STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155210	A. BUILDING 00 B. WING	04/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLOWS OF GREENSBURG	410 PARK RD GREENSBURG, IN 47240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: April 01, 02, 03, 04, and 07, 2025. Facility number: 000117 Provider number: 155210 AIM number: 100266460 Census Bed Type: SNF/NF: 60 Total: 60 Census Payor Type: Medicare: 6 Medicaid: 29 Other: 25 Total: 60 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on April 10, 2025.	F 0000	**Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law.** **We respectfully request paper compliance for this survey.**	
F 0577 SS=C Bldg. 00	483.10(g)(10)(11) Right to Survey Results/Advocate Agency Info Based on observation and interview, the facility failed to ensure State Survey Results were available to view for 3 of 5 days during the survey. Findings include: During an observation, on 04/02/25 at 3:00 P.M., the survey results were not available to view. There was no posting close to the front entrance	F 0577	F 577 Right to Survey Results What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents affected by the deficient practice How other residents having the potential to be affected by the same deficient practice will be identified and what corrective	04/24/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kelsey Meal	HFA	04/24/2025

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	indicating where the results were located. During an observation, on 04/03/25 at 11:30 A.M., the survey results were not available to view. There was no posting close to the front entrance indicating where the results were located. During an observation, on 04/03/25 at 12:37 P.M., a sign in the hallway by the therapy department indicated the State Survey results could be found in the file on the wall pocket. The survey results were not in the wall pocket and there was nothing posted close to the front door that indicated where the results were located. During an observation, on 04/04/25 at 9:10 A.M., the survey results were not available to view. There was no posting close to the front entrance indicating where the results were located. During an interview, on 04/04/25 at 12:24 P.M., the Administrator indicated that the State Survey results should be out where visitors could view them without having to ask. The current, undated, and untitled facility policy was provided by the Administrator on 04/04/25 at 12:59 P.M. The policy indicated, "...The purpose of this policy is to uphold a resident's right to examine the results of the most recent survey of the facility conducted by federal or state surveyors and any planned correction in effect with respect to the facility...A readable copy...is maintained in a 3-ring loose-leaf binder...located [in the main lobby]...is readily accessible without one having to ask staff members for the information..." 3.1-3(b)(1)		action(s) will be taken; No residents affected by the deficient practice What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Signage Placed by front door updated to current location of survey results 4/18/2025. Wall pocket hung in appropriate location containing a binder of the most recent survey results 4/18/2025. How the corrective action(s) will be monitored to ensure the deficient practice will not i.e.; what quality assurance program will be put into place; QAPI tool for monitoring of survey results in appropriate location will be monitored weekly x 4 weeks, monthly x 4 and bi-monthly x 2 by Administrator/Designee. If 100% threshold is not achieved an action plan will be developed. This information will be presented to the QAPI committee during the monthly meeting.	

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F 0578 SS=D Bldg. 00	483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir Based on record review and interview, the facility failed to document an appropriate advance directive for 1 of 16 residents' advanced directives reviewed. (Resident 260) Findings include: The clinical record for Resident 260 was reviewed on 04/02/25 at 11:20 A.M. An Admission Minimum Data Set (MDS) assessment, dated 01/23/25, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, hypertension, diabetes, and non-Alzheimer's dementia. The resident had a signed Out of Hospital Do Not Resuscitate (DNR) Declaration and Order, dated 01/17/25, along with a Physician Orders for Scope of Treatment (POST) form that indicated the resident was a DNR signed the same day. A current, open-ended physician's order, dated 01/17/25, indicated the resident was to receive Cardiopulmonary Resuscitation (CPR). During an interview, on 04/03/25 at 12:48 P.M., Licensed Practical Nurse (LPN) 2 indicated when a resident admitted to the facility the nurse would complete the POST Forms and the Out of Hospital DNR with the family and transcribe the order to indicate if the resident was to receive CPR or if the resident was a DNR. During an interview, on 04/03/25 at the Director of Nursing (DON) indicated when a resident admitted the Social Service Director would complete resident's POST Forms. The	F 0578	F 578 Request/Refuse/discontinue Adv Dir What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident #260 electronic chart was updated in accordance with advance directive wishes on 04.03.2025 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents that reside in the facility have the potential to be affected by the alleged deficient practice. All written advance directives were reviewed by IDT team and compared to electronic record to ensure accuracy on and or by 04.23.2025 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All staff members were educated on how to obtain a POST form upon arrival on and or by 04/25/2025. IDT will review/ - admission written advanced directives the next business day following arrival the facility. How the corrective action(s) will be monitored to ensure the deficient practice will not i.e.; what quality assurance program will be put into place; QAPI tool for monitoring of Code status accuracy will be	04/24/2025

