| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 155535 | A. BUILDING 00<br>B. WING | 02/18/2025 |

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| WILLOW CROSSING HEALTH & REHABILITATION CENTER | 3550 CENTRAL AVE<br>COLUMBUS, IN 47203 |

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| F 0000<br><br>Bldg. 00 | This visit was for a Recertification and State Licensure Survey and Investigation of Complaints IN00452652 an IN00453337.<br><br>Complaint IN00452652 - No deficiencies related to the allegations are cited.<br><br>Complaint IN00453337 - No deficiencies related to the allegations are cited.<br><br>Survey dates: February 12, 13, 14, 17, and 18, 2025<br><br>Facility number: 000572<br>Provider number: 155535<br>AIM number: 100267710<br><br>Census Bed Type:<br>SNF/NF: 97<br>Total: 97<br><br>Census Payor Type:<br>Medicare: 12<br>Medicaid: 81<br>Other: 4<br>Total: 97<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed on February 26, 2025. | F 0000 | Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under and state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey. Due to the low scope and severity of the survey finding, please find the sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance. Should additional information be necessary to confirm said compliance, feel free to contact me. | |
| F 0684<br>SS=D<br>Bldg. 00 | 483.25<br>Quality of Care<br><br>Based on record review and interview, the facility failed to follow physician's orders related to medication hold parameters for 2 of 22 residents | F 0684 | F684 The facility will follow physician's orders related to hold parameters for blood pressures. | 03/06/2025 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Alisha Miller | HFA | 03/06/2025 |

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| | reviewed for Quality of Care. (Residents 71 and 5)<br><br>Findings include:<br><br>1. The clinical record for Resident 71 was reviewed on 02/17/25 at 9:00 A.M. A Quarterly Minimum Data Set (MDS) assessment, dated 11/13/24, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, schizoaffective disorder, heart failure, hypertension, diabetes, and depression.<br><br>The current open-ended physician's order, with a start date of 09/03/24, indicated the resident was to receive Lisinopril (a blood pressure medication) 10 milligrams (mg), twice a day. The staff were to hold the medication when the systolic blood pressure (SBP) was less than 130 or the heart rate was less than 60.<br><br>The January and February 2025 Electronic Medication Administration Record (EMAR) indicated the resident had received the medication when the blood pressure was less than 130 or the heart rate was less than 60 on the following dates and times:<br><br>- On 01/01/25 in the evening, when the resident's blood pressure was 122/67,<br>- On 01/04/25 in the evening, when the resident's blood pressure was 110/71,<br>- On 01/06/25 in the morning, when the resident's blood pressure was 121/70,<br>- On 01/08/25 in the evening, when the resident's blood pressure was 120/73,<br>- On 01/09/25 in the morning, when the resident's blood pressure was 109/81,<br>- On 01/10/25 in the morning, when the resident's blood pressure was 118/67,<br>- On 01/19/25 in the evening, when the resident's | | 1. Resident 71 and 5's physician orders were reviewed for residents receiving blood pressure medications to ensure parameters were established and being followed.<br>2. All residents have the potential to be affected. A complete audit was conducted to ensure parameters orders were being followed. No further concerns were noted. See below for corrective measures.<br>3. The Physician Orders policy was reviewed with no changes made. (See attachment A) The staff was inserviced on the above procedure.<br>4. The DON or his designee will review the medication administration records daily to ensure parameters are being followed for blood pressure medications per physician orders. The DON or his designee will utilize the monitoring tool daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment B) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly if warranted. **If compliance is not obtained or maintained, the staff member will be re-educated one on one** | |

