STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155158	A. BUILDING 00 B. WING	01/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LIFE CARE CENTER OF THE WILLOWS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00424101. Complaint IN00424101 - Federal/state deficiencies related to the allegations are cited at F677 and F689. Survey dates: December 27, 28 and 29, 2023 and January 2 and 3, 2024. Facility number: 000078 Provider number: 155158 AIM number: 100289310 Census Bed Type: SNF/NF: 52 Total: 52 Census Payor Type: Medicare: 4 Medicaid: 44 Other: 4 Total: 52 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 1/9/24.	F 0000	The facility requests that this plan of correction be considered its credible allegations of compliance. Submission of this response and Plan of Correction is not a legal admission that a deficiency exits or that this statement of deficiency was correctly cited and is also not to be construed as an admission of interest against the facility, the Administrator, or any employee, agents, or other individuals who draft or may be discussed in the response and Plan of Correction. In addition, preparation and submission of the Plan of Correction does not constitute an 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 prior to the resolution of Appeal of 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 Title 19 programs. The submission of Plan of Correction within this timeframe should in no way be of non-compliance or admission by	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tami Adams	Executive Director	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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155158	A. BUILDING 00 B. WING	01/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LIFE CARE CENTER OF THE WILLOWS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			the facility. This facility respectfully requests consideration of paper compliance for the cited deficiencies	
F 0561 SS=D Bldg. 00	483.10(f)(1)-(3)(8) Self-Determination §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. Based on observation, record review, and interview, the facility failed to honor a resident's	F 0561	What Corrective Action will be accomplished for those residents	02/01/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155158	A. BUILDING 00 B. WING	01/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LIFE CARE CENTER OF THE WILLOWS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	preference related to dressing for 1 of 1 residents reviewed for choices. (Resident 21) Finding includes: During an interview on 12/27/23 at 10:37 a.m., Resident 21 indicated he would like to wear regular day clothes and not a hospital gown. The record for Resident 21 was reviewed on 12/28/23 at 2:37 p.m. Diagnoses included, but were not limited to, paranoid personality disorder, adult failure to thrive, and bipolar disorder. A Significant Change in Status Minimum Data Set (MDS) assessment, dated 8/1/23, indicated the resident was moderately impaired for daily decision making. He required extensive assistance with two persons physical assist for dressing. The daily and activity preferences section indicated it was very important to the resident to choose what clothes to wear. A Care Plan, dated 12/28/22, indicated he liked to wear a facility/hospital gown for comfort and ease. Interventions included, but were not limited to, staff will dress the resident in accordance with his preferences. During an interview on 12/29/23 at 3:45 p.m., the Social Services Director (SSD) indicated that the care plan was not updated to reflect the MDS and it was just an oversight. It should have been updated. On 12/29/23 at 3:50 p.m., the Administrator was observed speaking with Resident 21. At this time, the resident indicated he was sick of wearing the hospital gowns every day and he would like to get dressed each morning in regular day clothes. The		found to have been affected by this deficient practice: 1. Resident 21 had no negative outcomes. He was offered choices immediately in r/t dressing and facility honored his wishes. 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 resident have the potential to be affected by the alleged deficient practice therefore an in house audit will be completed by SSD/ Nursing/Designee to obtain residents preferences with dressing. Care plans and Kardex will be updated by date of compliance. What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur: 1. Education will be provided by ED to SSD Activities and IDT team that choices and preferences need to be reviewed at least quarterly per care plan schedule and as needed to ensure compliance. No departments involved in choices or preferences will work past date of compliance without education completed and this will be offered upon hire, at least annually and as needed. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155158	A. BUILDING 00 B. WING	01/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LIFE CARE CENTER OF THE WILLOWS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Administrator indicated that she would have the staff start helping to get him dressed each morning. 3.1-3(u)(3)		quality assurance program will be put in place: 1. SSD will review 3 charts weekly x 3 months then 2 charts weekly x 3 months to ensure compliance. ED will review 2 charts weekly x 6 months to ensure compliance. 2. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 02/01/2024. The Administrator at Life Care center of the Willows is responsible in ensuring compliance in this Plan of Correction.	
F 0641 SS=A Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on record review and interview, the facility failed to ensure a Minimum Data Set (MDS) assessment was accurately completed related to weight loss coded incorrectly for 1 of of 21 MDS assessments reviewed. (Resident 37) Finding includes: Record review for Resident 37 was completed on 12/28/23 at 2:26 p.m. Diagnoses included, but were not limited to, hypertension, end stage renal disease, and atrial fibrillation.	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 therefore MDS has completed an in house audit on the last MDS submitted per resident to assure weights are coded accurately. If any issues noted modifications will be	02/01/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155158	A. BUILDING 00 B. WING	01/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LIFE CARE CENTER OF THE WILLOWS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The Quarterly MDS assessment, dated 10/11/23, indicated the resident was cognitively impaired. The resident required setup assistance for eating meals. His weight was 138 lbs (pounds), which indicated he had a significant weight loss and was not on a prescribed weight-loss regimen. The Weight Task record indicated weights on the following dates: - /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 10/3/23. During an interview on 12/28/23 at 3:30 p.m., the MDS Coordinator indicated the Quarterly MDS was coded incorrectly and the resident had not had a weight loss. 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 that any weights had been completed on the resident from 10/3/23 until 12/28/23. She indicated making sure residents were weighed monthly had been an ongoing issue at the facility which she was trying to improve.		completed and resubmitted prior to date of compliance. What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur: 1. MDS will be in serviced by the Regional CRS on the accuracy of assessments by date of compliance. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place: 1. DON/Designee will validate weight accuracy of 3 MDS weekly x 3 months then 2 times weekly x 3 months to ensure compliance. 2. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date:02/01/2024. The Administrator at Life Care Center of the Willows is responsible in ensuring compliance in this Plan of Correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155158	A. BUILDING 00 B. WING	01/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LIFE CARE CENTER OF THE WILLOWS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3.1-31(d)(3)			
F 0655 SS=D Bldg. 00	483.21(a)(1)-(3) Baseline Care Plan §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155158	A. BUILDING 00 B. WING	01/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LIFE CARE CENTER OF THE WILLOWS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION 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 failed to develop an initial plan of care within 48 hours of admission related to Activities of Daily Living (ADL) for 1 of 19 residents whose care plans were reviewed. (Resident B). Finding includes: The record for Resident B was reviewed on 3/26/19 at 9:03 p.m. The resident was admitted on 3/1/23. Diagnoses included, but were not limited to bipolar disorder, respiratory failure, and dementia. The baseline care plan was initiated on 3/13/23 which included ADL status, discharge plan, pain, skin integrity, and risk for change in mood or behavior due to a medical condition. During an interview on 1/2/24 at 3:45 p.m., the Assistant Director of Nursing indicated the baseline care plan should have been created within 48 hours after admission regarding his ADL status. 3.1-30(a)	F 0655	F 655 Base Line Care Plan What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice: 1. Resident B had no negative outcomes. Base line care plan was completed immediately. 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 on residents will be completed by MDS to validate residents have Base line care plans in place and they are timely by date of compliance. What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur: 1. DON/Designee will educate MDS, Clinical management team, IDT team and licensed nursing on completing a base line care plan timely on new admission by date of compliance. MDS, Clinical management team. IDT team and licensed nursing will not work past	02/01/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155158	A. BUILDING 00 B. WING	01/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LIFE CARE CENTER OF THE WILLOWS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			date of compliance without this education being completed. This education will be presented upon hire, at least annually as needed. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place: 1. MDS will validate any new admissions within 48 hours to ensure compliance. The clinical management team will complete chart audits daily Monday through Friday in morning meeting/clinical meeting and validate base line care plan in place and timely ongoing. 2. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 02/01/2024. The Administrator at Life Care Center of the Willows is responsible in ensuring compliance in this Plan of Correction.	