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	management staff would complete an admission review to ensure that the POST form matched the resident's orders. If the resident had an Out of Hospital DNR then they should have a physician's order for being a DNR and not for CPR. The current, undated, facility policy titled, "Code Status" was provided by the DON on 04/03/25 at 1:18 P.M. The policy indicated, "...to adhere to resident's rights to formulate advance directives. In accordance to these rights, this facility will implement procedures to communicate a resident's code status to those individuals who need to know this information..." 3.1-(f)(5)		monitored weekly x 4 weeks, monthly x 4 and bi-monthly x 2 by Administrator/Designee. If 100% threshold is not achieved an action plan will be developed. This information will be presented to the QAPI committee during the monthly meeting.	
F 0656 SS=E Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan Based on record review, observation, and interview, the facility failed to ensure care planned interventions were followed related to fall interventions and care plans were in place for residents with a diagnosis of Post Traumatic Stress Disorder (PTSD) for 6 of 16 residents reviewed for Care Plans. (Residents 48, 18, 260, 51, 22, 7) Findings include: 1. Resident 48's clinical record was reviewed on 04/03/25 at 3:23 P.M. A Quarterly Minimum Data Set (MDS) assessment, dated 03/09/25, indicated the resident was moderately cognitively impaired. The resident used a walker and a wheelchair and required partial to moderate assist from staff for mobility. The resident's diagnoses included, but were not limited to, Parkinson's disease,	F 0656	F 656 Develop/ Implement Comprehensive Care Plan What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident #48 room assessed for current fall interventions in place and accurate on 04.24.2025 Resident #18 room assessed for current fall interventions in place and accurate on 04.24.2025 Resident #260 room assessed for current fall interventions in place and accurate on 04.24.2025 Resident #51 social services completed psychosocial status with no noted negative outcomes care plan remains active, personalized interventions	04/24/2025

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	hypertension, and dementia. The resident experienced two or more falls without injury since the last assessment. An Incident Note, dated 09/04/24 at 8:16 A.M., indicated the resident experienced a fall on 09/4/24 at 1:15 A.M. The resident was observed laying on the floor in his room. The resident was not injured and indicated he was sitting in his recliner and wanted to go over towards his closet. An intervention to hang a sign to remind the resident to use his call light for assistance was added to his plan of care. An Incident Note, dated 02/14/25 at 9:46 A.M., indicated the resident experienced a fall earlier that day. The resident was found by staff sitting next to his bed. An intervention to add non-skid strips to the floor next to the resident's bed was added to his plan of care. The resident's Care Plan for falls included, but was not limited to the following interventions: - An intervention, with a start date of 09/04/24, for call light signage to be hung in the resident's room to remind him to use the call light for assistance, and - An intervention, with a start date of 02/14/25, for non-skid strips to be placed on the floor next to the bed. The resident's room was observed on 04/02/25 at 10:15 A.M. The resident was in his wheelchair in the room. There was no signage hanging in the room related to the call light and no non-skid strips visible on the floor near the resident's bed. The resident's room was observed on 04/02/25 at		added on 4/22/2025 Resident #22 room/assistive device assessed for current fall interventions in place and accurate on 4/24/2025 Resident #7 social services completed psychosocial status with no noted negative outcomes, appropriate care plan added per diagnosis with personalized interventions on 4/03/2025 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents that residue in the facility have the potential to be affected by the alleged deficient practice. All residents room/assistive devices were reviewed for accuracy of fall interventions on and or by 4/25/25. All staff Inservice was conducted for education on fall interventions and room modifications was completed on and or by 04.25.2025 The Social Services Director completed building wide audit for current and new resident(s) diagnosis and mood and behavior care plans to ensure accuracy on 04.24.2025 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Social Services Director was educated on 4/18/2025 by SS consultant on care plan accuracy as well as care plan	

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	1:49 P.M. The resident was in bed. There was no signage hanging in the room related to using the call light. There were non-skid strips on the floor to the left of the bed, but under the bed. The strips were placed in the wrong direction, with only about 5 inches of one strip visible. The resident's room was observed on 04/03/25 at 8:51 A.M. The resident was in his chair. There was no signage hanging in the room related to using the call light. The non-skid strips were under the resident's bed and not visible. The resident's room was observed with Licensed Practical Nurse (LPN) 2 on 04/03/25 at 2:13 P.M. There was no signage noted on the walls and the bed was covering the non-skid strips on the floor. LPN 2 indicated there should be a sign on the wall to remind the resident to use his call light. The sign was face down on the resident's bedside stand. The non-skid strips were on the floor, but the bed was covering them. The strips should be placed parallel to the bed, alongside of it, so the resident would step on them if he got out of bed. These strips were going the wrong way. The bed had always been in the position it was in; it had not been recently moved. 2. Resident 18's clinical record was reviewed on 04/03/25 at 3:11 P.M. A Quarterly MDS assessment, dated 01/04/25, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, dementia, cancer, anemia, and hypertension. The resident used a walker and a wheelchair and required partial to moderate assist from staff for mobility. The resident experienced two or more falls without injury since the last assessment. An Incident Note, dated 10/28/24 at 9:53 A.M.,		timeliness. MDS coordinator was educated on care plan accuracy on 4/11/2025 by Director of Nursing. Mandatory staff in-service was completed on/by 4/25/2025 to educate staff on where to locate fall interventions that are currently in place per resident and ensuring accuracy. How the corrective action(s) will be monitored to ensure the deficient practice will not i.e.; what quality assurance program will be put into place; QAPI tool for monitoring of survey results in appropriate location will be monitored weekly x 4 weeks, monthly x 4 and bi-monthly x 2 by Administrator/Designee. If 100% threshold is not achieved an action plan will be developed. This information will be presented to the QAPI committee during the monthly meeting.	

