR		
LIFE CAF	RE CENTER OF TH	IE WILLOWS			RAISO, IN 46383		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE
F 0684	483.25						
SS=D	Quality of Care						
Bldg. 00	§ 483.25 Quality of	of care					
	Quality of care is a	a fundamental principle that					
	applies to all treat	ment and care provided to					
	facility residents. I	Based on the					
	•	ssessment of a resident, the					
	-	e that residents receive					
		e in accordance with					
		lards of practice, the					
		erson-centered care plan,					
	and the residents'						
		on, record review, and	F 06	584	F 684 Quality of Care		02/01/2024
		ity failed to ensure residents			What Corrective Action will be		
		ary treatment and services			accomplished for those reside		
		f a Physician's Order for a neck			found to have been affected b	y this	
		onitoring and assessments of			deficient practice:		
		and skin treatments not			1. Resident 19, 36 had no neg		
	_	ed for 1 of 2 residents			outcomes. Res # 36 had bruis	es	
	_	oning and limited range of esidents reviewed for			measured immediately and		
					additional skin UDAS were		
	-	onditions. (Residents D, 36,			completed as well. Res D no	41	
	and 19)				longer resides in facility and R		
	Findings include:				non pressure area had improv	ea.	
	i maniga menude.				Res # 19 actually had an improvement in his wound.		
	 1. On 12/27/23 at 1	0:23 a.m., Resident D was			2.		
		ed watching television. The			How other residents having the	e	
		brace in place. She indicated			potential to be affected by the	-	
		would help her put it on and			same deficient practice will be		
		not like to wear it when she			identified and what corrective		
	was lying down.				action will be taken:		
					An in house audit has been		
	On 12/28/23 at 11:1	3 a.m., Resident D was			completed on residents with n		
		the front lobby with other			braces ordered, and who has		
		lent had a neck brace in place.			pressure areas to assure being		
		•			monitored per facility policy by	-	
	Record review for I	Resident D was completed on			wound nurses and to be		
		.m. Diagnoses included, but			completed by date of compliar	nce.	
		vertebral fracture, anxiety, and			Any issues identified will be		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 01/03/2024 155158 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1000 ELIZABETH DR LIFE CARE CENTER OF THE WILLOWS VALPARAISO, IN 46383 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE depression. The resident was admitted to the corrected immediately. facility on 12/21/23. What measures and what systemic changes will be made to A Care Plan, dated 12/27/23, indicated the resident ensure that the deficient practice frequently removed her C-Collar that was to be doesn't recur: worn at all times. An intervention included to 1. Licensed nursing and aides will educate the resident of the possible outcomes of be educated on the policy for not complying with treatment of care. reporting, tracking and assuring appropriate entities have been A Physician's Progress Note, dated 12/26/23, notified as well as appropriate indicated an assessment plan included for her documentation is in place. This cervical fracture was a hard collar when up. will also include residents with neck braces and non-pressure There was a lack of documentation to indicate a areas. No nurses. QMAS or aides Physician's Order was in place for the neck brace, will work after date of compliance that included when the resident was supposed to without this education being wear it and assistance to put it on and off if completed. This education will be needed. presented upon hire, at least annually, and as needed. The During an interview on 12/28/23 at 2:05 p.m., the wound nurse will be educated she Assistant Director of Nursing (ADON) indicated must observe new and there was not a Physician's Order transcribed into readmissions herself to determine the order summary for the neck brace so nursing if any of the above issues need could document when it was on and off. She addressed. clarified with the Physician and he indicated the How the corrective action will be resident was supposed to wear the neck brace monitored to ensure the deficient when she was up and not while she was in bed. practice will not recur. i.e., what quality assurance program will be 2. On 12/28/23 at 9:39 a.m., Resident 36 was put in place: observed sitting in bed. The resident had multiple 1. The wound nurse/designee will red/purple discolorations to both arms. The observe new and readmissions to resident indicated she would bruise easily when ensure compliance ongoing. The she bumped her arms. IDT team will complete chart audits the next business day to On 12/28/23 at 11:09 a.m., Resident 36 was ensure skin issues, neck braces, observed lying in bed. The same discolorations and appropriate documentation is were observed to both arms. completed ongoing. 2. The results of these reviews will Record review for Resident 36 was completed on be discussed at the monthly 12/28/23 at 11:10 a.m. Diagnoses included, but facility Quality Assurance

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	LETED
		155158	B. W	ING		01/03	/2024
				_			
NAME OF F	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
					LIZABETH DR		
LIFE CAF	RE CENTER OF TH	HE WILLOWS		VALPA	RAISO, IN 46383		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	were not limited to,	, heart failure, respiratory			Committee meeting monthly for	or a	
	failure, anemia, and	d hypertension. The resident			total of 3 months and then		
	was admitted to the	e facility on 12/1/23.			quarterly thereafter once		
					compliance is at 100%.		
	The Admission Min	nimum Data Set (MDS)			Frequency and duration of rev	views	
		2/6/23, indicated the resident			will be increased as needed, it		
		act. The resident required			compliance is below 100%.		
	assistance with bath	-			Compliance date: 02/01/2024.	. The	
					Administrator at Life Care Cer		
	A Care Plan, dated	12/4/23 and revised 12/11/23,			of the Willows is responsible in		
	indicated the reside				ensuring compliance in this Pl		
		latelet therapy related to atrial			of Correction.		
		ervention included to observe			0. 0000		
		reactions of anticoagulant					
	therapy that include	_					
	13	S					
	An Admission Asse	essment, dated 12/1/23,					
	indicated the reside	ent had multiple bruising to the					
	bilateral upper extre	emities and trunk.					
	A Skin Assessment	t, dated 12/22/23, indicated the					
	resident's skin was	intact with no new findings.					
		any documentation the					
		esident had on admission were					
		ions still observed. There was					
		ation the discolorations were					
	being monitored.		1				1
		10/00/00 + 10 17					
		v on 12/29/23 at 10:17 a.m., the					
		ne could not provide any					
		discolorations on admission					
		ions still being observed.					
	1 -	nentation to indicate the					
		rved were assessed and being					
	monitored.						
		observed on 12/27/23 at 2:52					
	_	to have his left lower leg					
	wrapped with kerlix	x and an ace bandage.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA				NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		155158	B. W	ING		01/03/	/2024
	PROVIDER OR SUPPLIER		<u>•</u>	1000 EL	NDDRESS, CITY, STATE, ZIP COD LIZABETH DR RAISO, IN 46383	•	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.16	DATE
	12/28/23 at 2:43 p.r were not limited to dementia, and heart The Quarterly Mini	mum Data Set, dated 10/26/23,					
		nt was moderately impaired for ng. He used oxygen therapy culcers.					
	cleanse the left later Dakin's solution, pa wrap with kerlix, co	dated 11/17/23, indicated to ral leg with normal saline or t dry, apply hydrofera blue, over with an Ace bandage, and e times weekly and as needed dislodged.					
	Record (TAR) was for the treatment to	3 Treatment Administration not checked off as completed the left lateral leg on 12/1/23, 2/10/23, 12/13/23, and 12/27/23.					
	Infection Prevention to locate documenta completed on those	on 12/29/23 at 1:52 p.m., the nist indicated she was unable ation of the treatment being days.					
F 0688 SS=D Bldg. 00	§483.25(c) Mobilit §483.25(c)(1) The resident who ente range of motion do reduction in range resident's clinical of	Decrease in ROM/Mobility y. I facility must ensure that a rs the facility without limited pes not experience of motion unless the condition demonstrates range of motion is					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SUI			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	
		155158	B. W	NG		01/03/	/2024
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1000 ELIZABETH DR VALPARAISO, IN 46383				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		DROVIDEDIS DI ANI OE CODDECTIONI		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
TAG	§483.25(c)(2) A remotion receives a services to increase prevent further de §483.25(c)(3) A rereceives appropria assistance to main with the maximum unless a reduction demonstrably una Based on observation interview, the facility received the necessed decrease in range of splint not in place a reviewed for position 1) Finding includes: On 12/27/23 at 11:00 a.m., Resident 1 was were closed and her There was a hand splint was observed in bed. The and a splint was observed in bed. The resident's record 2:55 p.m. Diagnose to, hemiplegia (one hemiparesis (one sincerebral vascular extended in the control of the contro	esident with limited range of ppropriate treatment and se range of motion and/or to crease in range of motion. esident with limited mobility ate services, equipment, and intain or improve mobility in practicable independence in in mobility is avoidable. In precord review, and the fact that are treatment to prevent a fact that are treatment to prevent a fact that are treatment to a hand as ordered for 1 of 1 residents coming and mobility. (Resident are was no splint on her night stand. In p.m., the resident was here was no splint on her hand served on her night stand. In p.m., the resident was here was no splint on her hand served on her night stand. In the resident was here was no splint on her hand served on her night stand. In the resident was here was no splint on her hand served on her night stand. In the resident was here was no splint on her hand served on her night stand. In the resident was here was no splint on her hand served on her night stand. In the resident was here was no splint on her hand served on her night stand. In the resident was here was no splint on her hand served on her night stand. In the resident was here was no splint on her hand served on her night stand.	F 00		F 688 Increase/Prevent Decre in ROM/Mobility What Corrective Action will be accomplished for those reside found to have been affected by deficient practice: 1. Res 1 had no negative outcomes and no longer reside facility. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: 1. An in house audit has been completed by nursing management on residents that have adaptive equipment to prevent decrease in ROM and Mobility by date of compliance. Orders have been received for these devices to read as tolera by resident. Any issues identification will be corrected by date of compliance. Care plans and Kardex have been updated to	ase nts y this es in e	02/01/2024
		ent, and was dependent on staff			reflect current orders and		
	for bed mobility, tra	ansfers, toileting and eating.	1		appliances.		