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| | blood pressure was 101/69,<br>- On 01/22/25 in the morning when the resident's blood pressure was 118/76,<br>- On 01/23/25 in the evening when the resident's blood pressure was 124/71,<br>- On 01/24/25 in the morning when the resident's blood pressure was 120/76,<br>- On 01/26/25 in the evening when the resident's blood pressure was 94/72,<br>- On 01/27/25 in the morning when the resident's blood pressure was 108/69, and in the evening when the blood pressure was 113/65,<br>- On 02/01/25 in the evening when the resident's blood pressure was 127/71,<br>- On 02/02/25 in the morning when the resident's blood pressure was 122/67, and in the evening when the blood pressure was 126/65,<br>- On 02/03/25 in the morning when the resident's blood pressure was 126/68,<br>- On 02/05/25 in the evening when the resident's blood pressure was 122/67,<br>- On 02/06/25 in the evening when the resident's blood pressure was 122/75,<br>- On 02/07/25 in the morning when the resident's blood pressure was 128/74,<br>- On 02/08/25 in the evening when the resident's blood pressure was 126/76,<br>- On 02/09/25 in the evening when the resident's blood pressure was 124/73,<br>- On 02/11/25 in the evening when the resident's blood pressure was 126/71,<br>- On 02/12/25 in the evening when the resident's blood pressure was 126/77,<br>- On 02/13/25 in the evening when the resident's blood pressure was 124/76,<br>- On 02/14/25 in the evening when the resident's blood pressure was 123/78,<br>- On 02/15/25 in the evening when the resident's blood pressure was 127/63, and<br>- On 02/17/25 in the morning when the resident's | | **regarding the medication administration policy and procedure and the importance of following the parameters set by the physician. Additional monitoring will occur if compliance not met by having the DON or his designee be present for all medication administration times that have blood pressure parameters to ensure blood pressures are obtained when ordered.**<br>5. The above corrective measures will be completed on or before March 6, 2025. | |

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| | blood pressure was 90/86, and in the evening when the blood pressure was 112/67.<br><br>The "HEART DISEASE" Care Plan included, but was not limited to, an intervention to monitor the resident's vital signs as ordered and as needed, and administer medications as ordered.<br>2. The clinical record for Resident 5 was reviewed on 02/14/25 at 2:00 P.M. A Quarterly MDS assessment, dated 11/22/24 indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, stroke, coronary artery disease, hypertension, and dementia.<br><br>The resident's current MD orders included, but were not limited to the following:<br><br>An open-ended order, with a start date of 11/07/24, to administer amlodipine (a cardiac medication) 5 mg, twice a day. The medication was to be held if the resident's SBP was less than 120.<br><br>The January and February 2025 EMARs were reviewed and indicated the medication was administered when the resident's SBP was less than 120 on the following dates and times:<br><br>- On 01/01/25 the morning the resident's blood pressure was 118/77,<br>- On 01/02/25 the morning the resident's blood pressure was 115/75,<br>- On 01/06/25 the morning the resident's blood pressure was 101/64,<br>- On 01/07/25 the morning the resident's blood pressure was 93/66,<br>- On 01/08/25 the morning the resident's blood pressure was 105/60 and the evening blood pressure was 107/66,<br>- On 01/09/25 the evening the resident's blood pressure was 111/69, | | | |

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| | - On 01/11/25 the morning the resident's blood pressure was 110/60,<br>- On 01/12/25 the morning the resident's blood pressure was 104/73 and the evening blood pressure was 111/71,<br>- On 01/22/25 the morning the resident's blood pressure was 109/77,<br>- On 01/26/25 the morning the resident's blood pressure was 112/67,<br>- On 02/04/25 the morning the resident's blood pressure was 98/64 and the evening blood pressure was 112/76,<br>- On 02/05/25 the morning the resident's blood pressure was 94/60,<br>- On 02/06/25 the morning the resident's blood pressure was 105/70,<br>- On 02/08/25 the morning the resident's blood pressure was 104/80, and<br>- On 02/11/25 the morning the resident's blood pressure was 102/60 and the evening blood pressure was 110/78.<br><br>During an interview on 02/18/25 at 10:17 A.M., RN 3 indicated if a resident had a cardiac medication withhold parameters, she would check the resident's blood pressure and heart rate before administering the medication. If the resident's blood pressure or heart rate was out of range, she would hold the medication. She would document in the EMAR that the medication was held.<br><br>The current facility policy titled "PHYSICIAN ORDERS", dated 10/2014, was provided by the Assistant Director of Nursing (ADON) on 02/18/25 at 1:15 P.M. The policy indicated, "...Physician's orders are administered...Ensure any follow through is completed..."<br><br>The current facility policy titled "MEDICATION ADMINISTRATION", dated 04/2017, was | | | |

