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	11/13/2024

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 IN00446389. Complaint IN00446389 - No deficiencies related to the allegations are cited. Survey dates: November 6, 7, 8, 12, and 13, 2024 Facility number: 000078 Provider number: 155158 AIM number: 100289310 Census Bed Type: SNF/NF: 64 Total: 64 Census Payor Type: Medicare: 4 Medicaid: 48 Other: 12 Total: 64 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 11/18/24.	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	11/27/2024

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

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			the facility. This facility respectfully requests consideration of paper compliance for the cited deficiencies	
F 0583 SS=D Bldg. 00	483.10(h)(1)-(3)(i)(ii) Personal Privacy/Confidentiality of Records Based on observation and interview, the facility failed to ensure resident's privacy was maintained related to the electronic medication record left open and unlocked in the hallway during medication pass for 2 of 5 residents observed during medication pass. (Residents 113 and 6) Finding includes: On 11/8/24 at 8:15 a.m., LPN 1 was observed passing medications to Resident 113. She prepared the medications in the hallway on the East Hall cart using the electronic medication record on the computer. She then took the medications to the resident in his room. The computer screen was left open and on, leaving the residents medications and personal information available to view. At 8:25 a.m., LPN 1 returned to the East Hall cart and prepared medications for Resident 6. She then took the medications to the resident in his room and again left the computer screen open and unlocked with personal information available to view in the hallway. During an interview on 11/8/24 at 8:37 a.m., LPN 1 indicated she should have locked the screen but didn't know how to unlock it. During an interview on 11/8/24 at 8:44 a.m., the	F 0583	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ***Residents 113 and 6 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(s) will be taken:** ***Other residents have the potential to be affected therefore education will be provided to the licensed staff by the DON/HIM/Designee on maintaining residents personal and medical information being kept confidential*** **What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur:** ***All Nurses/QMA's will be educated on the process to ensure that personal and medical information is kept***	12/06/2024

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	Director of Nursing indicated that computer screens should be locked when the nurse walked away and she would speak to the nurse. 3.1-3(p)(2)		***confidential during Medication/Tx administration by DON/HIM/Designee by date of compliance. This education will be provided upon hire, at least yearly and as indicated. No licensed staff will work past date of compliance with out this education being completed.*** **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** ***Nursing management will complete 10 observations weekly x 3 months then 5 observations weekly x 3 months to ensure compliance. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting 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: 12-06-24*** ***The Administrator at The Willows is responsible in ensuring compliance in this Plan of Correction.*** **Results will be presented to PI x 6 months. PI will determine the need for further audits.**	
F 0641 SS=A	483.20(g) Accuracy of Assessments			

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Bldg. 00	Based on record review and interview, the facility failed to ensure the Minimum Data Set (MDS) comprehensive assessments were accurately completed related to antibiotic use for 2 of 20 MDS assessments reviewed. (Residents 28 and 36) Findings include: 1. Resident 28's record was reviewed on 11/12/24 at 2:38 p.m. Diagnoses included, but were not limited to, osteoporosis with pathological fracture (vertebrae), wedge compression third lumbar vertebra, chronic obstructive pulmonary disease, and hypertension. The Quarterly Minimum Data Set (MDS) assessment, dated 9/26/24, indicated the resident was cognitively intact, required moderate to complete assistance with activities of daily living, and was taking antibiotics. The Physician's Orders and the electronic Medication Administration Record (eMAR) for September 2024 did not indicate the resident was taking antibiotics. During an interview on 11/13/24 at 1:12 p.m., the Clinical Reimbursement Specialist indicated she could find no record of the resident receiving antibiotics, and the MDS must have been coded as such in error. 2. Resident 36's record was reviewed on 11/12/24 at 9:38 a.m. Diagnoses included, but were not limited to, acute respiratory failure, acute pulmonary edema, undifferentiated schizophrenia, hyperlipidemia (high cholesterol), and	F 0641	***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** 1 Resident #28 and Resident #36 OBRA September Quarterly assessments were modified, transmitted and accepted into the CMS repository 11/15/2024 related to inaccurate coding that they received antibiotics. ***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 All residents have the potential to be affected, therefore, the most recent required OBRA assessment for all active residents was reviewed for accurate coding of Antibiotic therapy. Affected assessments were modified and transmitted into the repository 11/15/2024. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** 1 Training provided to interim MDSCs on 11/25/24 for accurate coding of antibiotics in section "N0415F 2 CRS, RN or designee will review all required OBRA	12/06/2024