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	OR MEDICARE & MEDIC				OMB NO. 0938-039
STATEME	ENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	N OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		155158	B. WING		01/03/2024
	PROVIDER OR SUPPLIEF ARE CENTER OF TH SUMMARY		1000 E	ADDRESS, CITY, STATE, ZIP COD ELIZABETH DR ARAISO, IN 46383 PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	· ·	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE
IAG	A Physician's Orderesident was to weat left hand at all time checks. The current Hand S resident required a shand to prevent confinerview with the 2 on 12/28/23 at 2:20 told last week the h	r, dated 8/25/22, indicated the ar a resting hand splint to her s except for hygiene and skin plint Care Plan indicated the resting hand splint to her left	IAG	2. What measures and what systemic changes will be madensure that the deficient practice doesn't recur: 1. Education has been provide the SDC by date of compliant licensed nursing, QMAS, and aides on assuring adaptive deare in place as ordered and tolerated. Refusals must be reported to nurse and nurse may report to MD. No licensed nurse of compliance without educatic completed. Education will be completed upon hire, at least annually, and as needed. 2. How the corrective action will monitored to ensure the deficit practice will not recur, i.e., who quality assurance program will put in place: 1. Nursing management will observe 3 residents weekly x months then 2 residents weekly x months to ensure compliance. Care plan, order and Kardex was also be validated. 2. The results of these reviews be discussed at the monthly facility Quality Assurance. Committee meeting monthly for total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of rewill be increased as needed, in will be increased as needed, in which is the provided and the requirements.	le to cice ed by ce to evices nust ses, date on be ent at II be 3 dy x ce. will s will or a

compliance is below 100%.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155158		ľ í	JLTIPLE CO ILDING NG	(X3) DATE COMPL 01/03	ETED		
		100100	B. WI	_		01/03/	202 1
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 1000 ELIZABETH DR VALPARAISO, IN 46383			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	Compliance date: 02/01/2024. Administrator at Life Care Cer of the Willows is responsible in ensuring compliance in this Pl of Correction.	nter n	DATE
F 0689 SS=D Bldg. 00	remains as free of possible; and §483.25(d)(2)Eacl adequate supervise to prevent accider Based on observation interview the facility measures were in placed to seizure proprecautions not imphelmet not in use as reviewed for accide Findings include: 1. On 12/27/23 at 9 observed in her bed complaining her sto wearing a post-op hed rails on her bed and a mat on the floand 12:59 p.m., the there were no seizuresident was not we helmet was observed.	nts. nsure that - resident environment accident hazards as is n resident receives sion and assistance devices	F 06	589	F 689 Free of Accident Hazards/Supervision/Devices What Corrective Action will be accomplished for those reside found to have been affected b deficient practice: 1. Res G, F, and E had no negative outcomes. Res E has had helmet dcd r/t improveme RES G often refuses and this care planned and she had sei; pads added to bed. Res F had care plan reviewed and placed 3 day bladder diary to determi actual pattern. How other residents having th potential to be affected by the same deficient practice will be identified and what corrective action will be taken: 1. In house audit has been completed on residents with	nts y this s nt, is zure d d on ne	02/01/2024