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| | provided by the ADON on 02/18/25 at 1:15 P.M. The policy indicated, "...Always take pulse and B/P as indicated in ordered prior to giving certain cardiac or antihypertensive drugs...Notify the physician if the vital signs are not within the acceptable range..."<br><br>3.1-37(a) | | | |
| F 0686 SS=D Bldg. 00 | 483.25(b)(1)(i)(ii)<br>Treatment/Svcs to Prevent/Heal Pressure Ulcer<br>Based on observation, interview, and record review, the facility failed to prevent and ensure a resident's wound was identified prior to the resident developing a Stage III pressure ulcer for 1 of 3 residents reviewed for pressure ulcers. (Resident 64)<br><br>Findings include:<br><br>The resident's clinical record was reviewed on 02/18/25 at 1:29 P.M.<br><br>A Quarterly Minimum Data Set assessment, dated 07/16/24, indicated the resident was moderately cognitively impaired. The resident's diagnoses included, but were not limited to, stroke, hemiplegia affecting the right dominate side, malnutrition, dementia, peripheral vascular disease, and neuromuscular dysfunction of the bladder. The resident was always incontinent of bowel and had an indwelling urinary catheter. The resident was dependent on staff for toileting, hygiene, and mobility, including rolling left to right. The resident was at risk for pressure ulcers but had no pressures at the time of the assessment. The resident utilized pressure reducing devices for the bed and chair. | F 0686 | F686 The facility will prevent and ensure aresident's wound was identified prior to the resident developing a Stage III pressure ulcer.<br>1. Resident #64 pressure ulcer is healing.<br>2. All residents have the potential to be affected. Head to toe assessments were conducted immediately to ensure all residents were free of any new pressure ulcers. No further concerns were noted. See below for corrective measures.<br>3. The Skin Management Program policy was reviewed with no changes made. (See attachment C) The staff was inserviced on the above procedure.<br>4. The DON or his designee will complete head to toe skin assessments on five residents daily to ensure pressure ulcer prevention is occurring and any skin issues are identified immediately with a treatment added timely. The DON or his | 03/06/2025 |

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| | The clinical record lacked documentation the resident had been absent from the facility for any services for an extended period of time during the month of August.<br><br>A shower sheet, dated 08/24/24, indicated the resident had a red open area above her buttocks.<br><br>During an interview on 02/18/25 at 10:30 A.M., the Director of Nursing (DON) indicated when the resident's wound was identified on 08/24/24 he would have assessed it and obtained a physician's order for treatment. He didn't document an assessment of the wound. If he documented a wound's severity or wound stage in the computer, and then the wound specialist came in and staged the wound as less severe, they wouldn't be able to change the wound staging. The wound specialist that came into the facility documented the initial wound assessment on 08/29/24.<br><br>The resident's physician orders included an order, with a start date of 08/25/24, for a daily treatment to the sacral (base of the spine) wound. The wound was to be cleansed with normal saline. A skin protectant was to be applied to the skin around the wound. An antimicrobial wound gel and calcium alginate was to be applied to the wound bed. The wound was to be covered with a gauze dressing.<br><br>The Wound Specialist documentation, dated 08/29/24, indicated the wound was a Stage III (full thickness skin loss that may extend into the subcutaneous tissue) pressure ulcer that measured 1.2 centimeters (cm) x (by) 1 cm, with a depth of 0.1 cm. There was a moderate amount of serous (watery, clear, or slightly yellow/tan/pink fluid) exudate. The wound was 70% granulation | | designee will utilize the monitoring tool daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment B) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly if warranted. **If compliance is not obtained or maintained, the DON will be re-educated one on one on the importance of identifying skin issues timely and receiving a treatment. Additional monitoring will occur if compliance not met by having the nurse consultant conduct head to toe skin assessments on five residents daily to ensure pressure ulcer prevention is occurring and any skin issues are identified immediately and treatment added timely.**<br>5 . The above corrective measures will be completed on or before March 6, 2025. | |

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(new, pink/red moist) tissue and 30% slough (non-viable, dead) tissue.