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155158	A. BUILDING 00 B. WING	01/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LIFE CARE CENTER OF THE WILLOWS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155158	A. BUILDING 00 B. WING	01/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LIFE CARE CENTER OF THE WILLOWS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on observation, record review, and interview, the facility failed to ensure a comprehensive care plan was developed and in place for a resident with a history of dehydration for 1 of 19 resident care plans reviewed. (Resident G) Finding includes: 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 again on 12/28/23 at 9:56 a.m., and 12:59 p.m., and 1/2/24 at 8:15 a.m. in bed with no beverage in the room. On 12/29/23 at 9:32 a.m., staff 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 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 a beverage on the overbed 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 Broda chair in the dining room. There was no beverage on the table. At 1:13 p.m., the resident was still in the dining room, she had a lunch in front of her and was feeding herself, however, there was no beverage present. At 1:40 p.m., the lunch tray had been removed. There were 3 other	F 0656	F 656 Develop/implement Comprehensive Care Plan What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice: 1. Resident G had care plan updated immediately. 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. MDS/Designee will do an in house audit on residents with dx of Dehydration and assure a care plan is in place by date of compliance. What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur: 1. MDS, IDT team and clinical management team will be in-serviced by the CRS on revising care plans when changes occur immediately by date of compliance. MDS, IDT team and clinical management team will not work past date of compliance without this education being completed. This education will be offered upon hire, at least annually and as needed. How the corrective action will be monitored to ensure the deficient	02/01/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155158	A. BUILDING 00 B. WING	01/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LIFE CARE CENTER OF THE WILLOWS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	residents seated at the table with a beverage, the resident did not have one. 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. The Significant Change Minimum Data Set assessment, dated 12/20/23, indicated the resident had significant cognitive impairment, and required extensive staff assistance for bed mobility, transfers and toileting and supervision for eating. A Physician's Note, dated 12/18/23, indicated the resident was dehydrated. An order for intravenous (IV) fluid D5.45 normal saline be infused because the resident had not taken anything orally for 72 hours. A Physician's Note, dated 12/20/23, indicated the resident needed to be fed and was a full assist, and the patient was dehydrated. There was no care plan in place to address the resident's dehydration. Interview with the Assistant Director of Nursing (ADON) on 1/2/24 at 10:57 a.m., she was made aware of the above observations and indicated residents who were dehydrated should have fluids pushed and labs monitored. She indicated there should be a care plan in place related to her hydration status. 3.1-35(a)		practice will not recur, i.e., what quality assurance program will be put in place: 1. Rar committee will review residents with current dx of dehydration weekly to ensure care plans in place with appropriate interventions ongoing. 2. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 02/01/2024. The Administrator at Life Care Center of the Willows is responsible in ensuring compliance in this Plan of Correction.	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155158	A. BUILDING 00 B. WING	01/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LIFE CARE CENTER OF THE WILLOWS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, record review, and interview, the facility failed to ensure residents received the necessary care for activities of daily living care (ADL) related to not receiving bathing after admission and twice weekly, dirty fingernails, and the lack of shaving a beard for 3 of 3 residents reviewed for ADL care. (Residents D, B, and C) Findings include: 1. On 12/27/23 at 10:23 a.m., Resident D was observed lying in bed. The resident's fingernails had visible debris underneath them. The resident indicated she had not received any bathing at the facility since she was admitted. Record review for Resident D was completed on 12/28/23 at 11:14 a.m. Diagnoses included, but were not limited to, vertebral fracture, anxiety, and depression. The resident was admitted to the facility on 12/21/23. The Bathing Task record indicated the resident had 1 shower on 12/27/23. The record lacked any documentation the resident had a shower prior to 12/27/23 since she was admitted on 12/21/23. During an interview on 12/28/23 at 11:40 a.m., the Assistant Director of Nursing (ADON) indicated she could not provide any documentation the resident had received any bathing since being admitted on 12/1/23, until 12/27/23. 2. During an interview on 12/27/23 at 1:52 p.m., Resident B's representative indicated he liked to	F 0677	F 677 ADL Care Provided for Dependent Residents What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice: 1. Residents D, B, and C had no negative outcomes. The residents cited had adl care performed immediately 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 including observations of residents to include nails, hair, oral care, shaving and bathing 2 times weekly will be completed by date of compliance by nursing management. Any issues noted will be addressed immediately. What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur: 1. Education will be provided by the SDC to all nursing including aides, QMAS, and nurses on the policy for assuring personal ADL care is being completed as expected up to and including observing residents prior to leaving for hospital and or appointments. No aides, nurses or QMAS will	02/01/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155158	A. BUILDING 00 B. WING	01/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LIFE CARE CENTER OF THE WILLOWS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	be clean shaven and it appeared he hadn't received assistance with shaving for a while. Resident B was observed to have facial hair at the time. Resident B was observed on 12/29/23 at 10:47 a.m., sitting in a wheelchair in the hallway with facial hair noted. The record for Resident B was reviewed on 12/29/23 at 10:51 a.m. Diagnoses included, but were not limited to bipolar disorder, respiratory failure, and dementia. The Quarterly Minimum Data Set, dated 10/9/23, indicated the resident was significantly impaired for daily decision making. A Care Plan, dated 3/13/23, indicated the resident required assistance with mobility and activities of daily living (ADLs) as needed. The record had no documentation of Resident B being offered assistance with shaving. During an interview on 1/2/24 at 3:45 p.m., the Assistant Director of Nursing the resident should be clean shaven if that is his preference. 3. During an interview on 12/27/23 at 10:37 a.m., Resident C indicated he did not get assistance with shaving often. His fingernails were long and dirty. He had long facial hair on his chin. Resident C was observed on 12/28/23 at 2:24 p.m. He was laying in bed in a hospital gown. He had facial hair noted to his chin and his nails were still long and dirty.		work without this education being completed and competencies completed on basic adls. This education and competencies will be offered upon hire, at least annually and as needed. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place: 1. The clinical management team will observe 5 resident's weekly x 3 months then 3 residents weekly x 3 months to ensure compliance. The DON/Designee will validate showers daily with supporting shower sheets ongoing. 2. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 02/01/2024. The Administrator at Life Care Center of the Willows is responsible in ensuring compliance in this Plan of Correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155158	A. BUILDING 00 B. WING	01/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LIFE CARE CENTER OF THE WILLOWS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The record for Resident C was reviewed on 12/28/23 at 2:37 p.m. Diagnoses included, but were not limited to, paranoid personality disorder, adult failure to thrive, and bipolar disorder. The Quarterly Minimum Data Set, dated 10/30/23, indicated the resident was moderately cognitively impaired for daily decision making. He had functional limitation in range of motion of both upper and lower extremities. He required assistance from staff for activities of daily living. A Care Plan, dated 2/1/19, indicated he had been known to refuse showers/bed baths, haircuts, and shaving at times. Interventions included, but were not limited to, offer bed baths and haircuts in his room and staff was to offer alternate staff members to give him bed baths, haircuts, and shaving. The Bathing task sheet for December 2023 indicated the resident refused a shower/bath on 12/4/23, received a sponge bath on 12/8/23, refused a shower/bath on 12/11/23, and received a sponge bath on 12/22/23 and 12/25/23. There was no documentation of alternate staff members offering bed baths upon refusals or documentation of shaving offered to the resident. During an interview on 1/2/23 at 3:45 p.m., the Assistant Director of Nursing indicated she was unable to find documentation of shaving and nail care offered to the resident. This citation relates to Complaint IN00424101. 3.1-38(a)(3)(D) 3.1-38(a)(3)(E) 3.1-38(b)(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155158	A. BUILDING 00 B. WING	01/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LIFE CARE CENTER OF THE WILLOWS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, record review, and interview, the facility failed to ensure residents received the necessary treatment and services related to the lack of a Physician's Order for a neck brace, the lack of monitoring and assessments of skin discolorations, and skin treatments not signed out as ordered for 1 of 2 residents reviewed for positioning and limited range of motion and 2 of 4 residents reviewed for non-pressure skin conditions. (Residents D, 36, and 19) Findings include: 1. On 12/27/23 at 10:23 a.m., Resident D was observed lying in bed watching television. The resident had a neck brace in place. She indicated sometimes the staff would help her put it on and take it off. She did not like to wear it when she was lying down. On 12/28/23 at 11:13 a.m., Resident D was observed sitting in the front lobby with other residents. The resident had a neck brace in place. Record review for Resident D was completed on 12/28/23 at 11:14 a.m. Diagnoses included, but were not limited to, vertebral fracture, anxiety, and	F 0684	F 684 Quality of Care What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice: 1. Resident 19, 36 had no negative outcomes. Res # 36 had bruises measured immediately and additional skin UDAS were completed as well. Res D no longer resides in facility and Res # non pressure area had improved. Res # 19 actually had an improvement in his wound. 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 on residents with neck braces ordered, and who has non pressure areas to assure being monitored per facility policy by wound nurses and to be completed by date of compliance. Any issues identified will be	02/01/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155158	A. BUILDING 00 B. WING	01/03/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155158	A. BUILDING 00 B. WING	01/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LIFE CARE CENTER OF THE WILLOWS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	were not limited to, heart failure, respiratory failure, anemia, and hypertension. The resident was admitted to the facility on 12/1/23. The Admission Minimum Data Set (MDS) assessment, dated 12/6/23, indicated the resident was cognitively intact. The resident required assistance with bathing. A Care Plan, dated 12/4/23 and revised 12/11/23, indicated the resident was on anticoagulant/antiplatelet therapy related to atrial fibrillation. An intervention included to observe and report adverse reactions of anticoagulant therapy that included bruising. An Admission Assessment, dated 12/1/23, indicated the resident had multiple bruising to the bilateral upper extremities and trunk. A Skin Assessment, dated 12/22/23, indicated the resident's skin was intact with no new findings. The record lacked any documentation the discolorations the resident had on admission were the same discolorations still observed. There was a lack of documentation the discolorations were being monitored. During an interview on 12/29/23 at 10:17 a.m., the ADON indicated she could not provide any documentation the discolorations on admission were the discolorations still being observed. They was no documentation to indicate the discolorations observed were assessed and being monitored. 3. Resident 19 was observed on 12/27/23 at 2:52 p.m. and was noted to have his left lower leg wrapped with kerlix and an ace bandage.		Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 02/01/2024. The Administrator at Life Care Center of the Willows is responsible in ensuring compliance in this Plan of Correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155158	A. BUILDING 00 B. WING	01/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LIFE CARE CENTER OF THE WILLOWS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The record for Resident 19 was reviewed on 12/28/23 at 2:43 p.m. Diagnoses included, but were not limited to chronic respiratory failure, dementia, and heart failure. The Quarterly Minimum Data Set, dated 10/26/23, indicated the resident was moderately impaired for daily decision making. He used oxygen therapy and had no pressure ulcers. A Physician Order, dated 11/17/23, indicated to cleanse the left lateral leg with normal saline or Dakin's solution, pat dry, apply hydrofera blue, wrap with kerlix, cover with an Ace bandage, and apply tubigrips three times weekly and as needed for soilage or when dislodged. The December 2023 Treatment Administration Record (TAR) was not checked off as completed for the treatment to the left lateral leg on 12/1/23, 12/6/23, 12/8/23, 12/10/23, 12/13/23, and 12/27/23. During an interview on 12/29/23 at 1:52 p.m., the Infection Preventionist indicated she was unable to locate documentation of the treatment being completed on those days. 3.1-37(a)			
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155158	A. BUILDING 00 B. WING	01/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LIFE CARE CENTER OF THE WILLOWS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	§483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. Based on observation, record review, and interview, the facility failed to ensure a resident received the necessary treatment to prevent a decrease in range of motion related to a hand splint not in place as ordered for 1 of 1 residents reviewed for positioning and mobility. (Resident 1) Finding includes: On 12/27/23 at 11:02 a.m., and 12/28/23 at 11:04 a.m., Resident 1 was observed in bed. Her eyes were closed and her hands were under the covers. There was a hand splint on her night stand. On 12/28/23 at 1:01 p.m., the resident was observed in bed. There was no splint on her hand and a splint was observed on her night stand. The resident's record was reviewed on 12/28/23 at 2:55 p.m. Diagnoses included, but were not limited to, hemiplegia (one sided paralysis) and hemiparesis (one sided weakness) following a cerebral vascular event and vascular dementia. The Quarterly Minimum Data Set assessment, dated 11/21/23, indicated the resident had severe cognitive impairment, and was dependent on staff for bed mobility, transfers, toileting and eating.	F 0688	F 688 Increase/Prevent Decrease in ROM/Mobility What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice: 1. Res 1 had no negative outcomes and no longer resides in 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 or Mobility by date of compliance. Orders have been received for these devices to read as tolerated by resident. Any issues identified will be corrected by date of compliance. Care plans and Kardex have been updated to reflect current orders and appliances.	