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155158	B. W	ING		01/03/	/2024
		L		CTREET	ADDRESS CITY STATE ZIR COR	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD LIZABETH DR		
	DE CENTED OF T	HE WILLOWS			LIZABETH DR RAISO, IN 46383		
LIFE CAR	RE CENTER OF TI	TE VVILLOVVS		VALPA	RAISU, III 40363		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		es included, but were not limited			seizure dx or high fall risk to		
		phalopathy, muscle weakness,			ensure interventions are on c	are	
	unspecified convul	sions and diabetes mellitus.			plan and Kardex. Any issues		
					identified will be corrected		
	_	ange Minimum Data Set			immediately. Nursing		
		12/20/23, indicated the resident			management will have this		
	"	gnitive impairment, and required			completed by date of complia	nce.	
		stance for bed mobility,			What measures and what		
	transfers and toilet	ing.			systemic changes will be mad		
					ensure that the deficient prac	tice	
		lated 12/12/23, indicated the			doesn't recur:		
		in her room. She was sent to			Education has been compl	eted	
		m and diagnosed with			by the DON/Designee on the		
		orrhage (bleeding around the			entire policy and protocol for		
	brain). She returne	ed to the facility on 12/13/23.			management to the IDT team	, and	
					other staff. This education		
	1	er, dated 12/14/23, indicated the			includes fall or incident will be		
		ar a post-op helmet (protective			reviewed in morning meeting		
	helmet). The order	did not specify when to wear.			discussed, interventions assu		
					put in place, on care plan and		
		23 Treatment Administration			Kardex and team will go to ro		
		ked documentation when the			to validate as well as assuring	-	
	post-op helmet was	s put on, removed or refused.			assessments and documenta		
					is in place. No staff will work		
		e Care Plan, indicated the			date of compliance without th		
		of injury related to seizures.			education being completed p	rior to	
		ded, but were not limited to,			date of compliance. This		
	seizure pads on bed	d rails.			education will be offered upor		
		10/00/00 . 1.50			yearly, and as needed. If patt		
	_	w on 12/28/23 at 1:58 p.m., LPN			determined with particular sta		
		dent was fitted for a helmet but			member progressive disciplin	e will	
		t with wearing it. The LPN also			be completed.		
		d to be seizure pads on the			How the corrective action will		
		ed had been swapped out on			monitored to ensure the defic		
		resident went on hospice			practice will not recur, i.e., wh		
		l not been seizure pads on the			quality assurance program wi	II be	
	bed since.				put in place:		
					1. DON/Designee will review	-	
	_	w on 12/28/23 at 2:20 p.m., the			event upon occurrence to ens	sure	
	Assistant Director	of Nursing indicated the			assessments completed per		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155158	B. W.			01/03/	
		100.00		_	_	0 1, 0 0,	
NAME OF I	PROVIDER OR SUPPLIER	2			ADDRESS, CITY, STATE, ZIP COD		
TWINE OF I	NO VIDER OR SETTEME			1000 EI	LIZABETH DR		
LIFE CAI	RE CENTER OF TH	HE WILLOWS		VALPA	RAISO, IN 46383		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	resident should hav	re the helmet in her room but			policy, md and family notificati	on	
	only had to wear it	when up. She would add the			per policy, interventions put in		
	order to the TAR.	Seizure pads had been ordered			place immediately, care plan a	and	
	for overnight delive	ery and the bed rails were being			Kardex updated and 72 hour f		
	_	arter rails. If seizure pads were			up charting is completed ongo		
		ws or bedding could be used by			2. The results of these reviews		
	nursing staff.	,			be discussed at the monthly		
					facility Quality Assurance		
	2. On 12/27/23 at 3	2:00 p.m., Resident F was			Committee meeting monthly for	or a	
		om near her bathroom door. She			total of 3 months and then	u	
		herself, her pants and brief			quarterly thereafter once		
		kles, and when she reached the			compliance is at 100%.		
		began to urinate. Staff was			Frequency and duration of rev	iewe	
	notified and came t	_			will be increased as needed, if		
	notified and came t	o assist ner.			compliance is below 100%.		
	On 12/28/23 at 11:6	06 a.m., 1/2/24 at 8:50 a.m. and			Compliance date: 02/01/2024.	Tho	
		, the resident was observed in			•		
		ed, quarter rails x 2 in the up			Administrator at Life Care Cer		
		-			of the Willows is responsible in		
	position. There was	s no body pillow in the bed.			ensuring compliance in this Pl of Correction.	an	
	The resident's recor	rd was reviewed on 12/28/23 at					
	11:08 a.m. Diagnos	ses included, but were not					
		enosis, traumatic subdural					
	_	fibrillation and a history of falls.					
	-	•					
		imum Data Set assessment,					
		licated the resident had severe					
		ent and required partial to					
	moderate staff assis	stance for toileting and					
	transfers.						
	A Progress Note. da	ated 10/14/23, indicated the					
		on her back at the foot of her					
		of pain to her back. She was					
		and returned with a large					
	abrasion to her back						
	aurasion to her bach	Λ.					
	A Progress Note A	ated 10/31/23, indicated the					
	_						
		sitting on her buttocks on the					
	bathroom floor.						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155158	B. W	ING		01/03/	2024
NAME OF P	ROVIDER OR SUPPLIER		•		ADDRESS, CITY, STATE, ZIP COD		
LIFE CAF	RE CENTER OF TH	HE WILLOWS			LIZABETH DR RAISO, IN 46383		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	1	TAG	DEFICIENCY)		DATE
	resident was observ bed and bleeding wa	ated 11/15/23, indicated the red lying on floor near foot of as noted around her head. to the hospital and returned					
		her head and a staple to lower					
		ated 12/31/23 at 12:16 p.m., nt was found on the floor at					
		She had a laceration above her					
		ent to the hospital for					
	resident was to be to	ng Care Plan indicated the oileted every 2 hours to have of falls related to self transfer					
	was toileted on 12/31, to the fall on 12/31, 3.5 hours prior to the	ntation indicated the resident 81/23 at 6:13 a.m., 6 hours prior and at 10:28 a.m. on 12/27/23, ne observation on 12/27. The mentation the resident was ars.					
	therapy) was to eval	re Plan, indicated PT (physical luate the resident to determine ody pillow to prevent					
	indicated there had	1, on 1/2/24 at 3:20 p.m., been no referral made to PT valuation, that was normally a					
	1/3/24 at 11:00 a.m. resident had frequen	Executive Director (ED), on ., indicated she was aware the nt falls and they occurred apting to transfer herself to the					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE A. BUILDING 00 COMPLETED					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00		
		155158	B. W	ING		01/03/	2024
NAME OF F	PROVIDER OR SUPPLIER	2			ADDRESS, CITY, STATE, ZIP COD		
LIFE CAF	RE CENTER OF TH	HE WILLOWS			LIZABETH DR RAISO, IN 46383		
	<u> </u>			L	V 1100, 11V +0000		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
		ad been placed on a toileting					
	schedule. When ask	xed if the staff was monitored					
		n the toileting schedule, there					
	was no information	provided. Observed on 12/28/23 at 9:44					
		oda chair with non-slid socks					
	_	ion in his room, with no helmet					
	noted.						
	On 12/20/22 of 10-2	39 a.m., Resident E was					
		a Broda chair with non-skid					
		television in his room, with no					
	helmet noted.						
	Th	14					
		dent E was reviewed on .m. Diagnoses included, but					
		, intracranial injury, dementia,					
	and Alzheimer's dis						
		D (G ((1 (DG))					
		mum Data Set (MDS) 0/2/23, indicated the resident					
		tively impaired for daily					
	decision making.	avery impulses for early					
		dated 9/9/22, indicated the					
	helmet.	post-operative protection					
		d on 12/1/23, indicated the					
		post-operative protection					
		history of traumatic brain injury					
		procedure. The resident was to ative protection helmet when					
	up out of bed as tole						
	_						
		d on 11/22/22, indicated the					
		ue to poor balance and resident was to wear a helmet					
	per the Physician O						
	1 1 11, 5101411 0						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV						
AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING D B. WING		00	COMPLETED 01/03/2024					
		133130	D. W.			01/03/	2024	
NAME OF I	PROVIDER OR SUPPLIER	2			ADDRESS, CITY, STATE, ZIP COD LIZABETH DR			
LIFE CAI	RE CENTER OF TH	HE WILLOWS		VALPARAISO, IN 46383				
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE	
	During an interview Assistant Director of resident was suppor times when he was sometimes would re This citation relates	or on 12/29/23 at 10:21 a.m., the of Nursing indicated the sed to have his helmet on at all out of bed, however he emove the helmet on his own.						
F 0692 SS=D Bldg. 00	3.1-45(a)(2) 483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;							
	to maintain prope §483.25(g)(3) Is of when there is a not health care provide Based on observation interview, the facility hydration and nutrical to providing fluids weights being montage	offered sufficient fluid intake or hydration and health; offered a therapeutic diet outritional problem and the ler orders a therapeutic diet. In property of the property of the ler orders at the ler orders at the ler orders at the left of	F 06	592	F692 Nutrition/Hydration Statu Maintenance What Corrective Action will be accomplished for those reside found to have been affected b	ents	02/01/2024	