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	dependence on renal dialysis The Quarterly Minimum Data Set (MDS) assessment, dated 9/24/24, indicated the resident was cognitively intact, required moderate assistance with activities of daily living, and was taking antibiotics. The Physician's Orders and the electronic Medication Administration Record (eMAR) for September 2024 did not indicate the resident was taking antibiotics. During an interview on 11/13/24 at 1:12 p.m., the Clinical Reimbursement Specialist indicated she could find no record of the resident receiving antibiotics, and the MDS must have been coded as such in error. 3.1-31(i)		assessments for accurate coding of antibiotic therapy in N0415F prior to MDS submission. ***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 CRS or designee will review for accuracy all required OBRA assessments coded with antibiotic therapy in N0415F prior to MDS submission weekly x 1 month; then 5 assessments every two weeks x 3 months, then 5 assessments monthly x 2 month 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%.	
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision Based on record review and interview, the facility failed to ensure care plans were implemented for 1 of 19 resident care plans reviewed. (Resident 9) Finding includes:	F 0657	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ***Resident # 9 had no negative***	12/06/2024

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	Resident 9's record was reviewed on 11/8/24 at 10:20 a.m. Diagnoses included, but were not limited to, senile degeneration of the brain and dementia. The Quarterly Minimum Data Set (MDS) assessment, dated 10/14/24, indicated the resident was severely cognitively impaired for daily decision making. She required maximal to total dependence on staff for activities of daily living (ADL) care. She received antipsychotic, anti-anxiety, antidepressant, and opioid medications. She was on hospice care. The November 2024 Physician Order Summary indicated Resident 9 received morphine sulfate (opioid pain medication) 20 milligram/milliliter (mg/ml), 5 mg by mouth every two hours as needed. The resident was to be observed for opioid medication side effects every shift. There were no care plans related to pain and opioid use. During an interview on 11/12/24 at 3:50 p.m., the Director of Nursing indicated there were no care plans for pain and opioid use in the current care plan for the resident. 3.1-35(c)(1)		***outcomes from alleged 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:** ***Nursing management has completed an in-house audit for residents with pain to ensure a specific care plan is in place by date of compliance.*** **What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur:** ***Nursing management will validate that all admits and readmits will have a Pain or Risk for Pain Care Plan within 21 days post admit. Pain/Risk for Pain Care Plans will be updated; as necessary. All admits/readmits will be kept on attached log to ensure that the plan of care is put into place.*** **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** ***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***	

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			compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. ***Compliance date: 12-06-24. The Administrator of The Willows is responsible in ensuring compliance in this Plan of Correction.*** **Results will be presented to PI x 6 months. PI will determine the need for further audits.**	
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer Based on observation, record review, and interview, the facility failed to ensure a resident with a pressure ulcer received the necessary treatment and services to promote healing related to a treatment not provided as ordered for 1 of 3 residents reviewed for pressure ulcers. (Resident 39) Finding includes: On 11/8/24 at 10:40 a.m., wound care for Resident 39 was observed with the Infection Prevention (IP) Nurse. The resident had a stage 4 pressure ulcer to her sacrum. She was in bed and turned onto her right side. The nurse removed the old dressing and cleansed the wound with wound wash, patted the area dry and checked measurements. She then applied skin prep to the skin surrounding the wound and applied an antimicrobial gel to the wound bed. She then packed the wound with calcium alginate and covered the area with an island border dressing.	F 0686	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ***Resident # 39 had the treatment completed correctly immediately. The resident did not experience harm. MD/ Hospice/POA was notified.*** **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:** ***Other residents have the potential to be affected therefore the wound nurse reviewed all orders for treatments for pressure ulcers to ensure orders are concise, specific and easy to***	12/06/2024