02/01/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155158	A. BUILDING 00 B. WING	01/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LIFE CARE CENTER OF THE WILLOWS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A Physician's Order, dated 8/25/22, indicated the resident was to wear a resting hand splint to her left hand at all times except for hygiene and skin checks. The current Hand Splint Care Plan indicated the resident required a resting hand splint to her left hand to prevent contracture. Interview with the Assistant Director of Nursing on 12/28/23 at 2:20 p.m., indicated she had been told last week the hand splint needed to be reordered. She was unsure if it had been ordered yet. 3.1-42(a)(2)		2. What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur: 1. Education has been provided by the SDC by date ofr compliance to licensed nursing, QMAS, and aides on assuring adaptive devices are in place as ordered and tolerated. Refusals must be reported to nurse and nurse must report to MD. No licensed nurses, Qmas, or aides will work past date of compliance without education completed. Education will be completed upon hire, at least annually, and as needed. 2. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place: 1. Nursing management will observe 3 residents weekly x 3 months then 2 residents weekly x 3 months to ensure compliance. Care plan, order and Kardex will also be validated. 2. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155158	A. BUILDING 00 B. WING	01/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LIFE CARE CENTER OF THE WILLOWS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			Compliance date: 02/01/2024. The Administrator at Life Care Center of the Willows is responsible in ensuring compliance in this Plan of Correction.	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview the facility failed to ensure safety measures were in place to prevent accidents related to seizure precautions not in use, fall precautions not implemented, and a post-op helmet not in use as ordered for 3 of 3 residents reviewed for accidents. (Residents G, F and E) Findings include: 1. On 12/27/23 at 9:26 a.m., Resident G was observed in her bed. She was moaning and complaining her stomach hurt. She was not wearing a post-op helmet. There were full length bed rails on her bed with no seizure pads in place and a mat on the floor. On 12/28/23 at 9:56 a.m. and 12:59 p.m., the resident was observed in bed, there were no seizure pads on the bed and the resident was not wearing a post-op helmet. A helmet was observed on a cabinet next to the bed. The resident's record was reviewed on 12/28/23 at	F 0689	F 689 Free of Accident Hazards/Supervision/Devices What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice: 1. Res G, F, and E had no negative outcomes. Res E has had helmet dcd r/t improvement, RES G often refuses and this is care planned and she had seizure pads added to bed. Res F had care plan reviewed and placed on 3 day bladder diary to determine actual pattern. 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. In house audit has been completed on residents with	02/01/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155158	A. BUILDING 00 B. WING	01/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LIFE CARE CENTER OF THE WILLOWS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	1:02 p.m. Diagnoses included, but were not limited to, metabolic encephalopathy, muscle weakness, unspecified convulsions and diabetes mellitus. The Significant Change Minimum Data Set assessment, dated 12/20/23, indicated the resident had significant cognitive impairment, and required extensive staff assistance for bed mobility, transfers and toileting. A Progress Note, dated 12/12/23, indicated the resident had fallen in her room. She was sent to the emergency room and diagnosed with subarachnoid hemorrhage (bleeding around the brain). She returned to the facility on 12/13/23. A Physician's Order, dated 12/14/23, indicated the resident was to wear a post-op helmet (protective helmet). The order did not specify when to wear. The December 2023 Treatment Administration Record (TAR) lacked documentation when the post-op helmet was put on, removed or refused. The current Seizure Care Plan, indicated the resident was at risk of injury related to seizures. Interventions included, but were not limited to, seizure pads on bed rails. During an interview on 12/28/23 at 1:58 p.m., LPN 1 indicated the resident was fitted for a helmet but was non-compliant with wearing it. The LPN also indicated there used to be seizure pads on the bedrails, but the bed had been swapped out on 12/23/23 when the resident went on hospice services. There had not been seizure pads on the bed since. During an interview on 12/28/23 at 2:20 p.m., the Assistant Director of Nursing indicated the		seizure dx or high fall risk to ensure interventions are on care plan and Kardex. Any issues identified will be corrected immediately. Nursing management will have this completed by date of compliance. What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur: 1. Education has been completed by the DON/Designee on the entire policy and protocol for fall management to the IDT team, and other staff. This education includes fall or incident will be reviewed in morning meeting, discussed, interventions assured put in place, on care plan and Kardex and team will go to room to validate as well as assuring all assessments and documentation is in place. No staff will work past date of compliance without this education being completed prior to date of compliance. This education will be offered upon hire, yearly, and as needed. If pattern determined with particular staff member progressive discipline will be completed. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place: 1. DON/Designee will review every event upon occurrence to ensure assessments completed per	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155158	A. BUILDING 00 B. WING	01/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LIFE CARE CENTER OF THE WILLOWS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	resident should have the helmet in her room but only had to wear it when up. She would add the order to the TAR. Seizure pads had been ordered for overnight delivery and the bed rails were being changed back to quarter rails. If seizure pads were not available, pillows or bedding could be used by nursing staff. 2. On 12/27/23 at 2:00 p.m., Resident F was observed in her room near her bathroom door. She was ambulating by herself, her pants and brief were around her ankles, and when she reached the bathroom door she began to urinate. Staff was notified and came to assist her. On 12/28/23 at 11:06 a.m., 1/2/24 at 8:50 a.m. and 1/3/23 at 8:15 a.m., the resident was observed in bed with eyes closed, quarter rails x 2 in the up position. There was no body pillow in the bed. The resident's record was reviewed on 12/28/23 at 11:08 a.m. Diagnoses included, but were not limited to, spinal stenosis, traumatic subdural hemorrhage, atrial fibrillation and a history of falls. The Quarterly Minimum Data Set assessment, dated 10/20/23, indicated the resident had severe cognitive impairment and required partial to moderate staff assistance for toileting and transfers. A Progress Note, dated 10/14/23, indicated the resident was found on her back at the foot of her bed and screaming of pain to her back. She was sent to the hospital and returned with a large abrasion to her back. A Progress Note, dated 10/31/23, indicated the resident was found sitting on her buttocks on the bathroom floor.		policy, md and family notification per policy, interventions put in place immediately, care plan and Kardex updated and 72 hour follow up charting is completed ongoing. 2. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 02/01/2024. The Administrator at Life Care Center of the Willows is responsible in ensuring compliance in this Plan of Correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155158	A. BUILDING 00 B. WING	01/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LIFE CARE CENTER OF THE WILLOWS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

A Progress Note, dated 11/15/23, indicated the resident was observed lying on floor near foot of bed and bleeding was noted around her head. Resident was sent to the hospital and returned with a laceration to her head and a staple to lower head.