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	indicated the resident experienced a fall on 10/25/24 at 6:45 P.M. The resident was witnessed by staff standing up from his recliner. The resident began walking when he lost his balance and fell backwards. Staff was unable to reach him before he fell. The resident was not injured. An intervention to place a clip alarm to notify staff when the resident was attempting to stand without assistance was added to the resident's plan of care. An Incident Note, dated 12/23/24 at 8:33 A.M., indicated the resident was observed climbing back into bed from the floor in his room. The resident did have an abrasion to his forehead. The fall alarm was unplugged from the alarm box. Staff were educated on ensuring the alarm was in place, plugged in, and functioning appropriately. The alarm box was placed out of the resident's reach so he couldn't unplug it without staff's knowledge. A Health Status Note, dated 03/07/25 9:39 A.M., indicated the resident experienced a fall on 03/06/25. The resident was on the floor across the room. A Hospice Aide had just given the resident a shower and did not plug in the floor mat alarm. The resident suffered no injuries. Education was to be provided to hospice staff related to fall interventions. The resident's Care Plan for falls included, but was not limited to the following interventions: - An intervention, with a start date of 03/12/25, to use a clip alarm as ordered. The resident was observed on 04/03/25 at 1:16 P.M. The resident was in his room in bed. The resident's wheelchair was in the room near the			

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	bed. The resident's clip alarm was attached to the wheelchair and not with the resident in bed. During an interview, on 04/03/25 at 1:20 P.M. Certified Nurse Aide (CNA) 3 indicated the resident's clip alarm should have been moved from the wheelchair to the resident's bed. Hospice staff had assisted him with a shower and put him to bed earlier that day, they should have put the alarm in place. 3. During an observation of Resident 260's room, on 04/02/25 at 11:01 A.M., there were no noticeable non-skid strips in front of the resident's recliner. During an observation of Resident 260's room, on 04/02/25 at 1:52 P.M., there were no noticeable non-skid strips in front of the resident's recliner. During an observation of Resident 260's room, on 04/03/25 at 8:59 A.M., there were no noticeable non-skid strips in front of the resident's recliner. During an observation of Resident 260's room, on 04/03/25 at 12:53 P.M., there were no noticeable non-skid strips in front of the resident's recliner. The clinical record for Resident 260 was reviewed on 04/02/25 at 11:20 A.M. An Admission MDS assessment, dated 01/23/25, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, hypertension, diabetes, and non-Alzheimer's dementia. A Progress Note, dated 03/17/25 at 2:25 P.M., indicated the resident was placed in his recliner to elevate his legs. The resident had slid to the end of the recliner to the floor. The call light was in reach but was not initiated. There were no injuries			

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	noted. A Progress Note, 03/18/25 at 9:46 A.M., indicated the IDT had reviewed the resident's unwitnessed fall on 03/17/25. The nurse was called to the resident's room and was found to be sitting on his buttocks in front of the recliner. The resident was unable to describe the fall. All interventions were reviewed and believed the non-skid strips in front of the recliner would be beneficial related to the fall. The current care plan included an intervention, but was not limited to, non-skid strips in front of the recliner related to a fall on 03/17/25. During an interview, on 04/03/25 at 1:41 P.M., Qualified Medication Aide (QMA) 6 indicated if a resident had a fall, she would find new fall interventions on their CNA pocket sheets or in report. During an interview, on 04/03/25 at 1:46 P.M., LPN 5 indicated she would find resident's fall interventions that were new on the home screen of their computer system, and they would stay there for 24 hours. All the other interventions would be found in the resident's orders and were passed on to them during report. The Director of Nursing (DON) and Assistance Director of Nursing (ADON) were responsible for inputting new interventions and making sure the interventions were in place. During an interview and observation of Resident 260's room on 04/03/25 at 1:50 P.M., LPN 5 indicated the resident had lacked non-skid strips in front if the recliner. 4. The clinical record for Resident 51 was reviewed			

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	on 04/03/25 at 9:18 A.M. A Quarterly MDS assessment, dated 02/26/25, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, dementia, anemia, hypertension, renal insufficiency, diabetes, anxiety, post-traumatic stress disorder (PTSD), sleep terrors, and nightmare disorder. The Complete Care Plan lacked an appropriate care plan and interventions related to the residents PTSD diagnosis. During an interview, on 04/07/25 at 11:11 A.M., the Social Service Director (SSD) indicated she would develop care plans for residents if they had a diagnosis of PTSD. The care plan would have interventions related to the diagnosis and would explain what the resident's PTSD was related to, to help staff with their triggers. 5. Resident 22's clinical record was reviewed on 04/02/25 at 2:02 P.M. A Quarterly MDS assessment, dated 01/17/25, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, Parkinson's disease, heart failure, hypertension, anxiety, and dementia. The resident used a wheelchair and required partial to moderate assist from staff for mobility. The resident experienced two or more falls without injury and two or more falls with injury since the last assessment. An Incident Note, dated 01/23/25 at 10:01 A.M., indicated the resident experienced an unwitnessed fall on 01/22/25 at 7:20 A.M. The resident fell from his wheelchair in the dining room. The resident was not injured and denied pain. An intervention to place bright colored tape on the brakes of the wheelchair to remind and encourage the resident to lock brakes on the wheelchair when attempting to stand would be beneficial.			