During an observation, on 02/17/25 at 10:09 A.M., Resident 64's sacral wound was observed with RN 3 and the Director of Nursing (DON). The wound was about 3 cm in diameter, with a depth of 1 cm. There was an area of undermining (a separation of the wound edge from the surrounding healthy tissue) along one side of the wound approximately 2 cm long. The wound bed was reddish/pink. There was no drainage or sign of infection.

During an interview, on 02/18/25 at 1:45 P.M., Qualified Medication Aide (QMA) 4 indicated the resident required extensive assistance from two staff members for care. Staff would provide catheter care and incontinence care multiple times each day.

The current facility policy, titled "SKIN MANAGEMENT PROGRAM", dated 10/2013, was provided by the DON on 02/18/24 at 2:40 P.M. The policy indicated, "...Residents who receive assistance with bathing and/or pericare will be observed daily by nursing staff and any observance of red areas, open areas...will be reported to the licensed nurse for further assessment..."

The current facility policy, titled "PRESSURE ULCERS", dated 10/2014, was provided by the DON on 02/18/24 at 2:45 P.M. The policy indicated, "...assure that residents with pressure ulcers will receive necessary care and treatment to promote healing, prevent new ulcers from developing and prevent infection..."

3.1-49(a)(2)

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| F 0692 SS=D Bldg. 00 | 483.25(g)(1)-(3)<br>Nutrition/Hydration Status Maintenance<br><br>Based on record review and interview, the facility failed to document meal consumption values for 2 of 4 residents reviewed for nutrition. (Residents 55 and 62)<br><br>Findings include:<br><br>1. A Quarterly Minimum Data Set (MDS) assessment, dated 01/29/25, indicated Resident 55 was cognitively intact. The resident's diagnoses included, but were not limited to, hypertension, urinary tract infection, seizure disorder, anxiety, depression, and bipolar. The resident had experienced weight loss.<br><br>A Weight Loss Care Plan, with a start date of 01/18/25, included, but was not limited to, the following intervention: Monitor meal consumption and encourage resident to consume 100% (percent) of meals.<br><br>The January and February 2025 Meal Consumption Record for the resident lacked documented meal intake values for the following dates:<br><br>- 01/18/25 at dinner,<br>- 01/26/25 at lunch,<br>- 02/03/25 at breakfast,<br>- 02/10/25 at dinner, and<br>- 02/17/25 at breakfast.<br><br>2. A Quarterly MDS assessment, dated 11/27/24, indicated Resident 62 was severely cognitively impaired. The resident's diagnoses included, but were not limited to, dementia, hypertension, Alzheimer's disease, seizure disorder, malnutrition, | F 0692 | =”” spanthe=”” facility=”” will=”” ensure=”” to=”” document=”” meal=”” consumption=”” values.<=”” p=””><br>=”” p=””><br>!--[endif]-- resident=”” 55=”” and=”” 62=”” food=”” consumption=”” records=”” were=”” reviewed=”” to=”” ensure=”” residents=”” receiving=”” proper=”” nutrition.=”” <=”” p=””><br>=”” p=””><br>=”” p=””><br>F692 The facility will ensure to document meal consumption records.<br>1. Resident 55 and 62's food consumption records were reviewed to ensure residents were receiving proper nutrition.<br>2. All residents have the potential to be affected. All food consumption records were reviewed for the last 30 days ensuring they were receiving proper nutrition. No further concerns noted. See below for corrective measures.<br>3. The Meal Consumption Record policy and procedure was reviewed with no changes made. (See attachment D) The staff was inserviced on the above procedure.<br>4. The DON or his designee will monitor all meal consumption records daily ensuring | 03/06/2025 |