A Progress Note, dated 12/31/23 at 12:16 p.m., indicated the resident was found on the floor at the foot of her bed. She had a laceration above her right eye and was sent to the hospital for evaluation.

The current Toileting Care Plan indicated the resident was to be toileted every 2 hours to have decreased incidents of falls related to self transfer to the bathroom.

The Tasks documentation indicated the resident was toileted on 12/31/23 at 6:13 a.m., 6 hours prior to the fall on 12/31, and at 10:28 a.m. on 12/27/23, 3.5 hours prior to the observation on 12/27. The Tasks lacked documentation the resident was toileted every 2 hours.

The current Fall Care Plan, indicated PT (physical therapy) was to evaluate the resident to determine safety of adding a body pillow to prevent recurrent falls.

Interview with PTA 1, on 1/2/24 at 3:20 p.m., indicated there had been no referral made to PT for a body pillow evaluation, that was normally a nursing intervention.

Interview with the Executive Director (ED), on 1/3/24 at 11:00 a.m., indicated she was aware the resident had frequent falls and they occurred when she was attempting to transfer herself to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155158	A. BUILDING 00 B. WING	01/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LIFE CARE CENTER OF THE WILLOWS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	bathroom, so she had been placed on a toileting schedule. When asked if the staff was monitored for compliance with the toileting schedule, there was no information provided. 3. Resident E was observed on 12/28/23 at 9:44 a.m., sitting in a Broda chair with non-slid socks on watching television in his room, with no helmet noted. On 12/29/23 at 10:39 a.m., Resident E was observed sitting in a Broda chair with non-skid socks on watching television in his room, with no helmet noted. The record for Resident E was reviewed on 12/28/23 at 11:06 a.m. Diagnoses included, but were not limited to, intracranial injury, dementia, and Alzheimer's disease. The Quarterly Minimum Data Set (MDS) assessment, dated 10/2/23, indicated the resident was severely cognitively impaired for daily decision making. A Physician Order, dated 9/9/22, indicated the resident required a post-operative protection helmet. A Care Plan, revised on 12/1/23, indicated the resident required a post-operative protection helmet related to a history of traumatic brain injury with a craniotomy procedure. The resident was to wear the post-operative protection helmet when up out of bed as tolerated. A Care Plan, revised on 11/22/22, indicated the resident had falls due to poor balance and unsteady gait. The resident was to wear a helmet per the Physician Orders.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155158	A. BUILDING 00 B. WING	01/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LIFE CARE CENTER OF THE WILLOWS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an interview on 12/29/23 at 10:21 a.m., the Assistant Director of Nursing indicated the resident was supposed to have his helmet on at all times when he was out of bed, however he sometimes would remove the helmet on his own. This citation relates to Complaint IN00424101. 3.1-45(a)(2)			
F 0692 SS=D Bldg. 00	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; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on observation, record review, and interview, the facility failed to ensure residents' hydration and nutritional needs were met related to providing fluids to a dependent resident and weights being monitored for a resident with weight loss for 2 of 6 residents reviewed for	F 0692	F692 Nutrition/Hydration Status Maintenance What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:	02/01/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155158	A. BUILDING 00 B. WING	01/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LIFE CARE CENTER OF THE WILLOWS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	hydration and nutrition. (Residents G and 37) Findings 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 again on 12/28/23 at 9:56 a.m., and 12:59 p.m., and 1/2/24 at 8:15 a.m. in bed with no beverage in the room. On 12/29/23 at 9:32 a.m., staff 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 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 a beverage on the overbed 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 Broda chair in the dining room. There was no beverage on the table. At 1:13 p.m., the resident was still in the dining room, she had a lunch in front of her and was feeding herself, there was no beverage present though. At 1:40 p.m., the lunch tray had been removed. There were 3 other residents seated at the table with a beverage, the resident did not have one. 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. The Significant Change Minimum Data Set		1. Res G and 37 had no negative outcomes Res G had fluids put within her reach immediately 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 the same deficient practice will be identified and what corrective action will be taken: 1. An in house audit has been completed on dependent residents to ensure fluids are within reach and care plan and Kardex state for staff to offer fluids when in room. This audit also includes any significant weight loss in the past 30 days to ensure on RAR, care plan and Kardex indicate interventions including weekly weights until deemed stable by RAR members by date of compliance. Any issues identified will be corrected immediately. What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur: 1. Education has been provided to licensed nurses, QMAS, aides on appropriate interventions r/t offering fluids to residents if dependent on staff by SDC and education has been provided to Dietary Manager, RAR members, and any staff involved with obtaining weights or being	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155158	A. BUILDING 00 B. WING	01/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LIFE CARE CENTER OF THE WILLOWS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	assessment, dated 12/20/23, indicated the resident had significant cognitive impairment, and required extensive staff assistance for bed mobility, transfers and toileting and supervision for eating. A Physician's Note, dated 12/18/23, indicated the resident was dehydrated. An order for intravenous (IV) fluid D5.45 normal saline be infused because the resident had not taken anything orally for 72 hours. A Physician's Note, dated 12/20/23, indicated the resident needed to be fed and was full assist, and the patient was dehydrated. A Progress Note, dated 12/18/23, indicated the IV was infusing at 60 milliliters/ hr x 2 liters. The record lacked documentation fluid intake or output was being monitored. There was no documentation or orders to increase fluids. During an interview on 1/2/24 at 10:57 a.m., the Assistant Director of Nursing (ADON) was made aware of the above observations and indicated residents who were dehydrated should have fluids pushed and labs monitored. She indicated the resident wasn't eating or drinking anything, so should probably be in the assisted dining room or one on one feeding assist.2. Record review for Resident 37 was completed on 12/28/23 at 2:26 p.m. Diagnoses included, but were not limited to, hypertension, end stage renal disease, and atrial fibrillation. The Quarterly Minimum Data Set (MDS) assessment, dated 10/11/23, indicated the resident was cognitively impaired. The resident required setup assistance for eating meals. His weight was 138 lbs (pounds), which indicated he had a		responsible for weights being obtained by the SDC and completed by date of compliance. No licensed nurses, QMAS, aides, Dietary manager or RAR committee members will work without this education being completed. This education will be offered upon hire, at least annually, and as needed. Licensed nursing will be responsible for assuring the aides obtain weights as per policy and they will turn into appropriate clinical manager. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place: 1. Nurse manager responsible for RAR will validate 10 weights weekly x 3 months then 5 weights weekly x 3 months for being obtained, accurate and documented appropriately ongoing. Compliance date: 02/01/2024. The Administrator at Life Care Center of the Willows is responsible in ensuring compliance in this Plan of Correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155158	A. BUILDING 00 B. WING	01/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LIFE CARE CENTER OF THE WILLOWS	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 APPROPRIATE 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 10/3/23. 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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155158	A. BUILDING 00 B. WING	01/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LIFE CARE CENTER OF THE WILLOWS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on record review and interview, the facility failed to ensure each resident's medication regimen was managed and monitored to promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being related to non-pharmacological interventions provided prior to administering pain medications and not following Pharmacy recommendations for 2 of 5 residents reviewed for unnecessary medications (Residents 4 and 48) and 1 of 1 residents reviewed for pain. (Resident 105) Findings include: 1. Resident 4's record was reviewed on 12/29/23 at 1:12 p.m. Diagnoses included, but were not limited to bipolar disorder, depression and polyneuropathy. The Quarterly Minimum Data Set assessment,	F 0757	F 757 Drug Regimen is Free from Unnecessary Drugs What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice: 1. Resident 4, 48 and 105 had no negative outcomes. 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 managers on past 30 day's pharmacy recommendations to ensure have been completed. Audit in house of resident's last 30 days of PRN pain medication usage as well and	02/01/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155158	A. BUILDING 00 B. WING	01/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LIFE CARE CENTER OF THE WILLOWS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	dated 10/24/23, indicated the resident had mild cognitive deficits and took opioid pain medications. The December 2023 Physician's Order Summary (POS) indicated the resident took acetaminophen, 650 milligrams (mg) every 8 hours as needed for mild pain. The resident also took hydrocodone/ acetaminophen (opioid pain medication) 5/325 mg every 12 hours as needed for severe pain. The POS indicated two non-pharmacological interventions should be attempted prior to giving any as needed pain medication and documented. The December 2023 Medication Administration Record (MAR) indicated acetaminophen had been used two times and hydrocodone/ acetaminophen had been used 27 times. The MAR lacked any documentation of non-pharmacological interventions attempted prior to the medications being administered. During an interview on 12/29/23 at 2:20 p.m., LPN 1 indicated two or three interventions should be attempted prior to giving as needed pain medication and they would usually try to redirect the resident. She indicated that was not documented anywhere. 2. On 12/27/23 at 9:26 a.m., Resident 105 was observed in her bed. She was moaning and complaining her stomach hurt. 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 and diabetes mellitus. The Significant Change Minimum Data Set		determining if non pharmalogical interventions had been implemented prior to prn pain medication being administered. Md and families will be notified of any issues. To be completed by date of compliance. 2. What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur: 1. Education will be completed to licensed nursing by the SDC on the policy and procedure for administering PRN pain medications to include offering and documenting 2 non med interventions prior to administering PRN pain medication. DON/Designee have been educated on the best practice and policy for completing pharmacy recommendations timely. No licensed nurse will work past date of compliance without this education being completed. This education will be completed upon hire, at least annually, and as needed. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place: 1. Nursing managers will review medication sheets daily Monday through Friday in clinical meeting to review for PRN pain meds and appropriate interventions	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155158	A. BUILDING 00 B. WING	01/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LIFE CARE CENTER OF THE WILLOWS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	assessment, dated 12/20/23, indicated the resident had significant cognitive impairment, and required extensive staff assistance for bed mobility, transfers and toileting. The December 2023 POS indicated the resident took hydrocodone/ acetaminophen 5/325 mg every 6 hours as needed for severe pain and morphine sulfate (an opioid pain medication) 10 mg/0.5 milliliters (ml) give 0.25 ml every two hours as needed for severe pain. The POS indicated two non-pharmacological interventions should be attempted prior to giving any as needed pain medication and documented. The December 2023 MAR indicated hydrocodone/acetaminophen was used 18 times and morphine sulfate was used 35 times. There was no documentation non-pharmacological interventions had been attempted prior to giving the as needed medications. During an interview on 12/29/23 at 2:20 p.m., LPN 1 indicated two or three interventions should be attempted prior to giving as needed pain medication and they would usually try to redirect the resident. She indicated that was not documented anywhere. 3. Resident 48's record was reviewed on 12/29/23 at 2:52 p.m. Diagnoses included, but were not limited to, high blood pressure, depression, dementia, and chronic atrial fibrillation. The Quarterly Minimum Data Set (MDS) assessment, dated 12/11/23, indicated the resident was cognitively impaired for daily decision making. A Physician's Order, dated 8/14/2023, indicated		attempted prior to administration. DON/Designee will remotely review Mars on weekends and holidays x 6 months. 2. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 02/01/2024. The Administrator at Life Care Center of the Willows is responsible in ensuring compliance in this Plan of Correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155158	A. BUILDING 00 B. WING	01/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LIFE CARE CENTER OF THE WILLOWS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the resident was to receive Benadryl Allergy Oral Tablet 50 milligrams (mg) by mouth once a day at bedtime for insomnia. The December 2023 Consultation Report from Pharmacy indicated the dose of Benadryl Allergy Oral Tablet 50 milligrams (mg) was recommended to be reduced to 25 mg at bedtime with the end goal of discontinuation. Nonpharmacological interventions should be implemented prior to and maintained throughout the treatment of insomnia. The recommendation was accepted by the doctor. There was no documentation that the order was changed. During an interview on 1/2/23 at 12:14 p.m., the Assistant Director of Nurse (ADON) indicated the family didn't want the medication to be discontinued and the order was not changed. 3.1-48(a)(6)			
