| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155228 | A. BUILDING 00<br>B. WING | 05/30/2025 |

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| WILLOWS OF RICHMOND | 2070 CHESTER BLVD<br>RICHMOND, IN 47374 |

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| F 0000<br><br>Bldg. 00 | This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00455673 and IN00454984.<br><br>Complaint IN00455673 - No deficiencies related to the allegations are cited.<br><br>Complaint IN00454984 - No deficiencies related to the allegations are cited.<br><br>Survey dates: May 27, 28, 29, and 30, 2025<br><br>Facility number: 000133<br>Provider number: 155228<br>AIM number: 100266080<br><br>Census Bed Type:<br>SNF/NF: 51<br>Total: 51<br><br>Census Payor Type:<br>Medicare: 1<br>Medicaid: 43<br>Other: 7<br>Total: 51<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed on June 3, 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. Please accept this Plan of Correction as Credible Allegations of Compliance. The facility respectfully requests paper compliance for this citation. | |
| F 0558<br>SS=D<br>Bldg. 00 | 483.10(e)(3)<br>Reasonable Accommodations Needs/Preferences<br>Based on observation, interview, and record review, the facility failed to ensure availability of | F 0558 | **What corrective action(s) will be accomplished for those** | 06/12/2025 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Merry Goodwin | HFA | 06/13/2025

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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| | fluids at the bedside for 1 of 1 resident reviewed for accommodation of needs. (Resident 35)<br><br>Findings include:<br><br>The clinical record for Resident 35 was reviewed on 5/28/25 at 11:45 a.m. The diagnoses included, but were not limited to, dementia and protein-calorie malnutrition.<br><br>During an observation on 5/27/25 at 1:54 p.m., Resident 35 was lying in bed with no water available at the bedside.<br><br>During an observation on 5/28/25 at 9:54 a.m., Resident 35 had an empty clear cup at the bedside. No water was available at the bedside.<br><br>During an observation on 5/28/25 at 1:19 p.m., Resident 35 was lying in bed with no fluids at the bedside.<br><br>During an observation on 5/29/25 at 9:01 a.m. and 1:30 p.m., Resident 35 did not have any fluids available at the bedside.<br><br>An Annual Minimum Data Set (MDS) assessment, dated 4/22/25, indicated Resident 35 was severely cognitively impaired and required partial/moderate assistance with using suitable utensils to bring food and/or liquid to the mouth and swallow.<br><br>The plan of care for Resident 35, dated 9/12/22, indicated the resident required assistance with activities of daily living (ADLs) related to weakness. The interventions included, but were not limited to, being well nourished daily with staff assistance.<br><br>The plan of care for Resident 35, dated 9/12/22, | | **residents found to have been affected by the deficient practice:**<br>Facility Registered Dietitian and ADNS reviewed fluid needs and hydration status for resident #35 on 6/10/2025 (Attachment 1). The care plan was revised to reflect hydration status (Attachment 2). Staff reeducated on hydration involving resident #35 (Attachment 3). There were no negative outcomes.<br>**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:**<br>All applicable residents have the potential to be affected by the alleged deficient practice. A facility wide audit using the Dehydration Risk Screener tool completed on 6/12/2025 (Attachment 4) by nursing administration to identify those residents at risk of dehydration. Care plans updated if needed.<br>**What measures will be put in place and what systematic changes will be made to ensure that the deficient practice does not recur:**<br>All nursing staff in serviced by DNS on the importance of fluid intake and ensuring that there is adequate intake between meals on 6/12/2025 (Attachment 5).<br>**How the corrective action(s) will be monitored to ensure the** | |

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| | indicated the resident was at risk for altered nutrition related to the diagnosis of dementia. The interventions included, but were not limited to, encourage the resident to consume fluids and fluid availability at the bedside.<br><br>During an interview with the Director of Nursing (DON) on 5/29/25 at 1:40 p.m., she indicated Resident 35 should have water at the bedside. The DON indicated staff needed to offer Resident 35 water and/or fluids anytime they went into her room since she was unable to initiate it herself.<br><br>The "Hydration Policy" was provided by the Administrator on 5/29/25 at 12:10 p.m. It indicated,"... the facility offers each resident sufficient fluid, including water and other liquids, consistent with resident needs and preferences to maintain proper hydration and health...4.(b)(i) Offer the resident a variety of fluids during and in between meals...4.(b)(iii) Ensure beverages are available and within reach..."<br><br>3.1-3(v)(1) | | **deficient practice will not recur, i.e., what quality assurance program will be put in place:**<br>DON or designee will monitor current and all new admissions for the risk of dehydration 5 times a week for 4 weeks, 3 times a week for 4 weeks, biweekly times 2 months, and weekly times 8 weeks. Ongoing thereafter during morning clinical meeting (Attachment 6).<br>Any findings will be immediately corrected, and DON/designee will report all audits during the QAPI meetings, and all recommendations will be followed. | |
| F 0677 SS=D Bldg. 00 | 483.24(a)(2)<br>ADL Care Provided for Dependent Residents<br><br>Based on observation, interview, and record review, the facility failed to provide assistance with eating for 1 of 3 residents reviewed for activities of daily living (ADLs). (Resident 35)<br><br>Findings include:<br><br>The clinical record for Resident 35 was reviewed on 5/28/25 at 11:45 a.m. The diagnoses included, but were not limited to, dementia and protein-calorie malnutrition. | F 0677 | **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**<br>Resident #35 reviewed and is now up for all meals and will be assisted. There were no negative outcomes.<br>**How other residents having the potential to be affected by the same deficient practice will be** | 06/12/2025 |