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DESTRICTION NUMBER A. BILLING D.	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE	SURVEY	
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF THE WILLOWS (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX AG BERGULATORY OR SCIENTIFICING INFORMATION In the food in the foot. There was no beverage in the room. On 12/29/23 at 9.26 a.m. the Resident Was observed again on 12/28/23 at 9.32 a.m., staff was observed again on 12/28/23 at 9.32 a.m., staff was observed removing the resident's breakfast ray from her room. The beverage have breakfast ray from her room. The beverage in the resident was observed removing the resident's heakfast ray from her room. On 12/29/23 at 12:15 p.m. and 2:35 p.m., the resident was in bed with the side rails up and a mat on the floor. There was no beverage on the overhed table that was located out of reach beyond the foot of the bed. On 1/2/24 at 8.57 a.m., the resident was up in a Brods chair in the diming room, she had a lunch in front of her and was feeding herself, there was no beverage on the residents search at the table with a heverage, the resident scan can be considered and to, metabolic encephalopathy, muscle weakness, unspecified convolisions and diabetes mellitus. STREET ADDRESS, CITY, STATE, 2IP COD 1000 ELLZABETH DR VALPARAISO, IN 46883 ID VALPARAISO, IN 46883 ID VALPARAISO, IN 46883 ID PROVIDER PLAND CORRICTION COMPACTION COMPLETION COMPACTION COMPLETION COMPLETION CANNESS AND COMPLETION C	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPL	ETED
LIFE CARE CENTER OF THE WILLOWS AND SUMMARY STATEMENT OF DEFICIENCIE PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIE PREFIX TAG REGULATORY OR ISE DESTRIPTION INFORMATION Primitings include: 1. On 12/27/23 at 9:26 a.m. the Resident G was observed in her bed. The side rails were up, there was a mat on the floor. There was no beverage to drink in the room. The resident was observed removing the resident's breakfast tray from her room. The beverage was on the tray, full with a lid on it. The food had been untouched. There was no beverage in the resident was in bed with the side rails up and a mat on the floor. There was no beverage on the resident was located out of reach beyond the foot of the bed. On 12/29/23 at 12:15 p.m. and 2:35 p.m., the resident was so the two powers of the bed. On 1/29/24 at 8:57 a.m., the resident was up in a Broda chair in the dining room, the head a lunch in font of her and was feeding herself, there was no beverage on the tay had been removed. There were 3 other residents seated at the table with a beverage, the resident did not have one. PREFIX TAG 1. REGULATORY OR LISE DESTRIPTION INFORMATION TAG 1. RES G and 37 had no negative outcomes Res G had fluids put within he reach in the dids put within he reach in the dials put within her reach inmediately and staff offered her fluids. Res 37 had care plan reviewed and supplements were in place. Res 37 was put on weekly weights immediately. How other residents having the potential to be affected by th			155158	B. W	NG		01/03/	2024
LIFE CARE CENTER OF THE WILLOWS AND SUMMARY STATEMENT OF DEFICIENCIE PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIE PREFIX TAG REGULATORY OR ISE DESTRIPTION INFORMATION Primitings include: 1. On 12/27/23 at 9:26 a.m. the Resident G was observed in her bed. The side rails were up, there was a mat on the floor. There was no beverage to drink in the room. The resident was observed removing the resident's breakfast tray from her room. The beverage was on the tray, full with a lid on it. The food had been untouched. There was no beverage in the resident was in bed with the side rails up and a mat on the floor. There was no beverage on the resident was located out of reach beyond the foot of the bed. On 12/29/23 at 12:15 p.m. and 2:35 p.m., the resident was so the two powers of the bed. On 1/29/24 at 8:57 a.m., the resident was up in a Broda chair in the dining room, the head a lunch in font of her and was feeding herself, there was no beverage on the tay had been removed. There were 3 other residents seated at the table with a beverage, the resident did not have one. PREFIX TAG 1. REGULATORY OR LISE DESTRIPTION INFORMATION TAG 1. RES G and 37 had no negative outcomes Res G had fluids put within he reach in the dids put within he reach in the dials put within her reach inmediately and staff offered her fluids. Res 37 had care plan reviewed and supplements were in place. Res 37 was put on weekly weights immediately. How other residents having the potential to be affected by th					CTREET	ADDRESS CITY STATE ZIR COD		
LIFE CARE CENTER OF THE WILLOWS VALPARAISO, IN 46383	NAME OF F	PROVIDER OR SUPPLIER	2					
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appropriate interventions r/t The resident's record was reviewed on 12/28/23 at 1:02 p.m. Diagnoses included, but were not limited to, metabolic encephalopathy, muscle weakness, unspecified convulsions and diabetes mellitus. appropriate interventions r/t offering fluids to residents if dependent on staff by SDC and education has been provided to Dietary Manager, RAR members,			_			•		
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to, metabolic encephalopathy, muscle weakness, unspecified convulsions and diabetes mellitus. education has been provided to Dietary Manager, RAR members,		1:02 p.m. Diagnose	s included, but were not limited					
unspecified convulsions and diabetes mellitus. Dietary Manager, RAR members,					l ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '			
						_ I		
Tana any staninivolved with						and any staff involved with		
The Significant Change Minimum Data Set obtaining weights or being		The Significant Cha	ange Minimum Data Set			_		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPLI	
		155158	B. WI	NG		01/03/2	2024
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER	8			LIZABETH DR		
LIFE CAI	RE CENTER OF TH	IE WILLOWS			RAISO, IN 46383		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
	· · · · · · · · · · · · · · · · · · ·	2/20/23, indicated the resident			responsible for weights being		
	had significant cognitive impairment, and required				obtained by the SDC and		
		stance for bed mobility,			completed by date of complian	nce.	
	transfers and toileting and supervision for eating.				No licensed nurses, QMAS,	_	
	A Dhygiaian'a Nata	dated 12/19/22 indicated the			aides, Dietary manager or RA		
	-	dated 12/18/23, indicated the			committee members will work		
	resident was dehydi				without this education being		
	intravenous (IV) fluid D5.45 normal saline be infused because the resident had not taken				completed. This education will offered upon hire, at least	i be	
	anything orally for				annually, and as needed.		
	anything orany for	72 Hours.			Licensed nursing will be		
	Δ Physician's Note	dated 12/20/23, indicated the			responsible for assuring the a	ides	
resident needed to be fed and was full assist, and				obtain weights as per policy a			
the patient was dehydrated.				they will turn into appropriate			
	me patient was den.	, drated.			clinical manager.		
	A Progress Note, da	ated 12/18/23, indicated the IV			How the corrective action will	he	
	_	milliliters/ hr x 2 liters.			monitored to ensure the defici		
					practice will not recur, i.e., who		
	The record lacked d	locumentation fluid intake or			quality assurance program wil		
		onitored. There was no			put in place:		
		rders to increase fluids.			1. Nurse manager responsible	e for	
					RAR will validate 10 weights		
	During an interview	on 1/2/24 at 10:57 a.m., the			weekly x 3 months then 5 weight	ghts	
	Assistant Director of	of Nursing (ADON) was made			weekly x 3 months for being		
	aware of the above	observations and indicated			obtained, accurate and		
	residents who were	dehydrated should have			documented appropriately		
	fluids pushed and la	abs monitored. She indicated			ongoing.		
	the resident wasn't	eating or drinking anything, so			Compliance date: 02/01/2024.	. The	
		in the assisted dining room or			Administrator at Life Care Cer	nter	
	_	assist.2. Record review for			of the Willows is responsible in	n	
		mpleted on 12/28/23 at 2:26			ensuring compliance in this Pl	an	
	_	luded, but were not limited to,			of Correction.		
		tage renal disease, and atrial					
	fibrillation.						
	The Quarterly Minimum Data Set (MDS)						
		0/11/23, indicated the resident					
	was cognitively impaired. The resident required						
		eating meals. His weight was					
	_	which indicated he had a					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