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	The resident's record was reviewed on 11/7/24 at 3:31 p.m. Diagnoses included, but were not limited to, diabetes mellitus, adult failure to thrive, and a stage 4 pressure ulcer to sacral region. The Quarterly Minimum Data Set assessment, dated 8/1/24, indicated the resident had significant cognitive impairment, required substantial assistance for bed mobility, and had a stage 4 pressure ulcer present on admission. A Physician's Order, dated 7/18/24, indicated wound care to coccyx was to be provided three times weekly. Cleanse coccyx with wound wash and pat dry. Apply skin prep to periwound. Apply a thin layer of germ shield to the wound bed, apply one packet of collagen to wound bed, cover wound bed with silver alginate, and apply a small foam dressing. During an interview on 11/8/24 at 11:14 a.m., the IP Nurse indicated she had just reviewed the Physician Orders and she would redo the treatment for the resident. 3.1-40(a)(2)		***follow by date of compliance physician order for treatments are followed. Wound Nurse will observe to ensure that the order(s) for treatment(s) are followed.*** **What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur:** ***The DON educated the wound nurse on how to follow specific orders for treatments by date of compliance. This education includes taking a copy of the order with her when performing treatments.*** **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** ***Audits will be conducted by the DON/Designee on the wound nurse to ensure compliance of 2 treatments weekly x 3 months then 1 treatment weekly x 3 months. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting 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%.***	

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			Compliance Date: 12-06-24. The Administrator at The Willow is responsible in ensuring compliance in this Plan of Correction. **Results will be presented to PI x 6 months. PI will determine the need for further audits.**	
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance Based on observation, record review, and interview, the facility failed to ensure a nutritional supplement was offered during meal service and food consumption logs were completed for a resident with a history of weight loss for 1 of 2 residents reviewed for nutrition. (Resident 5) Finding includes: On 11/13/24 at 1:07 p.m., Resident 5 was seated at a table in a wheelchair in the Assisted Dining Area. The resident had a meal tray in front of her which included mashed potatoes, ground meatballs with gravy, vegetables, and ice cream. There was no bowl of soup observed. The resident's meal ticket had "Super Soup" written on the ticket. Record review for Resident 5 was completed on 11/12/24 at 10:45 a.m. Diagnoses included, but were not limited to, stroke, diabetes mellitus, hypertension, dementia, and end stage renal disease. The Quarterly Minimum Data Set (MDS) assessment, dated 8/1/24, indicated the resident was cognitively impaired. The resident had an impairment on one side of her upper and lower	F 0692	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident # 5 was being weighed weekly and had been stable for 3 weeks. **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:** An in-house audit has been completed on Fortified foods/supplements by date of compliance. Any concerns noted will be addressed. **What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur:** Education to Dietary staff has been provided by Dietary Director/Designee by date of compliance to include the	12/06/2024