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	The resident's Care Plan for falls included, but was not limited to the following interventions: - An intervention, with a start date of 05/09/23, to use anti roll backs on the wheelchair, and - An intervention, with a start date of 01/24/25, to use bright colored tape on the brakes of the wheelchair. The resident was observed on 04/02/25 at 11:09 A.M. The resident was in his room in his recliner. The resident's wheelchair was in the room near the closet. The wheelchair lacked anti roll back tippers on the back of the wheelchair and bright colored tape on the brakes. The resident was observed on 04/02/25 at 1:46 P.M. The resident was in his wheelchair by the nurse's station. The wheelchair lacked anti roll back tippers on the back of the wheelchair and bright colored tape on the brakes. The resident was observed on 04/03/25 at 9:27 A.M. The resident was in his room in his recliner. The resident's wheelchair was in the room near the closet. The wheelchair lacked anti roll back tippers on the back of the wheelchair and bright colored tape on the brakes. During an interview, on 04/03/25 at 1:38 P.M., CNA 8 indicated interventions were passed on in report at the beginning of each shift. The resident had a clip alarm on his person when in the recliner and a floor mat next to his bed. He was unaware of any interventions for the resident's wheelchair. 6. Resident 7's clinical record was reviewed on 04/03/25 at 11:00 A.M. A Quarterly MDS			

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WILLOWS OF GREENSBURG	410 PARK RD GREENSBURG, IN 47240

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	assessment, dated 01/24/25, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, dementia, hypertension, renal insufficiency, depression, anxiety, and PTSD. The Complete Care Plan lacked a care plan related to the residents PTSD diagnosis. During an interview, on 04/07/25 at 11:11 A.M., the SSD indicated there should have been a care plan for the resident related to his diagnoses of PTSD. The current, undated, facility policy titled, "Comprehensive Care Plans", was provided by the DON on 04/07/25 at 12:50 P.M. The policy indicated, "...It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that include measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment..." 3.1-31(a)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on record review and interview, the facility failed to follow MD orders related to cardiac medication administration order parameters for 1 of 16 residents reviewed for Quality of Care. (Resident 27) Findings include: The clinical record for Resident 27 was reviewed	F 0684	F 684 Quality of Care What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident #27 was assessed per licensed nurse with no negative outcome on 04.15.25	04/24/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155210	A. BUILDING 00 B. WING	04/07/2025

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WILLOWS OF GREENSBURG	410 PARK RD GREENSBURG, IN 47240

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	on 04/03/25 at 2:55 P.M. A Quarterly Minimum Data Set assessment, dated 12/31/24, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, anemia, orthostatic hypotension, and disorders of the autonomic nervous system. The resident's current physician's orders included an open-ended order, with a start date of 01/24/25, to administer midodrine (a medication for low blood pressure) 5 mg (milligrams) two times a day for hypotension. The medication was to be held if the resident's systolic (the top number) blood pressure was greater than 140. The resident's Electronic Medication Administration Record (EMAR) for February and March 2025 indicated the resident received the midodrine medication when their blood pressure was assessed and top number was above 140 on the following dates and times: - The medication was administered on 02/02/25 at 8:00 A.M., when the blood pressure was 141/86, - The medication was administered on 02/11/25 at 8:00 A.M., when the blood pressure was 172/59, - The medication was administered on 02/14/25 at 8:00 A.M., when the blood pressure was 180/68, - The medication was administered on 02/16/25 at 4:00 P.M., when the blood pressure was 147/86, - The medication was administered on 02/17/25 at 4:00 P.M., when the blood pressure was 173/87, - The medication was administered on 02/21/25 at 4:00 P.M., when the blood pressure was 157/78, - The medication was administered on 03/05/25 at 4:00 P.M., when the blood pressure was 161/85, - The medication was administered on 03/06/25 at 4:00 P.M., when the blood pressure was 161/90, - The medication was administered on 03/10/25 at 8:00 A.M., when the blood pressure was 156/88,		How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents that residue in the facility have the potential to be affected by the alleged deficient practice. Medication administration records were audited for all residents that receive blood pressure medication that require vital signs. Supplementary documentation was reviewed to ensure that it is in place per MD orders by Director of Nursing/Designee on 04.25.2025 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All nurses were educated on obtaining blood pressure prior to administration in alliance with the parameters on and or by 04.25.2025. How the corrective action(s) will be monitored to ensure the deficient practice will not i.e.; what quality assurance program will be put into place; QAPI tool for monitoring of blood pressure medications with	

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	- The medication was administered on 03/14/25 at 8:00 A.M., when the blood pressure was 154/70, - The medication was administered on 03/27/25 at 8:00 A.M., when the blood pressure was 162/60, and - The medication was administered on 03/27/25 at 4:00 P.M., when the blood pressure was 163/60. During an interview, on 04/04/25 at 11:25 A.M., Licensed Practical Nurse 7 indicated if a medication had hold parameters the nurse would check the resident's blood pressure and would not administer the medication if the blood pressure was out of range (too high or too low). The medication should be documented as "held" and there was a space to indicate why the medication was not given. The current, undated facility policy, titled "Medication Administration Policy" was provided by the Director of Nursing on 04/07/25 at 12:50 P.M. The policy indicated, "...Obtain and record vital signs, when applicable or per physician orders. When applicable, hold medications for those vital signs outside the physician's prescribed parameters..." 3.1-48(a)(6)		parameters will be monitored weekly x 4 weeks, monthly x 4 and bi-monthly x 2 by Administrator/Designee. If 100% threshold is not achieved an action plan will be developed. This information will be presented to the QAPI committee during the monthly meeting.	
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance Based on record review and interview, the facility failed to document meal consumption for 1 of 1 residents reviewed for nutrition. (Resident 12) Findings include: 1. The clinical record for Resident 12 was reviewed on 04/03/25 at 11:13 A.M. A Quarterly Minimum	F 0692	F 692 Nutrition/Hydration Status Maintenance What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident #12 was assessed by licensed nurse with no negative outcomes and	04/24/2025