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| | anxiety, and depression.<br><br>A Potential for Weight Loss Care Plan, with a start date of 10/01/24, included, but was not limited to, the following intervention: Monitor intake of each meal.<br><br>The December 2024, January and February 2025 Meal Consumption Record for the resident lacked documented meal intake values for the following dates:<br><br>- 12/01/24 at lunch,<br>- 12/07/24 at breakfast, lunch, and dinner,<br>- 12/11/24 at lunch,<br>- 12/12/24 at breakfast and lunch,<br>- 12/13/24 at breakfast,<br>- 12/14/24 at dinner,<br>- 12/22/24 at breakfast and lunch,<br>- 12/28/24 at breakfast and lunch,<br>- 01/18/25 at lunch,<br>- 01/19/25 at lunch,<br>- 01/25/25 at lunch,<br>- 02/01/25 at lunch,<br>- 02/05/25 at lunch, and<br>- 02/12/25 at breakfast and lunch.<br><br>During an interview, on 02/18/25 at 1:07 P.M., Qualified Medication Aide (QMA) 6 indicated residents' meal consumption values should be documented in the computer system after every meal.<br><br>The current facility policy titled, "Meal Consumption Record", dated 10/2014, was provided by the Assistant Director of Nursing (ADON) on 02/18/25 at 1:55 P.M. The policy indicated, "...To provide a means to monitor the resident's daily intake...At the end of each meal, resident trays should be observed and percentage | | consumption is documented for each meal per each resident. The DON or his designee will utilize the nursing monitoring tool daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment B)<br>The audits will be reviewed during the facility's quarterly quality assurance meeting and the plan of correction will be adjusted accordingly if warranted. If compliance is not obtained or maintained, the DON will be re-educated one on one. Further monitoring would also occur by having the administrator review all food consumption records daily ensuring meal consumption is documented for each meal per each resident.<br>5. The above corrective measures will be completed on or before March 6, 2025.<br><br>!--[endif]--=""> | |

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|---|---|---|---|
| | 155535 | A. BUILDING 00<br>B. WING | 02/18/2025 |

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| WILLOW CROSSING HEALTH & REHABILITATION CENTER | 3550 CENTRAL AVE<br>COLUMBUS, IN 47203 |

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| | of food consumed recorded on Meal Consumption Record..."<br><br>3.1-46(a)(1) | | | |
| F 0761 SS=D Bldg. 00 | 483.45(g)(h)(1)(2)<br>Label/Store Drugs and Biologicals<br><br>Based on observation and interview, the facility failed to store medications appropriately for 2 of 3 medication carts reviewed. (Back 200 Medication Cart and Front 100 Medication Cart)<br><br>Findings include:<br><br>1. The Back 200 Medication Cart was observed, on 02/18/25 at 2:33 P.M, with Qualified Medication Aide (QMA) 9. The medication cart contained the following loose pills laying loose in the bottom of the drawers:<br><br>- two small round white tablets,<br>- one small oval white tablet, and<br>- one small oval blue tablet.<br><br>The medication cart had several bits of debris/paper that were scattered heavily throughout the cart.<br><br>During an , on 02/18/25 at 2:35 P.M., QMA 9 indicated she didn't clean the medication cart; she just passed the medications.<br><br>2. The Front 100 Medication Cart was observed, on 02/18/25 at 2:39 P.M., with QMA 8. The medication cart contained the following loose pills laying loose in the bottom of the drawers.<br><br>- one small round white tablet,<br>- one medium round white tablet, and | F 0761 | =”” spanthe=”” facility=”” will=”” ensure=”” to=”” document=”” meal=”” consumption=”” values.<=”” p=””><br>=”” p=””><br>F761 The facility will store medications properly.<br>1. All medications carts were cleaned and loose pills destroyed per policy.<br>2. All residents have the potential to be affected. All medication carts were cleaned of debris and loose pills. No further concerns were noted. See below for corrective measures.<br>3. The Storing Drug policy and procedures were reviewed with no changes made. (See attachment D) The staff was inserviced on the above procedure.<br>4. The DON or designee will observe medication carts daily ensuring all medications are stored per policy. The DON or his designee will utilize the nursing monitoring tool daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See | 03/06/2025 |