J6PQ11

Facility ID: 000078

If continuation sheet Page 28 of 42

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155158		(X2) MULTIPLE CO A. BUILDING B. WING	nstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 01/03/2024	
	PROVIDER OR SUPPLIER RE CENTER OF THE WILLOWS	STREET ADDRESS, CITY, STATE, ZIP COD 1000 ELIZABETH DR VALPARAISO, IN 46383			
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	significant weight loss and was not on a prescribed weight-loss regimen.				
	The Weight Task record indicated weights on the following dates: - 3/27/23; 141 lbs - 4/27/23: 139 lbs - 6/9/23: 138 lbs - 7/12/23: 136 lbs - 7/12/23: 135 lbs, weight marked out on 7/12/23, indicated error - 7/12/23: 198 lbs, weight marked out on 9/12/23, indicated error - 9/10/23: 176.3 lbs, weight marked out on 10/19/23, indicated error - 10/3/23: 138.1 lbs There were no more documented weights since				
	During an interview on 12/29/23 at 10:29 a.m., the Assistant Director of Nursing (ADON) indicated the resident had not had a weight loss and the MDS completed in October was incorrect. She could not provide documentation any weights had been completed on the resident from 10/3/23 until 12/28/23. She further indicated making sure residents were weighed monthly had been an ongoing issue at the facility she was trying to improve. 3.1-46(a)(1) 3.1-46(b)				
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary				

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Event ID:

J6PQ11

Facility ID: 000078

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155158		(X2) MULTIP A. BUILDIN B. WING	LE CONSTRUCTION NG <u>00</u>	(X3) DATE SURVEY COMPLETED 01/03/2024		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1000 ELIZABETH DR VALPARAISO, IN 46383			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREF	CROSS-REFERENCED TO THE APPROPR		
	REGULATORY OF drug is any drug v §483.45(d)(1) In eduplicate drug the s483.45(d)(2) For s483.45(d)(3) Withor §483.45(d)(4) Withor its use; or §483.45(d)(5) In the consequences which should be reduced s483.45(d)(6) Any reasons stated in (5) of this section. Based on record regimen was managor maintain the resimental, physical, a related to non-pharm provided prior to account of the section of	excessive dose (including erapy); or excessive duration; or hout adequate monitoring; hout adequate indications he presence of adverse hich indicate the dose d or discontinued; or or combinations of the paragraphs (d)(1) through		F 757 Drug Regimen is Free Unnecessary Drugs What Corrective Action will be accomplished for those resident practice: 1. Resident 4, 48 and 105 has negative outcomes. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective will be identified and what corrective will be identified and what corrective.	e from 02/01/2024 De lents by this lad no the le oe	
	1:12 p.m. Diagnose to bipolar disorder, polyneuropathy.			action will be taken: 1. An in house audit has bee completed by nursing managon past 30 day's pharmacy recommendations to ensure been completed. Audit in house resident's last 30 days of PR	pers have use of	
	ine Quarterly Mini	mum Data Set assessment,	1	pain medication usage as we	eli and	

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Event ID:

J6PQ11 Facility ID: 000078

If continuation sheet Page 30 of 42

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155158	B. W	ING _		01/03	/2024
		1		STREET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	R			LIZABETH DR		
LIFE CAF	RE CENTER OF TH	HE WILLOWS			RAISO, IN 46383		
	NE OLIVIER OF TE	TE WILLOWS		V/\LI /\l			T
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	dated 10/24/23, indicated the resident had mild				determining if non pharmalogi	cal	
	cognitive deficits an	nd took opioid pain			interventions had been		
	medications.				implemented prior to prn pain		
	TI D 1 202	2 Pl - ' ' O G			medication being administered		
	The December 2023 Physician's Order Summary				Md and families will be notified		
	(POS) indicated the resident took acetaminophen,				any issues. To be completed by	ру	
	650 milligrams (mg) every 8 hours as needed for		1		date of compliance.		
	mild pain. The resident also took hydrocodone/ acetaminophen (opioid pain medication) 5/325 mg				2.		
		needed for severe pain.			What measures and what	- 4-	
	every 12 hours as h	reeded for severe pain.			systemic changes will be mad ensure that the deficient pract		
	The POS indicated two non-pharmacological				doesn't recur:	ice	
	interventions should be attempted prior to giving				1. Education will be completed	1 to	
any as needed pain medication and documented.				licensed nursing by the SDC of			
	any as needed pain	medication and documented.			the policy and procedure for	711	
	The December 202	3 Medication Administration			administering PRN pain		
		icated acetaminophen had been	medications to include offering and				
		hydrocodone/ acetaminophen	documenting 2 non med				
		mes. The MAR lacked any			interventions prior to administe	erina	
		ion-pharmacological			PRN pain medication.	3	
		pted prior to the medications			DON/Designee have been		
	being administered.				educated on the best practice	and	
	-				policy for completing pharmac		
	During an interview	v on 12/29/23 at 2:20 p.m., LPN			recommendations timely. No		
	1 indicated two or t	three interventions should be			licensed nurse will work past of	date	
	attempted prior to g	giving as needed pain			of compliance without this		
	medication and the	y would usually try to redirect			education being completed. T	his	
	the resident. She in	dicated that was not			education will be completed up	pon	
	documented anywh	nere.			hire, at least annually, and as		
					needed.		
		9:26 a.m., Resident 105 was			How the corrective action will	be	
		l. She was moaning and			monitored to ensure the defici-		
	complaining her sto	omach hurt.			practice will not recur, i.e., who		
					quality assurance program wil	l be	
	The resident's record was reviewed on 12/28/23 at		1		put in place:		
	1:02 p.m. Diagnoses included, but were not limited		Nursing managers will review				
	to, metabolic encephalopathy, muscle weakness				medication sheets daily Mond	•	
	and diabetes mellitt	us.			through Friday in clinical meet	-	
	TEL CI IN IN	NC 1 - D 1 - C 1			to review for PRN pain meds a	and	
1	L The Significant Cha	ange Minimum Data Set	1		annronriate interventions		1