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| | During an observation on 5/27/25 at 12:45 p.m., Resident 35 was lying in bed sleeping with a full lunch tray sitting in front of her.<br><br>During an observation on 5/27/25 at 1:25 p.m., Resident 35 continued to lay in bed asleep throughout lunch with a full lunch tray sitting in front of her. No staff were in to assist Resident 35 with eating.<br><br>During an observation on 5/28/25 at 11:55 a.m., Resident 35 had food sitting in front of her while lying in bed. She was pouring lemonade onto her lunch tray and appeared confused about what to do with the eating utensils. No staff members were in to assist Resident 35 with eating.<br><br>During an observation on 5/29/25 at 12:00 p.m., Resident 35 was sitting up in bed, attempting to feed herself. Resident 35 was noted to have difficulties getting the food onto her spoon and fork, missing her mouth with the food and dropping the food onto herself.<br><br>A physician's order, dated 7/2/23, indicated Resident 35 was on a regular diet with mechanical soft texture and thin liquid consistency.<br><br>An Annual Minimum Data Set (MDS) assessment, dated 4/22/25, indicated Resident 35 was severely cognitively impaired and required partial/moderate assistance with using suitable utensils to bring food and/or liquid to the mouth and swallow.<br><br>A Registered Dietician (RD) nutritional assessment, dated 4/23/25, indicated Resident 35 needed assistance/cueing at meals.<br><br>The plan of care for Resident 35, dated 9/12/22, indicated the resident required assistance with | | **identified and what corrective action(s) will be taken:**<br>All applicable residents have the potential to be affected by the alleged deficient practice. A facility wide audit completed on 6/12/2025 to ensure that all residents needing assistance will have staff support to ensure adequate meal consumption (Attachment 7).<br>**What measures will be put in place and what systematic changes will be made to ensure that the deficient practice does not recur:**<br>All nursing staff in serviced by DNS on the importance of meal consumption and assistance with feeding on 6/12/2025 (Attachment 8).<br>**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:**<br>DON or designee will monitor current and all new admissions on meal consumption and assistance with feeding 5 times a week for 4 weeks, 3 times a week for 4 weeks, biweekly times 2 months, and weekly times 8 weeks. Ongoing thereafter during morning clinical meeting (Attachment 9). Any findings will be immediately corrected, and DON/designee will report all audits during QAPI meetings, and all | |

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| | ADLs related to weakness. The interventions included, but were not limited to, being well nourished daily with staff assistance, and Resident 35 required one person assistance with eating.<br><br>During an interview with the Director of Nursing (DON) on 5/29/25 at 1:44 p.m., she indicated Resident 35 needed to be up out of bed for all meals to ensure she was consuming adequate nutrients, and Resident 35 should never have been left alone to feed herself.<br><br>An "Activities of Daily Living" policy was provided by the Administrator on 5/29/25 at 12:10 p.m. It indicated, "...Care and services will be provided for the following activities of daily living... 4. Eating to include meals and snacks...Policy Explanation and Compliance Guidelines...3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition..."<br><br>3.1-38(a)(2)(D)<br>3.1-38(a)(3) | | recommendations will be followed. | |
| F 0684<br>SS=D<br>Bldg. 00 | 483.25<br>Quality of Care<br><br>Based on interview and record review, the facility failed to timely address a resident's documented medication allergy for 1 of 1 resident whose medications were reviewed for allergies. (Resident 40)<br><br>Findings include:<br><br>The clinical record for Resident 40 was reviewed on 5/27/25 at 12:55 p.m. Her diagnoses included, but were not limited to, congestive heart failure. | F 0684 | **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**<br>DON placed call to daughter on resident #40 to clarify this was not an allergy that this was an intolerance. Point Click Care , care plan updated and notation of call (Attachment 10) at the time of | 06/12/2025 |