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155158	A. BUILDING 00 B. WING	01/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LIFE CARE CENTER OF THE WILLOWS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on record review and interview, the facility failed to ensure a gradual dose reduction (GDR) was attempted for 1 of 5 residents reviewed for unnecessary medications. (Resident E) Finding includes: The record for Resident E was reviewed on	F 0758	F 758 Free from Unnecessary Psychotropic Meds/PRN Use What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice: 1. Res E had no negative outcomes. The Psy NP was	02/01/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155158	A. BUILDING 00 B. WING	01/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LIFE CARE CENTER OF THE WILLOWS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	12/28/23 at 11:06 a.m. Diagnoses included, but were not limited to, intracranial injury, dementia, and Alzheimer's disease. The Quarterly Minimum Data Set (MDS) assessment, dated 10/2/23, indicated the resident was severely cognitively impaired for daily decision making. He received an antidepressant and antipsychotic medication on a routine basis only. A Physician Order, dated 11/7/22, indicated seroquel (an antipsychotic medication) 25 milligram (mg), give 1.5 tablet by mouth in the morning and 2.5 tablets by mouth at bedtime. A Care Plan, dated 9/26/22, indicated the resident used a psychotropic medication related to behavior management and was at risk for side effects. Interventions included, but were not limited to, consult with pharmacy and the Physician to consider dosage reduction when clinically appropriate, at least quarterly. A Psychosocial Note, dated 4/4/2023 at 4:42 p.m., indicated a behavior meeting was held with the Social Service Director, Psychiatric Nurse Practitioner, MDS Coordinator, Infection Preventionist, and the Assistant Director of Nursing (ADON). The resident's behavior and medications were discussed. The recommendation from the pharmacy for a gradual dose reduction (GDR) of Seroquel 25 mg was reviewed and the GDR was denied at this time. The resident was stable on the Seroquel at the time. During an interview on 1/2/24 at 3:46 p.m., the ADON indicated there was no appropriate diagnosis for the Seroquel and there was no GDR attempted due to a previous request by the family.		notified to obtain a GDR and appropriate DX. 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 SSD on residents with psychotropic medications to note appropriate dx for medication and GDR timely and if refused appropriate documentation by MD on why not by date of compliance. What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur: 1. Education will be completed to the clinical management team and SSD on the regulation regarding psychotropic medications, dx to support and GDRS by pharmacy by date of compliance. SSD and the clinical team will not work past date of compliance without this education being completed. Clinical managers and SSD will receive this education upon hire, at least yearly and as needed. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place: 1. Monthly GDRS will be reviewed and ensure completion by the DON/Designee/SSD with each monthly pharmacy report ongoing. SSD will audit residents monthly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155158	A. BUILDING 00 B. WING	01/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LIFE CARE CENTER OF THE WILLOWS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3.1-48(b)(1) 3.1-48(b)(2)		on psychotropic medications to ensure appropriate use and dx in place as well as if GDRS timely and documentation in place ongoing. 2. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 02/01/2024. The Administrator at Life Care Center of the Willows is responsible in ensuring compliance in this Plan of Correction.	
F 0770 SS=D Bldg. 00	483.50(a)(1)(i) Laboratory Services §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. Based on record review and interview, the facility failed to ensure an ordered urine culture was obtained and sent to the laboratory timely for 1 of 5 residents reviewed for unnecessary medications(Resident E). Finding includes:	F 0770	F770 Laboratory Services What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice: 1. Resident E had U/a picked up the following day after being	02/01/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155158	A. BUILDING 00 B. WING	01/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LIFE CARE CENTER OF THE WILLOWS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The record for Resident E was reviewed on 12/28/23 at 11:06 a.m. Diagnoses included, but were not limited to, intracranial injury, dementia, and Alzheimer's disease. The Quarterly Minimum Data Set (MDS) assessment, dated 10/2/23, indicated the resident was severely cognitively impaired for daily decision making. A Physician's Order, dated 5/6/23, indicated to obtain a urinalysis, culture and sensitivity (UA C&S). A Nurses' Progress Note, dated 5/5/23 at 11:00 p.m., indicated the resident was noted to have dark brown tinged urine with a fever of 102 degrees Fahrenheit and noted congestion with 90% oxygen saturation on room air. New orders were received from the Physician for a chest x-ray, UA C&S, oxygen as needed, and Rocephin (an antibiotic) 1 gram intramuscularly injection for 7 days. A Nurses' Progress Note, dated 5/6/23 at 3:00 a.m., indicated the urine was obtained for the UA and placed in the fridge for pick up. The laboratory was notified and stated they would pick up the sample in the morning. A Nurses' Progress Note, dated 5/6/23 at 5:49 p.m., indicated the laboratory stated they would pick up the same the next day as they had no same day pick-up available. A Nurses' Progress Note, dated 5/7/23 at 5:17 p.m., indicated the lab stated they had no pick up person on that day.		recollected. 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 on residents by nursing management with labs ordered past 30 days to ensure compliance. Any issues identified will be corrected, md and family notified and facility protocol to be followed. What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur: 1. Education to licensed nurses will be completed in r/t labs not being drawn as ordered or specimens not picked up by lab timely, to include MD and family notification, any new orders will be conveyed, and lab notified. Ed will contact lab and have discussion on meeting needs of facility timely and if not able to do this facility will look for another vendor for this need. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place: 1. IP will validate specimens related to possible infections have been picked up by lab timely ongoing. Nursing managers will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155158	A. BUILDING 00 B. WING	01/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LIFE CARE CENTER OF THE WILLOWS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A Nurses' Progress Note, dated 5/8/23 at 4:20 p.m., indicated the laboratory did not pick up the urine sample. The Physician was notified and new orders were given to obtain another UA that evening to be picked up by the laboratory in the morning. A Nurses' Progress Note, dated 5/9/23 at 7:22 a.m., indicated the UA was collected and picked up by the laboratory with pending results. During an interview on 1/3/24 at 11:12 a.m., the Assistant Director of Nursing indicated the UA C&S should have been sent to the lab more timely. 3.1-49(a)		audit 3 charts weekly x 6 months on residents with lab orders for that week to ensure compliance. 2. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 02/01/2024. The Administrator at Life Care Center of the Willows is responsible in ensuring compliance in this Plan of Correction.	