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WILLOWS OF GREENSBURG	410 PARK RD GREENSBURG, IN 47240

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	Data Set (MDS) assessment, dated 12/24/24, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, dementia, hypertension, diabetes, stroke, anxiety, and depression. The resident's meal consumption records lacked documented values on the following dates and times: - On 03/05/25 at breakfast and lunch, - On 03/07/25 at breakfast and lunch, - On 03/09/25 at lunch, - On 03/10/25 at breakfast and lunch - On 03/11/25 at breakfast and lunch, - On 03/12/25 at lunch, - On 03/13/25 at breakfast and lunch, - On 03/15/25 at breakfast and lunch, - On 03/16/25 at breakfast and lunch, - On 03/17/25 at breakfast and lunch, - On 03/18/25 at breakfast and lunch, - On 03/19/25 at breakfast and lunch, - On 03/20/25 at lunch, - On 03/23/25 at breakfast and lunch, - On 03/24/25 at breakfast and lunch, - On 03/25/25 at breakfast, - On 03/26/25 at lunch, - On 03/27/25 at breakfast and lunch, and - On 04/2/25 at breakfast and lunch.		reviewed by registered dietitian for need for additional nutritional supplement on 04.17.2025 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents that residue in the facility have the potential to be affected by the alleged deficient practice. Meal Documentation will be monitored daily by Scheduler/Designee assigned staff member will be asked to complete documentation prior to end of shift. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All appropriate staff members were educated on completion of POC documentation with accuracy is to be completed prior to end of shift on or by 04.25.2025 Scheduler was educated by the Director of nursing/Designee on how to review the completion of POC documentation on 04.17.2025 How the corrective action(s) will be monitored to ensure the deficient practice will not i.e.; what quality assurance program will be put into place; QAPI tool for monitoring of survey results in appropriate location will be monitored weekly x 4 weeks, monthly x 4 and bi-monthly x 2 by Administrator/Designee. If 100%	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	During an interview, on 04/03/25 at 3:06 P.M., Certified Nurse Aide (CNA) 10 indicated meal consumption should be recorded in the computer daily at the end of the shift. The current facility policy titled, "Meal Service", was provided by the Director of Nursing (DON) on 04/07/25 at 12:50 P.M. The policy indicated, "...Staff will document meal consumption in the medical record..." 3.1-46(a)(1)		threshold is not achieved an action plan will be developed. This information will be presented to the QAPI committee during the monthly meeting.	
F 0727 SS=D Bldg. 00	483.35(b)(1)-(3) RN 8 Hrs/7 days/Wk, Full Time DON Based on interview and record review, the facility failed to provide the required Registered Nurse (RN) on duty for eight consecutive hours a day for 2 of the 7 days reviewed. Findings include: The "as worked" nursing schedule, from 04/01/25 to 04/06/25, indicated there had not been an RN on duty for eight consecutive hours on Saturday, 04/05/25 and Sunday, 04/06/25. During an interview, on 04/07/25 at 1:42 P.M., the Director of Nursing (DON) indicated RN 3 worked night shift on Saturday 04/05/25 and Sunday 04/06/25. He was the only RN on the schedule for the weekend. His hours were not eight consecutive hours for each day. During an interview, on 04/07/25 at 2:10 P.M., the DON indicated the facility did not have a policy for RN coverage, they followed State and Federal regulations.	F 0727	F 727 RN 8Hrs/7 Days/, Full Time DON What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents negatively affected by the deficient practice How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents that residue in the facility have the potential to be affected by the alleged deficient practice. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Scheduler was educated by the Director of Nursing/Designee on 04.08.2025 on the state regulation to have 8 hours of	04/24/2025

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WILLOWS OF GREENSBURG	410 PARK RD GREENSBURG, IN 47240

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	3.1-17(b)(3)		consecutive RN coverage midnight to midnight, not including night shift. How the corrective action(s) will be monitored to ensure the deficient practice will not i.e.; what quality assurance program will be put into place; QAPI tool for monitoring of RN nursing coverage will be monitored weekly x 4 weeks, monthly x 4 and bi-monthly x 2 by Administrator/Designee. If 100% threshold is not achieved an action plan will be developed. This information will be presented to the QAPI committee during the monthly meeting.	
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records Based on record review and interview, the facility failed to transcribed medications on admission for 1 of 16 residents reviewed for pharmacy services. (Resident 3) Findings include: The clinical record for Resident 3 was reviewed on 04/02/25 at 1:59 P.M. An Annual Minimum Data Set (MDS) assessment, dated 01/22/25, indicated the resident was moderately cognitively impaired. The resident's diagnoses included, but were not limited to, diabetes, anemia, heart failure, hypertension, seizure disorder, non-Alzheimer's dementia, and depression. A Psychiatry Progress Note, dated 01/07/25, indicated the residents Fluoxetine (an antidepressant) medication was to be increased	F 0755	p="" paraid="1517496639" paraeid="{a8ade470-4da8-4c0b-b6e8-d3b7a21f7bcd}{249}">F 755 Pharmacy /Procedures/Pharmacist/Records What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident #3 was assessed per licensed nurse with no negative outcome. Psych NP was immediately notified of new orders to change order to original dosing on 04.07.2025 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All	04/24/2025