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLETED			ETED	
		155158	B. W	ING		01/03/	2024
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP COD		
LIEE OAE	DE OENTED OF TH	IE 14/II I 014/0			LIZABETH DR		
LIFE CAP	RE CENTER OF TH	IE WILLOWS		VALPAI	RAISO, IN 46383		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	assessment, dated 1	2/20/23, indicated the resident			attempted prior to administration	on.	
	had significant cognitive impairment, and required				DON/Designee will remotely		
	extensive staff assistance for bed mobility,				review Mars on weekends and		
	transfers and toileting.				holidays x 6 months.		
					2. The results of these reviews	will	
	The December 2023	3 POS indicated the resident			be discussed at the monthly		
	took hydrocodone/ acetaminophen 5/325 mg				facility Quality Assurance		
	•	eded for severe pain and			Committee meeting monthly fo	or a	
	morphine sulfate (an opioid pain medication) 10				total of 3 months and then		
	mg/0.5 milliliters (ml) give 0.25 ml every two hours				quarterly thereafter once		
	as needed for severe pain.				compliance is at 100%.		
					Frequency and duration of rev	iews	
	The POS indicated two non-pharmacological				will be increased as needed, if	:	
	interventions should be attempted prior to giving				compliance is below 100%.		
	any as needed pain	medication and documented.			Compliance date: 02/01/2024.	The	
					Administrator at Life Care Cen		
	The December 2023	3 MAR indicated			of the Willows is responsible ir	1	
	hydrocodone/acetar	ninophen was used 18 times			ensuring compliance in this Pla		
	and morphine sulfat	te was used 35 times. There			of Correction.		
	was no documentati	ion non-pharmacological					
	interventions had be	een attempted prior to giving					
	the as needed medic	cations.					
	During an interview	on 12/29/23 at 2:20 p.m., LPN					
	1 indicated two or the	hree interventions should be					
	attempted prior to g	iving as needed pain					
	medication and they	would usually try to redirect					
	the resident. She inc	dicated that was not					
	documented anywh	ere. 3. Resident 48's record					
	-	2/29/23 at 2:52 p.m. Diagnoses					
	included, but were i	not limited to, high blood					
	pressure, depression	n, dementia, and chronic atrial					
	fibrillation.						
	The Quarterly Mini	mum Data Set (MDS)					
		2/11/23, indicated the resident					
		paired for daily decision					
	making.	· · ·					
	-						
	A Physician's Order	r, dated 8/14/2023, indicated					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155158		(X2) MUI A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE (COMPL 01/03/	ETED	
	PROVIDER OR SUPPLIER			1000 EL	DDRESS, CITY, STATE, ZIP COD IZABETH DR AISO, IN 46383		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	P	ID REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION
TAG	the resident was to a Tablet 50 milligram bedtime for insomn The December 2022 Pharmacy indicated Oral Tablet 50 milligram to be reduced to 25 goal of discontinual interventions should maintained through The recommendation There was no document to the commendation of the properties of the commendation of	3 Consultation Report from a the dose of Benadryl Allergy igrams (mg) was recommended mg at bedtime with the end tion. Nonpharmacological d be implemented prior to and out the treatment of insomnia. On was accepted by the doctor. In mentation that the order was of Nurse (ADON) indicated the he medication to be e order was not changed.		TAG	DEFICIENCY)		DATE
F 0758 SS=D Bldg. 00	Use §483.45(e) Psych §483.45(c)(3) A partial proces drug that affects be with mental proced drugs include, but the following cates (i) Anti-psychotic; (ii) Anti-depressar (iii) Anti-anxiety; and (iv) Hypnotic Based on a comparesident, the facilities	Psychotropic Meds/PRN otropic Drugs. sychotropic drug is any orain activities associated sses and behavior. These are not limited to, drugs in gories:					

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CENTERDIO	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039
STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155158		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/03/2024	
	PROVIDER OR SUPPLIEI		1000 E	ADDRESS, CITY, STATE, ZIP COD ELIZABETH DR RAISO, IN 46383	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
TAG	psychotropic drug unless the medical specific condition documented in the §483.45(e)(2) Respondentially control of the general specific and psychotropic drug unless clinically control of the general specific and general	is are not given these drugs ation is necessary to treat a as diagnosed and e clinical record; sidents who use is receive gradual dose chavioral interventions, contraindicated, in an effort se drugs; sidents do not receive is pursuant to a PRN order ation is necessary to treat iffic condition that is e clinical record; and N orders for psychotropic to 14 days. Except as 45(e)(5), if the attending cribing practitioner believes ate for the PRN order to be 14 days, he or she should tionale in the resident's aid indicate the duration for	IAG	DETCHACT	DATE
	drugs are limited renewed unless the prescribing practif	N orders for anti-psychotic to 14 days and cannot be ne attending physician or cioner evaluates the resident eness of that medication.			
	Based on record re- failed to ensure a g was attempted for 1	view and interview, the facility radual dose reduction (GDR) of 5 residents reviewed for ations. (Resident E)	F 0758	F 758 Free from Unnecessary Psychotropic Meds/PRN Use What Corrective Action will be accomplished for those resider found to have been affected by deficient practice: 1. Res E had no negative	

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The record for Resident E was reviewed on

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outcomes. The Psy NP was

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CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039	
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		155158	B. WING		01/03/2024	
			CTREE	Γ ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER	₹		ELIZABETH DR		
LIEE CA	DE CENTED OF TH	JE WILLOWS				
LIFE CA	RE CENTER OF TH	ie Willows	VALE	ARAISO, IN 46383		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	12/28/23 at 11:06 a	.m. Diagnoses included, but		notified to obtain a GDR and		
	were not limited to,	intracranial injury, dementia,		appropriate DX.		
	and Alzheimer's dis	sease.		How other residents having th	ne	
				potential to be affected by the	;	
	The Quarterly Mini	mum Data Set (MDS)		same deficient practice will be	•	
	assessment, dated 1	0/2/23, indicated the resident		identified and what corrective		
	was severely cognit	tively impaired for daily		action will be taken:		
	decision making. H	Ie received an antidepressant		1. An in house audit has beer	1	
	and antipsychotic m	nedication on a routine basis		completed by SSD on resider	nts	
	only.			with psychotropic medications	s to	
				note appropriate dx for medic	ation	
	A Physician Order,	dated 11/7/22, indicated		and GDR timely and if refused	d	
	seroquel (an antipsy	ychotic medication) 25		appropriate documentation by	/ MD	
	milligram (mg), giv	ve 1.5 tablet by mouth in the		on why not by date of complia	ance.	
	morning and 2.5 tal	olets by mouth at bedtime.		What measures and what		
				systemic changes will be mad	le to	
	A Care Plan, dated	9/26/22, indicated the resident		ensure that the deficient pract	tice	
	used a psychotropic	e medication related to		doesn't recur:		
	behavior manageme	ent and was at risk for side		Education will be completed	d to	
	effects. Intervention	ns included, but were not		the clinical management team	n and	
	limited to, consult v	with pharmacy and the		SSD on the regulation regard	ing	
	Physician to consid	er dosage reduction when		psychotropic medications, dx	to	
	clinically appropria	te, at least quarterly.		support and GDRS by pharma	acy	
				by date of compliance. SSD a		
	_	te, dated 4/4/2023 at 4:42 p.m.,		the clinical team will not work	•	
		r meeting was held with the		date of compliance without the	is	
		ctor, Psychiatric Nurse		education being completed.		
	· ·	Coordinator, Infection		Clinical managers and SSD w		
		he Assistant Director of		receive this education upon h		
	• • •	The resident's behavior and		at least yearly and as needed		
		iscussed. The recommendation		How the corrective action will		
		for a gradual dose reduction		monitored to ensure the defic		
		25 mg was reviewed and the		practice will not recur, i.e., wh		
		this time. The resident was		quality assurance program wi	ll be	
	stable on the Seroqu	uel at the time.		put in place:		
				Monthly GDRS will be revie		
	_	v on 1/2/24 at 3:46 p.m., the		and ensure completion by the		
		ere was no appropriate		DON/Designee/SSD with eac	h	
	diagnosis for the Se	croquel and there was no GDR		monthly pharmacy report ong	oing.	