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| | The 4/15/25 Quarterly MDS (Minimum Data Set) assessment indicated she was moderately, cognitively impaired.<br><br>An interview was conducted with Resident 40 on 5/27/25 at 1:00 p.m. She indicated she could not take Tylenol (acetaminophen) because it made her legs swell. She was allergic to it, but the facility gave it to her anyway.<br><br>The 11/9/24 hospital discharge note indicated she was allergic to Tylenol with a reaction of swelling.<br><br>The 11/9/24 hospital discharge medication list indicated to stop taking acetaminophen 325 milligrams (mg) tablet.<br><br>The facility physician's orders indicated an order for acetaminophen tablet 325 mg, two tablets every six hours as needed for general discomfort, starting 11/17/24 with an end date of 2/5/25.<br><br>The December 2024 and January 2025 MARs (medication administration records) indicated she was administered acetaminophen on the following dates: 12/8/24, 12/11/24, 1/8/25, 1/16/25, and 1/21/25.<br><br>The 9/29/24 medication allergy care plan indicated acetaminophen was not added as an allergy until 5/6/25.<br><br>An interview was conducted with the DON (Director of Nursing) on 5/28/25 at 1:16 p.m. She indicated when Resident 40 came back from her last hospitalization, on 5/6/25, they recognized the hospital documentation referenced an allergy to acetaminophen. So, it was added as an allergy in the clinical record. They never noticed any side | | observation. There were no negative outcomes.<br>**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:**<br>All residents have the potential to be affected by the alleged deficient practice. A facility wide audit was performed on each resident to ensure physician orders and care plans match allergies listed on 6/12/2025 (Attachment 11).<br>**What measures will be put in place and what systematic changes will be made to ensure that the deficient practice does not recur:**<br>All nurses in serviced to ensure that all allergies are transcribed on 6/12/2025 (Attachment 12).<br>**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:**<br>DON or designee will monitor current and all new admissions for allergies 5 times a week for 4 weeks, 3 times a week for 4 weeks, biweekly times 2 months, and weekly times 8 weeks. Ongoing thereafter in clinical meeting (Attachment 13).<br>Any findings will be immediately corrected, and DON/designee will report all audits during the QAPI meetings, and all | |

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| | effects associated with acetaminophen use, but Resident 40 and her daughter said she had one. They were unaware her 11/9/24 hospital discharge notes also referenced an acetaminophen allergy.<br><br>An interview was conducted with the DON on 5/29/25 at 11:04 a.m. She indicated Resident 40 informed staff during a previous care plan meeting, that she wasn't able to take acetaminophen, but it was not documented and addressed at the time but should have been.<br><br>An interview was conducted with the DON on 5/29/25 at 1:08 p.m. She indicated nursing was responsible for recognizing and addressing the documented acetaminophen allergy, when she came back from the hospital on 11/9/24.<br><br>The Medication Administration policy was provided by the DON on 5/29/25 at 11:01 a.m. It indicated, "Compare medication source (bubble pack, vial, etc.) with MAR to verify resident name, medication name, form, dose, route, allergy and time."<br><br>3.1-37(a) | | recommendations will be followed. | |
| F 0695 SS=D Bldg. 00 | 483.25(i)<br>Respiratory/Tracheostomy Care and Suctioning<br>Based on observation, interview, and record review, the facility failed to ensure a resident had an oxygen order for 1 of 2 residents reviewed for respiratory care. (Resident 28)<br><br>Findings include:<br><br>The clinical record for Resident 28 was reviewed on 5/28/25 at 11:49 a.m. The diagnoses included, but were not limited to, congestive heart failure | F 0695 | **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**<br>Resident #28 reviewed, and physician order obtained to keep oxygen PRN at bedside and at nighttime on 6/9/2025. Care plans have been revised and reflect PRN | 06/12/2025 |

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| | and chronic obstructive pulmonary disease (COPD).<br><br>A Quarterly Minimum Data Set (MDS) assessment, dated 5/1/25, indicated Resident 28 was cognitively intact for daily decision making.<br><br>During an observation of Resident 28 on 5/28/25 at 9:15 a.m., he was sitting on the edge of his bed with his oxygen tubing laying on the bed beside him and the oxygen concentrator was located beside the bed.<br><br>During an interview with Resident 28 on 5/28/25 at 12:15 p.m., he indicated he wore his oxygen at bedtime. The oxygen concentrator continued to be at the bedside.<br><br>During an observation on 5/29/25 at 8:40 a.m., Resident 28's oxygen machine continued to be at the bedside.<br><br>An order summary report provided by the Administrator, on 5/30/25 at 10:15 a.m., indicated Resident 28 did not have an order for oxygen.<br><br>A plan of care for Resident 28, dated 4/25/25, indicated the resident had a diagnosis of COPD and was at risk for shortness of breath. The interventions included, but were not limited to, administer oxygen per the physician's order.<br><br>During an interview with the Director of Nursing (DON) on 5/29/25 at 1:37 p.m., she indicated Resident 28 did not have a physician's order for oxygen. The DON indicated the oxygen may have been placed as a nursing measure when Resident 28 was having a CHF (congestive heart failure) flare up and was short of breath and he was never taken off the oxygen. The DON indicated the | | order (Attachment 14).<br>**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:**<br>All residents have the potential to be affected by the alleged deficient practice. A facility wide audit completed on 6/10/25 to ensure that all residents requiring oxygen therapy have physician orders in place (Attachment 15).<br>**What measures will be put in place and what systematic changes will be made to ensure that the deficient practice does not recur:**<br>All nurses will be in serviced on the use of oxygen therapy and physician orders by 6/12/2025 (Attachment 16).<br>**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:**<br>DON or designee will monitor current and all new admissions for oxygen therapy orders 5 times a week for 4 weeks, 3 times a week for 4 weeks, biweekly times for 2 months, and weekly times for 8 weeks. Ongoing thereafter during morning clinical meeting (Attachment 17).<br>Any findings will be immediately corrected, and DON/designee will report all audits during QAPI | |