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	from 60 milligrams (mg) to 80 milligrams once a day, due to the resident having increased behaviors of increased irritability and being easily angered. The resident was admitted to the local hospital on 01/13/25 and returned to the facility on 01/15/25. The hospital discharge instructions, dated 01/15/25, indicated the resident was to receive Fluoxetine 80 mg once a day. A physician's order, dated 01/16/25 through 01/19/25, indicated the resident was to receive Fluoxetine 40 mg once a day. A current physician's order, with a start date of 01/19/25, indicated the resident was to receive Fluoxetine 40 mg once a day. The January, February, March, and April Electronic Medication Administration Record (EMAR) indicated the resident had received 40 mg of Fluoxetine instead of 80 mg each day from 01/16/25 through 04/07/25. During an interview, on 04/03/25 at 12:48 P.M., Licensed Practical Nurse (LPN) 2 indicated when a resident admitted to the facility the nurse would transcribe orders for the residents. During an interview, on 04/07/25 at 9:28 A.M., Licensed Practical Nurse (LPN) 7 indicated if a physician or Nurse Practitioner came to the facility and had new orders for a resident the nurse on the floor or the Assistant Director of Nursing would transcribe the orders. During an interview, on 04/07/25 at 1:39 P.M., the Director of Nursing (DON) indicated the resident		residents that residue in the facility have the potential to be affected by the alleged deficient practice. All nurses were educated by the Director of Nursing/designee on medication reconciliation for new and readmitting residents on or by 04.25.2025 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Medication reconciliation and review completed after hospital stay or MD appointment. Orders updated in PCC and pharmacy notified ADNS/Designee How the corrective action(s) will be monitored to ensure the deficient practice will not i.e.; what quality assurance program will be put into place; QAPI tool for monitoring of Medication Reconciliation will be monitored weekly x 4 weeks, monthly x 4 and bi-monthly x 2 by Administrator/Designee. If 100% threshold is not achieved an action plan will be developed. This information will be presented to the QAPI committee during the monthly meeting.	

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	had returned from the hospital on 01/15/25. The resident's order was transcribed wrong when she returned. She should have been receiving 80 mg of the Fluoxetine instead of 40 mg each day. The current, undated, facility policy titled, "Medication Orders", was provided by the DON on 04/07/25 at 2:03 P.M. The policy indicated, "...This facility shall use uniform guidelines for the ordering of medications...Clarify the order...Transcribe newly prescribed medications on the MAR [Medications Administration Record] or treatment record or ensure the order is in the electronic MAR..." 3.1-25(b)(9) 3.1-25(e)(3) 3.1-37(a)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observation, interview, and record review, the facility failed to appropriately store medications for 1 of 2 medication rooms reviewed. (Station 4 Medication Room) Findings include: The Medication Room on Station 4 was observed with Licensed Practical Nurse (LPN) 2 on 04/07/25 at 8:56 A.M. The medication refrigerator contained the following items: - A box that contained an opened vial of TB (Tuberculin) serum. The vial was not labeled with an "opened on" date. The box indicated the serum was received from the pharmacy on 02/06/25, and - A clear plastic bag that contained two boxes of	F 0761	F 761 Label/Store Drugs and Biologicals What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents negatively affected by the deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents that residue in the facility have the potential to be affected by the alleged deficient practice. The undated vial was disposed of immediately. What measures will be put into place	04/24/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155210	A. BUILDING 00 B. WING	04/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLOWS OF GREENSBURG	410 PARK RD GREENSBURG, IN 47240

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	TB serum. One of the vials had been opened and used. The vial was not labeled with an "opened on" date. The label on the bag indicated the serum was received from the pharmacy on 02/26/25. During an interview, on 04/07/25 at 8:56 A.M., LPN 2 indicated the TB serum should have been dated when it was opened and first used. There had been 3 or 4 residents admitted to Station 4 since the medication was delivered from the pharmacy. The TB serum package insert was provided by the Director of Nursing (DON) on 04/07/25 at 12:50 P.M. The directions for storage indicated, "...vials in use more than 30 days should be discarded..." The current facility policy, titled "VIALS AND AMPULES OF INJECTABLE MEDICATIONS", with a revision date of August 2014, was provided by the DON on 04/07/25 at 12:50 P.M. The policy indicated, "...Unopened vials expire on the manufacturer's expiration date...Opening a vial triggers a shortened expiration date that is unique for that product...At a minimum, the date opened must be recorded..." 3.1-25(o)		and what systemic changes will be made to ensure that the deficient practice does not recur; Facility medication rooms and carts and all vials (medication/vaccines/TB solution) labeled with open date and expiration date All nurses were educated by the Director of Nursing/designee on were expiration dates after opening are located, and regulation to have all items dated upon opening on and or before 04.25.2025 How the corrective action(s) will be monitored to ensure the deficient practice will not i.e.; what quality assurance program will be put into place; QAPI tool for monitoring of Medication rooms and carts will be monitored weekly x 4 weeks, monthly x 4 and bi-monthly x 2 by Administrator/Designee. If 100% threshold is not achieved an action plan will be developed. This information will be presented to the QAPI committee during the monthly meeting.	
F 0770 SS=D Bldg. 00	483.50(a)(1)(i) Laboratory Services Based on record review and interview, the facility failed to obtain a urinalysis in a timely manner for 1 of 6 residents reviewed for laboratory services. (Resident 27) Findings include:	F 0770	F 770 Laboratory Services What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident #27 was assessed by licensed nurse with no negative outcome on	04/24/2025