attempted due to a previous request by the family.

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SSD will audit residents monthly

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155158		A. BUILDING B. WING	00 00	COMPLETED 01/03/2024	
	PROVIDER OR SUPPLIER		1000 E	ADDRESS, CITY, STATE, ZIP COD LIZABETH DR RAISO, IN 46383	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	3.1-48(b)(1) 3.1-48(b)(2)			on psychotropic medications to ensure appropriate use and displace as well as if GDRS time and documentation in place ongoing. 2. The results of these reviews be discussed at the monthly facility Quality Assurance Committee meeting monthly for total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of rewwill be increased as needed, it compliance date: 02/01/2024. Administrator at Life Care Cerof the Willows is responsible in ensuring compliance in this Plof Correction.	k in ly s will or a liews f The lter
F 0770 SS=D Bldg. 00	obtain laboratory sof its residents. The quality and time (i) If the facility proservices, the services, the services pecified in part 48 Based on record reversiled to ensure an object of the services.	atory Services. facility must provide or services to meet the needs are facility is responsible for seliness of the services. Sovides its own laboratory ones must meet the ments for laboratories and of this chapter. The wand interview, the facility ordered urine culture was at the laboratory timely for 1 of all for unnecessary	F 0770	F770 Laboratory Services What Corrective Action will be accomplished for those reside found to have been affected b deficient practice: 1. Resident E had U/a picked the following day after being	nts y this

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CENTERS FOI	R MEDICARE & MEDIC	CAID SERVICES	OMB NO. 0938-039					
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	LETED	
		155158	B. W	NG		01/03	/2024	
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF I	PROVIDER OR SUPPLIE	ZR.			LIZABETH DR			
LIFE CA	RE CENTER OF T	HE WILLOWS		VALPARAISO, IN 46383				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
					recollected.			
		sident E was reviewed on			How other residents having the			
		a.m. Diagnoses included, but			potential to be affected by the			
		o, intracranial injury, dementia,			same deficient practice will be			
	and Alzheimer's di	sease.			identified and what corrective			
					action will be taken:			
		nimum Data Set (MDS)			1. An In house audit has beer			
		10/2/23, indicated the resident			completed on residents by nu	rsing		
		itively impaired for daily			management with labs ordere	ed		
	decision making.				past 30 days to ensure			
					compliance. Any issues identi	ified		
	A Physician's Order, dated 5/6/23, indicated to				will be corrected, md and fam	ily		
		, culture and sensitivity (UA			notified and facility protocol to	be		
	C&S).				followed.			
					What measures and what			
		s Note, dated 5/5/23 at 11:00			systemic changes will be mad	de to		
	_	resident was noted to have			ensure that the deficient pract	tice		
	_	urine with a fever of 102			doesn't recur:			
	_	t and noted congestion with			Education to licensed nurse			
		ation on room air. New orders			will be completed in r/t labs no	ot		
		n the Physician for a chest x-ray,			being drawn as ordered or			
		as needed, and Rocephin (an			specimens not picked up by la			
		intramuscularly injection for 7			timely, to include MD and fam	-		
	days.				notification, any new orders w			
					conveyed, and lab notified. E			
	A Nurses' Progress	s Note, dated 5/6/23 at 3:00 a.m.,			contact lab and have discussi			
		was obtained for the UA and			on meeting needs of facility ti	-		
		e for pick up. The laboratory			and if not able to do this facili	-		
		tated they would pick up the			will look for another vendor fo	r this		
	sample in the morr	ning.			need.			
	A Numacal Decare	Note deted 5/6/22 at 5:40 = ==			Llow the corrective action will	ha		
		s Note, dated 5/6/23 at 5:49 p.m.,			How the corrective action will			
		atory stated they would pick up			monitored to ensure the defic			
		day as they had no same day			practice will not recur, i.e., wh			
	pick-up available.				quality assurance program wi	ıı be		
	A Numana-! Desa-	Note detail 5/7/22 -4 5:17			put in place:			
		s Note, dated 5/7/23 at 5:17 p.m., tated they had no pick up			1. IP will validate specimens	h =		
	i muicated the lab st	iaicu mey nau no pick up	1		related to possible infections	nave	1	

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person on that day.

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been picked up by lab timely