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	extremities for a functional limitation in range of motion. The resident required a partial moderate assistance with eating. The resident also had a feeding tube and a mechanical therapeutic diet. A Care Plan, dated 1/10/24 and revised 8/2/24, indicated the resident was a nutritional risk due to hypertension, diabetes mellitus, anemia, depression, and dementia. The resident received tube feeding for nutrition and hydration. The resident received a therapeutic mechanically altered diet. Interventions included to provide supplements and diet as ordered to promote better nutritional value and to monitor intake and record every meal. The November 2024 Physician's Order Summary indicated the following orders: - Glucerna (diabetic nutritional supplement) via enteral feed, on at 8:00 p.m. and off at 8:00 a.m. - mechanically altered diet - fortified (nutrients added to them that don't naturally occur in the food) soup at lunch and supper The resident's weight on 5/1/24 was 136.2 lbs (pounds). On 11/4/24, the resident weighed 120.2 lbs. This was a weight loss of 11.75% (percent) in 6 months. A Nutrition/Dietary Note, dated 11/12/24, indicated the resident's weight was stabilizing for the past 3 weeks. The resident recently had fortified soup added for lunch and supper meals. The Task Meal Consumption Logs were documented with percentage of meals eaten. The last 30 days lacked documentation for the following meals: - Breakfast on 10/31/24		importance of reading and accurately serving the fortified foods/supplements and the understanding on the policy and for fortified foods. Dietary staff will not work if education not completed by date of compliance. New Dietary staff will receive this education in the orientation process. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** Dietary Director/designee will audit 5 trays weekly x 3 months, and then 3 trays s weekly for 3 months for completed and accurate serving of fortified foods/supplements. Audits will be presented to QAPI ongoing. Any issues or trends will be addressed. **Results will be presented to PI x 6 months. PI will determine the need for further audits.**	

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	- Lunch on 10/21, 10/31, and 11/7/24 During an interview on 11/13/24 at 1:07 p.m., CNA 1 indicated the resident did not normally receive soup at meal times that she was aware of. During an interview on 11/13/24 at 1:08 p.m., LPN 1 indicated she was unaware if the resident was supposed to receive any fortified soup and would look up the orders. She proceeded to look up the resident's order and indicated the resident did have an order for fortified soup at lunch and should have received it. During an interview on 11/13/24 at 1:14 p.m., the Dietary Manager indicated she would review the resident's meal consumption logs to see the percentage of meals the residents ate. The staff were expected to document percentages of every meal eaten. The meal percentages eaten were important to review to decide if the resident's enteral feeding would need to be adjusted. The resident had an order change recently for fortified soup at lunch and supper. She had hand written "Super Soup" on the resident's meal ticket. The cook should have put the fortified soup on the resident's meal tray for lunch and did not. 3.1-46(a)(1) 3.1-46(a)(2)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, record review, and interview, the facility failed to ensure infection control measures were implemented related to hand hygiene during medication pass for 2 of 5 residents observed during medication pass. (Residents 113 and 6, and LPN 1)	F 0880	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ***Residents # 113 and 6 had no***	12/06/2024

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	Finding includes: On 11/8/24 at 8:15 a.m., LPN 1 was observed passing medications to Resident 113. There was no hand hygiene observed prior to medication preparation. She gave the medications to the resident in his room and returned to the medication cart to prepare medications for Resident 6. There was no hand hygiene observed. After the medications had been poured into the medication cup, she used hand sanitizer. The nurse then took the medications to Resident 6 in his room. She returned to the medication cart and did not perform hand hygiene. During an interview on 11/8/24 at 8:37 a.m., LPN 1 indicated she thought she only had to wash her hands after every third resident. During an interview on 11/8/24 at 8:44 a.m., the Director of Nursing indicated the nurses had hand sanitizer that should be used and they should wash their hands after every third resident unless they touched something. The policy, "Hand Hygiene," dated 7/15/22, indicated, "... Associates perform hand hygiene (even if gloves are used) in the following situations: a. Before and after contact with the resident ... c. After contact with objects and surfaces in the resident's environment ...." 3.1-18(l)		***negative outcomes.*** **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:** ***Other residents have the potential to be affected therefore LPN # 1 was educated immediately on hand hygiene related to medication pass. Nursing management made random rounds during medication pass and no other issues were noted.*** **What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur:** ***Education will be provided by the Infection Preventionist to the licensed nursing staff and QMAS on Handwashing/hand sanitizing will be completed by the Nurse/QMA after each medication administration and as needed due to possible contamination by date of compliance. Audits will be completed across varied shifts during medication administration.*** ***Sample of 10 per week x's 4 weeks Then, 10 monthly.*** **How the corrective action(s) will be monitored to ensure the**	