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	155210	A. BUILDING 00 B. WING	04/07/2025

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WILLOWS OF GREENSBURG	410 PARK RD GREENSBURG, IN 47240

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	The clinical record for Resident 27 was reviewed on 04/03/25 at 2:55 P.M. A Quarterly Minimum Data Set assessment, dated 12/31/24, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, anemia, orthostatic hypotension, renal insufficiency, neurogenic bladder, and disorders of the autonomic nervous system. The resident had an indwelling urinary catheter. A Health Status Note, dated 02/18/25 at 6:16 P.M., indicated the resident had a new physician's order to obtain a urinalysis (UA) with Culture and Sensitivity (C&S). A Health Status Note, dated 02/22/25 at 9:48 P.M., indicated the resident had a pending UA at that time. A Health Status Note, dated 02/25/25 at 2:01 A.M., indicated the resident's urine had been collected for a UA. A Health Status Note, dated 03/03/25 at 7:24 P.M., indicated the resident received their first dose of Ceftriaxone (an antibiotic) for a UTI (Urinary Tract Infection). During an interview, on 04/07/25 at 8:48 A.M., Licensed Practical Nurse (LPN) 2 indicated if she received a physician's order to obtain a UA, the sample should be obtained within 24 hours. If she got the order, she would try to get the sample that same day before her shift was over. Samples were placed in the refrigerator for the Laboratory Technicians (Lab Techs) to pick up, they came to the facility every day. Once the sample went to the lab, it would take 48 to 72 hours for the C&S report. The lab faxed the results to the facility. The facility would notify the MD or Nurse Practitioner.		04.15.2025 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents that reside in the facility have the potential to be affected by the alleged deficient practice. Laboratory Audits were conducted by Director of Nursing/designee to ensure all monthly labs and new lab orders are obtained an outcome was verified and documented on 04.22.2025 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All nurses were educated by the Director or Nursing/designee on the regulation to obtain lab specimens in a timely manner with proper documentation on and or by 04.17.2025 Communication portal created to ensure all parties are aware of where specimens are located for pickup on 04.14.2025 Solaris access provided to all nurses on and or by 04.17.2025 Lab order report reviewed daily. Follow up with lab to ensure completion and notification to family/NP/MD is documented in PCC completed by ADNS/Designee. How the corrective action(s) will be monitored to ensure the deficient practice will not i.e.; what quality assurance program will be put into	

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	155210	A. BUILDING 00 B. WING	04/07/2025

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	During an interview, on 04/07/25 at 10:18 A.M., the Director of Nursing (DON) indicated they received a report from the laboratory that indicated the specimen collection for the UA that was ordered on 02/18/25 was cancelled. The collection date listed on the form was 02/20/25 and the cancellation was reported on 02/24/25. There was no explanation as to why it was cancelled. The facility obtained a new urine sample on 02/25/25, it was received in the lab on 02/26/25, and the results were available on 03/01/25. During an interview, on 04/07/25 at 10:10 A.M., Support staff from the Laboratory indicated the Lab Tech came to the facility to collect the urine sample on 02/20/25, 02/21/25, and on 02/24/25 but each time it wasn't available. They usually tried three times to collect a sample and if it wasn't available they would cancel the lab order. A facility nurse signed off on the cancellation. They did come back on 02/25/25 and collected a new sample. The current, undated facility policy, titled "Laboratory Services and Reporting", was provided by the DON on 04/07/25 at 12:50 P.M. The policy indicated, "...The facility must provide or obtain laboratory services...The facility is responsible for the timeliness of the services..." 3.1-49(a)		place; QAPI tool for monitoring of laboratory orders and results will be monitored weekly x 4 weeks, monthly x 4 and bi-monthly x 2 by Administrator/Designee. If 100% threshold is not achieved an action plan will be developed. This information will be presented to the QAPI committee during the monthly meeting.	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, interview, and record review, the facility failed to follow infection control guidelines related to Peripherally Inserted Central Catheter (PICC) lines and indwelling	F 0880	F 880 Infection Prevention and Control What corrective action(s) will be accomplished for those residents	04/24/2025

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	155210	A. BUILDING 00 B. WING	04/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLOWS OF GREENSBURG	410 PARK RD GREENSBURG, IN 47240