ongoing. Nursing managers will

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY						
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00		COMPLETED	
		155158	B. WI	NG		01/03/	/2024	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1000 ELIZABETH DR VALPARAISO, IN 46383					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	, 	COMPLETION	
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	IE	DATE	
	A Nurses' Progress	Note, dated 5/8/23 at 4:20 p.m.,			audit 3 charts weekly x 6 mon	ths		
	indicated the labora	tory did not pick up the urine			on residents with lab orders fo			
	sample. The Physic	ian was notified and new			that week to ensure compliand	ce.		
	orders were given to	o obtain another UA that			2. The results of these reviews	s will		
	evening to be picke	d up by the laboratory in the			be discussed at the monthly			
	morning.				facility Quality Assurance			
					Committee meeting monthly for	or a		
		Note, dated 5/9/23 at 7:22 a.m.,			total of 3 months and then			
		as collected and picked up by			quarterly thereafter once			
	the laboratory with	pending results.			compliance is at 100%.			
					Frequency and duration of rev			
	During an interview on 1/3/24 at 11:12 a.m., the Assistant Director of Nursing indicated the UA				will be increased as needed, it	:		
					compliance is below 100%.			
		een sent to the lab more			Compliance date: 02/01/2024.			
	timely.				Administrator at Life Care Cer			
	2 1 40(-)				of the Willows is responsible in			
	3.1-49(a)				ensuring compliance in this Pl	an		
					of Correction.			
F 0881	483.80(a)(3)							
SS=D	Antibiotic Steward	Iship Program						
Bldg. 00		on prevention and control						
	program.	'						
		establish an infection						
	•	ntrol program (IPCP) that						
	must include, at a	minimum, the following						
	elements:							
	§483.80(a)(3) An	antibiotic stewardship						
	program that inclu	ides antibiotic use protocols						
	•	nonitor antibiotic use.						
		view and interview, the facility	F 08	381	F 881 Antibiotic Stewardship		02/01/2024	
	-	ntibiotic stewardship by			Program			
		oriate use of antibiotic therapy			What Corrective Action will be			
	to reduce antibiotic resistance related to a physician prescribing antibiotics for a urinary tract infection without a urinalysis and culture				accomplished for those reside			
					found to have been affected b	y this		
					deficient practice:			
	_	5 residents reviewed for			1. Resident E had no negative			
	unnecessary medica	mons. (Resident E).			outcome from alleged deficien	ι		
					practice.	Ų		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 01/03/2024 155158 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1000 ELIZABETH DR LIFE CARE CENTER OF THE WILLOWS VALPARAISO, IN 46383 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Finding includes: How other residents having the The record for Resident E was reviewed on potential to be affected by the 12/28/23 at 11:06 a.m. Diagnoses included, but same deficient practice will be were not limited to, intracranial injury, dementia, identified and what corrective and Alzheimer's disease. action will be taken: 1. An in house audit will be The Quarterly Minimum Data Set (MDS) completed by the IP going back assessment, dated 10/2/23, indicated the resident 30 days for residents on antibiotic was severely cognitively impaired for daily to ensure Antibiotic Stewardship decision making. Program is being followed appropriately. Any issues A Physician's Order, dated 5/6/23, indicated to identified will be discussed with obtain a urinalysis, culture and sensitivity (UA the MD. C&S). What measures and what systemic changes will be made to A Physician's Order, dated 5/6/23, indicated ensure that the deficient practice ceftriaxone sodium injection solution doesn't recur: reconstituted (Rocephin) 1 gram, inject 1. Education will be provided to intramuscularly one time a day. the prescribing MDS on the policy and procedure for the Antibiotic A Nurses' Progress Note, dated 5/5/23 at 11:00 Stewardship Program by the IP p.m., indicated the resident was noted to have and ED by date of compliance. dark brown tinged urine with a fever of 102 Clear expectations will be degrees Fahrenheit and noted congestion with discussed to ensure compliance. 90% oxygen saturation on room air. New orders How the corrective action will be were received from the Physician for a chest x-ray, monitored to ensure the deficient UA C&S, oxygen as needed, and Rocephin (an practice will not recur, i.e., what antibiotic) 1 gram intramuscularly injection for 7 quality assurance program will be days. put in place: 1. The IP/DON will review all A Nurses' Progress Note, dated 5/6/23 at 3:00 a.m., antibiotic orders ongoing to assure indicated the urine was obtained for the UA and protocol being followed per placed in the fridge for pick up. The laboratory Antibiotic Stewardship was notified and stated they would pick up the Program/CDC recommendations. sample in the morning. Any concerns noted will be discussed with prescribing MD by A Nurses' Progress Note, dated 5/6/23 at 5:49 p.m., the IP to resolve concern. indicated the laboratory stated they would pick up 2. The results of these reviews will

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the same the next day as they had no same day

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be discussed at the monthly

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155158		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/03/2024	
	PROVIDER OR SUPPLIER		1000 E	ADDRESS, CITY, STATE, ZIP COD ELIZABETH DR ARAISO, IN 46383	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
F 0921	pick-up available. A Nurses' Progress indicated the lab sta person on that day. A Nurses' Progress indicated the labora sample. The Physic orders were given to evening to be picker morning. A Nurses' Progress indicated the UA with laboratory with During an interview Assistant Director of C&S should have be and the antibiotic the	Note, dated 5/7/23 at 5:17 p.m., ted they had no pick up Note, dated 5/8/23 at 4:20 p.m., tory did not pick up the urine ian was notified and new o obtain another UA that d up by the laboratory in the Note, dated 5/9/23 at 7:22 a.m., as collected and picked up by	IAG	facility Quality Assurance Committee meeting monthly f total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of re- will be increased as needed, compliance is below 100%. Compliance date: 02/01/2024 Administrator at Life Care Ce of the Willows is responsible in ensuring compliance in this P of Correction.	views if . The nter
F 0921 SS=E Bldg. 00	Safe/Functional/S. §483.90(i) Other E. The facility must p sanitary, and comresidents, staff and Based on observation failed to ensure the good repair related to	on and interview, the facility residents' environment was in to marred walls, a cracked doors, chipped paint, dirty pieces of baseboard for 2 of 2	F 0921	Plan of Correction F921 1. What corrective action(s) waccomplished for F921 to have been found deficient? The rooms listed are being corrected as follows: Room 4: New bathroom floor toilet scheduled to be installed and completed On Jan. 24. Room 7: Marred walls were	and

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED		
155158		155158	B. WING		01/03/2024		
		<u> </u>		CTDEET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER					LIZABETH DR		
LIEE CAI	RE CENTER OF TI	JE WILLOWS			RAISO, IN 46383		
LIFE CAI	NE CENTER OF TI	IE WILLOWS		VALFA	NAISO, IN 40303		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΛΤΕ.	COMPLETION
TAG				TAG	DEFICIENCY)		DATE
	on 1/3/24 at 1:38 p	.m., the following was observed:			patched and painted. Baseboa	ard	
					in bathroom was reattached.		
	1. East Unit:				Room 36: Walls to be patched	patched	
					and painted by 1-26. Baseboa		
	In Room 36, the flo	In Room 36, the floors were dirty, the walls were			already replaced.	· · · · · · · · · · · · · · · · · · ·	
	marred and paint was chipped on the side of bed			2. How will you identify F9.			
	2. There were missing pieces of the baseboard			having the potential to		cted	
	next to the restroom. One resident resided in the			by the same deficient prac		and	
	room.			what corrective action will			
					taken?		
	2. West Unit:				The inspection will note any		
					deficiencies and promptly corr	rect	
	a. In Room 4, the base of the toilet was cracked.				them.		
	Two residents resided in the room.				3. What measures will be put	into	
					place or what systemic chang	es	
	b. In Room 7, the walls were marred, and paint				will you make to ensure that the	ne	
	was chipped. The baseboard in the restroom was				deficiency does not recur?		
	marred. Two residents resided in the room.				The inspection schedule will b	е	
					revised to ensure that the		
	Interview with the Director of Maintenance on				deficiency does not recur.		
	1/3/24 at 1:40 p.m., indicated the areas were in		4. How will the corrective action(s)				
	need of repair.			be monitored to ensure the			
	-				deficient practice will not recu	r,	
	3.1-19(f)				i.e., what quality assurance		
				program will be put into place			
					including time frames and		
				person(s) responsible?			
				QA program will be put into place			
				to ensure that inspection will be			
				done monthly. The Director of			
				Maintenance will submit audits			
					monthly to the Executive Direct	ctor	
					to be reviewed at safety		
					committee and QA for a perio	d of	
					6 months to ensure 100%		
					compliance.		
				5. A Plan of Correction comple	etion		
					date has been		
					provided. Compliance date:		
				02/01/2024. The Administrato	r at		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155158		(X2) MULTIPLE CONSTRUCTION A. BUILDING D B. WING			(X3) DATE SURVEY COMPLETED 01/03/2024	
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF THE WILLOWS			STREET ADDRESS, CITY, STATE, ZIP COD 1000 ELIZABETH DR VALPARAISO, IN 46383				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
					Life Care Center of the Willows responsible in ensuring compliance in this Plan of Correction.	s is	

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