F 0881 SS=D Bldg. 00	483.80(a)(3) Antibiotic Stewardship Program §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. Based on record review and interview, the facility failed to promote antibiotic stewardship by ensuring the appropriate use of antibiotic therapy to reduce antibiotic resistance related to a physician prescribing antibiotics for a urinary tract infection without a urinalysis and culture completed for 1 of 5 residents reviewed for unnecessary medications. (Resident E).	F 0881	F 881 Antibiotic Stewardship Program What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice: 1. Resident E had no negative outcome from alleged deficient practice.	02/01/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155158	A. BUILDING 00 B. WING	01/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LIFE CARE CENTER OF THE WILLOWS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Finding includes: The record for Resident E was reviewed on 12/28/23 at 11:06 a.m. Diagnoses included, but were not limited to, intracranial injury, dementia, and Alzheimer's disease. The Quarterly Minimum Data Set (MDS) assessment, dated 10/2/23, indicated the resident was severely cognitively impaired for daily decision making. A Physician's Order, dated 5/6/23, indicated to obtain a urinalysis, culture and sensitivity (UA C&S). A Physician's Order, dated 5/6/23, indicated ceftriaxone sodium injection solution reconstituted (Rocephin) 1 gram, inject intramuscularly one time a day. A Nurses' Progress Note, dated 5/5/23 at 11:00 p.m., indicated the resident was noted to have dark brown tinged urine with a fever of 102 degrees Fahrenheit and noted congestion with 90% oxygen saturation on room air. New orders were received from the Physician for a chest x-ray, UA C&S, oxygen as needed, and Rocephin (an antibiotic) 1 gram intramuscularly injection for 7 days. A Nurses' Progress Note, dated 5/6/23 at 3:00 a.m., indicated the urine was obtained for the UA and placed in the fridge for pick up. The laboratory was notified and stated they would pick up the sample in the morning. A Nurses' Progress Note, dated 5/6/23 at 5:49 p.m., indicated the laboratory stated they would pick up the same the next day as they had no same day		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 will be completed by the IP going back 30 days for residents on antibiotic to ensure Antibiotic Stewardship Program is being followed appropriately. Any issues identified will be discussed with the MD. What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur: 1. Education will be provided to the prescribing MDS on the policy and procedure for the Antibiotic Stewardship Program by the IP and ED by date of compliance. Clear expectations will be discussed to ensure compliance. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place: 1. The IP/DON will review all antibiotic orders ongoing to assure protocol being followed per Antibiotic Stewardship Program/CDC recommendations. Any concerns noted will be discussed with prescribing MD by the IP to resolve concern. 2. The results of these reviews will be discussed at the monthly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155158	A. BUILDING 00 B. WING	01/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LIFE CARE CENTER OF THE WILLOWS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	pick-up available. A Nurses' Progress Note, dated 5/7/23 at 5:17 p.m., indicated the lab stated they had no pick up person on that day. A Nurses' Progress Note, dated 5/8/23 at 4:20 p.m., indicated the laboratory did not pick up the urine sample. The Physician was notified and new orders were given to obtain another UA that evening to be picked up by the laboratory in the morning. A Nurses' Progress Note, dated 5/9/23 at 7:22 a.m., indicated the UA was collected and picked up by the laboratory with pending results. During an interview on 1/3/24 at 11:12 a.m., the Assistant Director of Nursing indicated the UA C&S should have been sent to the lab more timely and the antibiotic therapy should not have been started until the UA C&S results were reviewed.		facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 02/01/2024. The Administrator at Life Care Center of the Willows is responsible in ensuring compliance in this Plan of Correction.	
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure the residents' environment was in good repair related to marred walls, a cracked toilet base, marred doors, chipped paint, dirty floors, and missing pieces of baseboard for 2 of 2 units. (East and West) Findings include: During the Environmental tour with the Director of Maintenance and the Director of Housekeeping	F 0921	Plan of Correction F921 1. What corrective action(s) will be accomplished for F921 to have been found deficient? The rooms listed are being corrected as follows: Room 4: New bathroom floor and toilet scheduled to be installed and completed On Jan. 24. Room 7: Marred walls were	02/01/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155158	A. BUILDING 00 B. WING	01/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LIFE CARE CENTER OF THE WILLOWS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	on 1/3/24 at 1:38 p.m., the following was observed: 1. East Unit: In Room 36, the floors were dirty, the walls were marred and paint was chipped on the side of bed 2. There were missing pieces of the baseboard next to the restroom. One resident resided in the room. 2. West Unit: a. In Room 4, the base of the toilet was cracked. Two residents resided in the room. b. In Room 7, the walls were marred, and paint was chipped. The baseboard in the restroom was marred. Two residents resided in the room. Interview with the Director of Maintenance on 1/3/24 at 1:40 p.m., indicated the areas were in need of repair. 3.1-19(f)		patched and painted. Baseboard in bathroom was reattached. Room 36: Walls to be patched and painted by 1-26. Baseboard already replaced. 2. How will you identify F921 having the potential to be affected by the same deficient practice and what corrective action will be taken? The inspection will note any deficiencies and promptly correct them. 3. What measures will be put into place or what systemic changes will you make to ensure that the deficiency does not recur? The inspection schedule will be revised to ensure that the deficiency does not recur. 4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, 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 Director to be reviewed at safety committee and QA for a period of 6 months to ensure 100% compliance. 5. A Plan of Correction completion date has been provided. Compliance date: 02/01/2024. The Administrator at	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155158	A. BUILDING 00 B. WING	01/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LIFE CARE CENTER OF THE WILLOWS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			Life Care Center of the Willows is responsible in ensuring compliance in this Plan of Correction.	