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| | nursing staff should have removed the concentrator from the room when his oxygen was no longer needed.<br><br>An "Oxygen Administration Policy" was provided by the Administrator on 5/29/25 at 8:35 a.m. It indicated oxygen was administered under orders of a physician.<br><br>3.1-47(a)(6) | | meetings, and all recommendations will be followed. | |
| F 0921 SS=F Bldg. 00 | 483.90(i)<br>Safe/Functional/Sanitary/Comfortable Environ<br><br>Based on observation and interview, the facility failed to maintain the kitchen in a sanitary manner with a black substance on the walls lining the dish sink and failed to ensure the walk-in freezer was maintained from ice buildup. This had the potential to affect 49 of 51 residents who consumed food from the kitchen. (Facility)<br><br>Findings include:<br><br>During a tour of the kitchen with the Dietary Manager (DM) on 5/27/25 at 11:30 a.m., a black substance was noted all along the dish sink area beside the dishwasher. The black substance lined the entire length of the sink, and some were also noted underneath the soap dispenser on the wall above the sink area. The DM indicated the black substance had been behind the sink area for about two weeks and she was waiting for maintenance to clean and re-caulk the area.<br><br>During an observation of the walk-in freezer, there was an ice buildup lining the ceiling, walls, fans, floor, bags of food, and door handle. The DM indicated they recently fixed the motor on one of the fans in the freezer. So, before it was fixed, | F 0921 | **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**<br>The Dietary Manager cleaned the black substance that lined the entire length of the sink, underneath the soap dispenser on the wall above the sink area at time of observation. Maintenance re-caulked area at time of observation. The freezer items were removed and stored in other freezers while waiting on the unit to thaw out. When the unit reached the appropriate temperature, all items transferred back to the unit.<br>**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:**<br>Dietary Manager reeducated on cleanliness of kitchen and | 06/11/2025 |

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| (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 |
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| | there was water condensation built up on the walls and ceiling and with having the new fan fixed, it all froze. The DM indicated there was ice on the floor and she had to be careful whenever entering the freezer because the floor was slick. The DM indicated she needed to remove everything from the freezer in for it to thaw out, but did not have anywhere to hold the food while it was being done.<br><br>During an interview with the Director of Maintenance on 5/27/25 at 12:57 p.m., he indicated he did not know about the area of black substance lining the dish sink and it looked like it needed to be bleached. He indicated there was a plastic wall behind the sink, so everything seen was on the surface and he just needed to bleach and re-caulk it. The Director of Maintenance indicated he was unaware of the ice building up in the freezer since the fan was repaired, and it should not be freezing up. He indicated the facility needed to come up with a plan to remove all the items from the freezer long enough to let the freezer thaw out.<br><br>A "Sanitation Inspection Policy" was provided by the Administrator on 5/29/25 at 8:35 a.m. It indicated, "...4. Sanitation inspections will be conducted in the following manner: a. Daily: Food service staff shall inspect refrigerators/coolers, freezers daily...b. Weekly: The dietary manager shall inspect all food service areas are clean and comply with sanitation and food service regulations... 5. Inspections will be conducted but not limited to the following areas: b. freezer...e. Pot wash...h. General dietary observations..."<br><br>3.1-19(a) | | upkeep/maintenance of kitchen.<br>**What measures will be put in place and what systematic changes will be made to ensure that the deficient practice does not recur:**<br>The Dietary Manager will reeducate the food services department on cleaning policy and ice buildup in the freezer by 6/11/2025 (Attachment 18).<br>**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:**<br>The Dietary Manager/Designee will complete audits 5 times a week for 4 weeks, 3 times a week for 4 weeks, biweekly times 2 months and ongoing thereafter (Attachment 19).<br>Any findings will be immediately corrected, and the Dietary Manger will report all audits during QAPI meetings, and all recommendations will be followed. | |