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| | - one large round white tablet.<br><br>The medication cart had several bits of debris/paper that were scattered throughout the cart.<br><br>During an interview, on 02/18/25 at 2:42 P.M., the Assistant Director of Nursing (ADON) indicated there should not be any loose pills in the medication carts.<br><br>The current "Storing Drugs" policy, dated 4/2021, was provided by the ADON on 02/18/25 at 3:06 P.M. The policy indicated "...Drugs and biologicals will be stored in a safe, secure, and orderly manner..."<br><br>3.1-25(j) | | attachment B) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly if warranted. **If compliance is not obtained or maintained, the nurse or QMA will be re-educated one on one to ensure they are knowledgeable about how to properly store medications per policy. Additional monitoring will occur if compliance not met by having the nurse consultant observe medication carts daily assuring medications is stored per policy.**<br>5. The above corrective measures will be completed on or before March 6, 2025. | |
| F 0770 SS=D Bldg. 00 | 483.50(a)(1)(i)<br>Laboratory Services<br><br>Based on record review and interview, the facility failed to obtain a urinalysis in a timely manner for 1 of 4 residents reviewed for laboratory services. (Resident 36)<br><br>Findings include:<br><br>A Quarterly Minimum Data Set assessment, dated 11/06/24, indicated Resident 36 was moderately cognitively impaired. The resident's diagnoses included, but were not limited to, vascular | F 0770 | =" " span=" " obtain=" " a=" " urinalysis=" " in=" " timely=" " manner<=" " span.<=" " span<=" " p=" "><br>=" " span<=" " p=" "><br>=" " span=" ">F770 The facility will obtain a urinalysis in a timely manner.<br>=" " span=" ">1. Resident 36 was placed on an antibiotic after the urinalysis results. | 03/06/2025 |

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| | dementia, diabetes, and stroke.<br><br>A progress note, dated 01/02/25 at 1:47 P.M., indicated the resident had a new physician's order to obtain a urine dip (a rapid urine test performed in the facility). If the urine dip was positive, nursing staff were to obtain a urine sample to send to the lab for urinalysis (UA) and a Culture and Sensitivity (C&S). The resident's family member was notified.<br><br>The lab report from the urinalysis indicated the urine sample was collected on 01/07/25 and resulted on 01/08/25. The report indicated there were greater than 100,000 CFU/ml (colony forming units per milliliter) of Streptococcus beta hemolytic Group B bacteria. The bacteria were universally susceptible to Penicillins (a type of antibiotic). Susceptibility testing was not routinely performed.<br><br>A progress note, dated 01/09/25 at 2:18 P.M., indicated the resident was to receive Amoxicillin (an antibiotic) 500 mg (milligrams) by mouth four times a day for a UTI.<br><br>During an interview, on 02/18/25 at 10:17 A.M., RN 3 indicated if there was an order to obtain a UA, she would put the order in the computer. She would fill out a lab requisition form and fax the form to the lab, so they were aware. She would collect the urine sample and place it in the designated refrigerator. If she was having a hard time obtaining a sample, she would document that in the computer. The lab technicians came every day, and staff could call the courier to pick up a sample as well. UA C&S results were usually available within 48 to 72 hours of the sample arriving at the lab. | | =”” span=””>2. All residents have the potential to be affected. All urinalysis orders in the last 30 days were reviewed to ensure urinalysis were obtained per physician's order. No further concerns were noted. See below for corrective measures.<br>3. The Specimen Collection Routine urine policy and procedure was reviewed with no changes made. (See attachment D) The staff was inserviced on the above procedure.<br>4. The DON or his designee will review all urinalysis orders daily and ensure urine is collected timely for testing. The DON or his designee will utilize the nursing monitoring tool daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment B) The audits will be reviewed during the facility’s quarterly quality assurance meetings and the plan of correction will be adjusted accordingly if warranted. **If compliance is not obtained or maintained, the DON will be re-educated one on one.**<br>**Further monitoring would also occur by having the nurse consultant review all urinalysis orders ensuring urine collection is in a timely manner for testing.** | |