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	urinary catheters for 3 of 6 residents reviewed for infection control. (Resident 27, 18, and 1) Findings include: 1. Resident 27's clinical record was observed on 04/03/25 at 2:55 P.M. A Quarterly Minimum Data Set (MDS) assessment, dated 12/31/24, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, anemia, orthostatic hypotension, renal insufficiency, neurogenic bladder, and disorders of the autonomic nervous system. A Health Status Note, dated 03/21/25 at 6:31 P.M., indicated a PICC line was placed in the resident's right arm. The resident denied pain or discomfort. The resident's current physician's orders included, but were not limited to the following: - An open-ended order, with a start date of 03/24/25, to change the PICC line dressing every 7 days and as needed, and - An open-ended order, with a start date of 03/24/25, to monitor the resident's IV site every shift for infection or infiltration. The resident was observed in her room on 04/01/25 at 1:25 P.M. The resident indicated she was recently treated with IV antibiotics for a urinary tract infection (UTI). A PICC line had been placed in her right arm for the medication. They were waiting to see if she needed more antibiotics before they removed the PICC. The dressing on the PICC was observed. There were no signs of infection. The dressing was dated 03/21/25.		found to have been affected by the deficient practice; Resident #27 was assessed per licensed nurse with no negative outcome. The license nurse immediately changed PICC line dressing per regulation on 04.03.2025 Resident #18 was assessed per licensed nurse with no negative outcome on 04.15.2025 Resident #1 was assessed per licensed nurse with no negative outcome on 04.15.2025 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents that reside in the facility have the potential to be affected by the alleged deficient practice. All residents that have a catheter were reviewed for proper placement of catheter in dignity bag while in wheelchair and in bed to ensure no part of catheter touching the floor by Director of Nursing/Designee on or by 4/25/2025. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All staff educated on proper placement of catheter in dignity bag while in wheelchair and in bed to ensure no part of the catheter is touching the floor by Director of Nursing/designee on or by 4/25/2025. PICC line orders reviewed and order for PICC line dressing change in place every 7	

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	The resident was observed in her room on 04/03/25 at 9:03 A.M. The resident's PICC line dressing was observed. The dressing was intact, and there were no signs of infection. The resident indicated nursing staff flushed the PICC twice a day to keep it patent, but no one had changed the dressing since they initially placed the PICC line on 03/21/25. The resident's PICC dressing was observed with Licensed Practical Nurse (LPN) 2 on 04/03/25 at 9:58 A.M. LPN 2 indicated the dressing was dated 03/21/25. She needed to double check the order, but she was sure the dressing should have been changed by now. The current, undated facility policy, titled "PICC/Midline/CV AD Dressing Change", was provided by the Director of Nursing (DON) on 04/07/25 at 12:50 P.M. The policy indicated, "...It is the policy of this facility to change... (PICC)...dressing weekly or if soiled...to decrease potential for infection and/or cross contamination..." 2. Resident 18 was observed on 04/01/25 at 11:10 A.M. The resident was in a chair near the nurses' station. The resident's indwelling urinary catheter bag was in a dignity sleeve, but the bottom of the urinary bag was resting on the floor near the chair. Resident 18 was assisted into the main dining room on 04/01/25 at 11:59 A.M. A staff member was pushing the resident in his wheelchair. The resident's catheter drainage bag was under the wheelchair and was dragging on the floor behind him. The bag was in a dignity sleeve, but the bottom of the urinary bag was touching the floor. Resident 18 was observed on 04/02/25 at 1:55 P.M.		days by Director of Nursing on 04.15.2025. How the corrective action(s) will be monitored to ensure the deficient practice will not i.e.; what quality assurance program will be put into place; QAPI tool for monitoring of survey results in appropriate location will be monitored weekly x 4 weeks, monthly x 4 and bi-monthly x 2 by Administrator/Designee. If 100% threshold is not achieved an action plan will be developed. This information will be presented to the QAPI committee during the monthly meeting.	

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	The resident was in bed and his urinary catheter drainage bag was hanging on the side of the bed. The corner of the bag was resting on the floor. Resident 18 was observed on 04/04/25 at 9:05 A.M. The resident was sitting in his chair near the nurses' station. The resident's urinary catheter bag and tubing were resting on the floor. During an interview, on 04/04/25 at 9:13 A.M., Certified Nurse Aide (CNA) 3 indicated the resident's urinary catheter bag should have a dignity sleeve on it and the bag shouldn't be touching the floor. She hung the bag under the resident's wheelchair. Resident 18 was observed on 04/04/25 at 11:20 A.M. The resident was sitting in his wheelchair near the nurses' station. The resident's urinary catheter bag was in a dignity sleeve hanging under his wheelchair, but the catheter tubing was resting on the floor under the chair. Resident 18's clinical record was reviewed on 04/03/25 at 3:11 P.M. A Quarterly MDS assessment, dated 01/04/25, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, dementia, cancer, and obstructive uropathy. The resident had an indwelling urinary catheter. 3. During an observation, on 04/03/25 at 1:33 P.M., Resident 1 was lying in bed, her urinary catheter bag was hanging on the left side of the bed. The bag was touching the floor. During an observation, on 04/03/25 at 2:20 P.M., Resident 1 was lying in bed, her urinary catheter bag was hanging on the left side of the bed. The bag was touching the floor.			

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	During an interview, on 04/04/25 at 2:24 P.M., Certified Nurse Aide (CNA) 9 indicated residents urinary catheter bags should not touch the floor. There was a dignity bag over the urinary catheter bag, but they were too big, and the urinary bag slid out of it due to a hole in bottom. The current, undated, facility policy titled, "Catheter Care" was provided by the ADON on 04/07/25 at 1:24 P.M. The policy indicated, "...It is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care and maintain their dignity and privacy when indwelling catheters are in use..." 3.1-18(b)			