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	155158	A. BUILDING 00 B. WING	11/13/2024

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			deficient practice will not recur: ***Nursing management will observe 3 licensed nurses/QMAS weekly x 3 months then 2 x 3 months to ensure compliance. The results of these reviews will be discussed at the monthly Quality Assurance Committee meeting 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: 12-06-24.*** ***The Administrator at The Willows is responsible in ensuring compliance in this Plan of Correction.*** **Results will be presented to PI x 6 months. PI will determine the need for further audits.**	
F 0881 SS=D Bldg. 00	483.80(a)(3) Antibiotic Stewardship Program 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 not following up on urine culture results in a timely manner for 1 of 2 residents reviewed for urinary tract infections. (Resident 40) Finding includes: Resident 40's record was reviewed on 11/12/24 at	F 0881	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ***Resident # 40 did not experience harm. MD notified.*** **How other residents having the potential to be affected by the same deficient practice will be**	12/06/2024

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	1:11 p.m. Diagnoses included, but were not limited to, vascular dementia, major depression, and a history of urinary tract infections (UTIs). The Quarterly Minimum Data Set assessment, dated 9/23/24, indicated the resident was cognitively intact and was dependent on staff for toileting assistance. The resident had been on antibiotics during the assessment period. A Health Status Note, dated 10/14/24, indicated the resident was sent to the hospital to be evaluated for vaginal bleeding. The resident returned to the facility later that day with an order for an antibiotic related to a UTI. A Physician's Order, dated 10/14/24, indicated to give ciprofloaxin (an antibiotic) 500 milligrams (mg), twice daily for seven days for a UTI. A Request for Hospital Records had been faxed to the hospital on 10/16/24 requesting the results of the urine culture and sensitivity (a report that indicates which antibiotics are effective). There were no additional requests for the test results or documentation the hospital had been contacted regarding the test results. The Medication Administration Record indicated the resident began ciprofloaxin on 10/14/24 and completed the medication on 10/21/24. A Health Progress Note, dated 10/22/24, indicated an order had been received from the hospital for cefuroxime 500 mg twice daily for seven days. The urine culture and sensitivity results indicated the infection was resistant to ciprofloaxin. The resident complained of pain to the right side and her urine was dark amber colored.		**identified and what corrective action(s) will be taken:** ***An in-house audit of residents who had a culture completed at an outside source going back 30 days from date of exit has been completed by the IP by date of compliance. No other issues have been noted.*** **What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur:** ***All admit and readmits from the hospital who are on an antibiotic involving a culture completed at an outside source will be reviewed in the morning Clinical Meeting. Lab work will be reviewed. Medical Records will request needed records daily until received and documentation of these requests will be kept. The MD/NP will be kept updated to review the need for continued prescribed treatment.*** **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** ***Log will be maintained for all involved residents (see attached) to ensure compliance. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee***	

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	The Urine Culture results, dated 10/17/24, indicated the infection was resistant to ciprofloaxin and susceptible to cefuroxime. The results were not faxed to the facility until 10/22/24. During an interview on 11/12/24 at 2:30 p.m., the Infection Prevention Nurse indicated they did not have access to the hospitals records or test results and had to request them by fax. It would often take several requests to get the results sent over. There was no additional information provided related to additional requests made or follow up related to the test results. The policy, "Antibiotic Stewardship," dated 5/16/24, indicated, "...The antibiotic stewardship program promotes the appropriate use of antibiotics and includes a system of monitoring to improve resident outcomes and reduce antibiotic resistance. This means that the antibiotic is prescribed for the correct indication, dose and duration to appropriately treat the resident while also attempting to reduce the development of antibiotic resistant organisms...."		***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: 12-06-24.*** ***The Administrator at The Willows is responsible in ensuring compliance in this Plan of Correction.*** **Results will be presented to PI x 6 months. PI will determine the need for further audits.**	