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| | During an interview, on 02/18/25 at 10:11 A.M., the ADON indicated the lab came in every morning to collect specimens to take to the local hospital. The order for the UA was given on 01/02/25. The sample was not collected until 01/07/25. It did not usually take five days to obtain a urine specimen.<br><br>The current facility policy, titled "SPECIMEN COLLECTION ROUTINE URINE", dated 10/2014, was provided by the ADON on 02/18/25 at 1:15 P.M. The policy indicated, "...obtain a fresh urine specimen for lab analysis...Routine urine specimens are collected as per physician's orders..."<br><br>3.1-49(a) | | 5 The above corrective measures will be completed on or before March 6, 2025. | |
| F 0812 SS=D Bldg. 00 | 483.60(i)(1)(2)<br>Food Procurement,Store/Prepare/Serve-Sanitary<br>Based on observation and interview, the facility failed to follow infection control guidelines during dining service for 1 of 2 dining observations. (Residents 102 and 15)<br><br>Findings include:<br><br>During a continuous observation on 02/12/25, from 11:49 A.M. to 11:57 A.M., in the Dementia Unit Dining Room, the following was observed:<br><br>At 11:49 A.M., Activity Aide (AA) 10 sat an empty lunch tray on a table, opened the trash can lid with her bare left hand, threw some trash into the can, went to the meal cart, and moved around several meal trays within the cart that were to be served to the residents. She retrieved a tray from the cart and served it to Resident 102. After serving the tray she sanitized her hands. At 11:54, | F 0812 | F812 The facility will follow infection control guidelines during dining service.<br>1. The staff was immediately educated on how to properly serve food in a sanitary manner per infection control guidelines.<br>2. All residents have the potential to be affected. All staff was immediately inserviced on how to properly serve food in a sanitary way per infection control guidelines. No further concerns were noted. See below for corrective measures.<br>3. The Meal Service policy and procedures was reviewed with no changes made. (See attachment G) The staff was inserviced on the | 03/06/2025 |

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| | she sat an empty tray on a table; opened the trash can lid with her bare left hand; threw some trash into the can; went to the meal cart; and moved several resident meal trays within the cart. She retrieved a meal tray and served it to Resident 15. After serving the tray she sanitized her hands.<br><br>During an interview, on 02/18/25 at 1:31 P.M., Certified Nurse Aide (CNA) 7 indicated when she was serving meal trays to residents, she would sanitize her hands after every tray served and wash her hands after every third tray served. If she ever touched anything besides the tray while serving, then she would immediately wash or sanitize her hands.<br><br>The current facility policy titled, "Meal Service" dated 10/2014 was provided by the Administrator on 02/18/25 at 2:00 P.M. The policy indicated, "...To ensure that all meals are delivered to resident as per physician's order..."<br><br>3.1-21(i)(3) | | above procedure.<br>4. The DON or his designee will observe one meal service a day in both dining rooms ensuring food is served in a sanitary manner per infection control guidelines. The DON or his designee will utilize the nursing monitoring tool daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment B) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly if warranted. **If compliance i**the staff member will be re-educated one on one to ensure they are knowledgeable about how to properly serve food in a sanitary manner per infection control guidelines. Additional monitoring will occur if compliance is not met by having the administrator observe one dining room meal service a day in both dining rooms opposite of the DON observations.<br><br>**5. The above corrective measures will be completed on or before March 6, 2025.** | |