STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155042	A. BUILDING 00 B. WING	10/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLOW MANOR	3801 OLD BRUCEVILLE ROAD, BOX 136 VINCENNES, IN 47591

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F 0000 Bldg. 00	This visit was for the investigation of Complaints IN00390618, IN00389593, and IN00383104. This visit included a COVID-19 Focused Infection Control Survey. Complaint IN00390618 - Substantiated. Federal/State deficiencies related to the allegations are cited at F880. Complaint IN00389593 - Substantiated. Federal/State deficiencies related to the allegations are cited at F804. Complaint IN00383104 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: October 3 & 4, 2022 Facility number: 000016 Provider number: 155042 AIM number: 100291500 Census Bed Type: SNF/NF: 96 Total: 96 Census Payor Type: Medicare: 34 Medicaid: 58 Other: 4 Total: 96 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed October 7, 2022.	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Ashli	Wesley	11/04/2022

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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F 0804 SS=E Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review, the facility failed to provide appetizing and palatable meals for 1 of 1 trays sampled on 1 of 3 units. Residents complained of cold food temperatures at meals and meals were served to residents below the facilities required temperature. (Locked Unit, Resident B, Resident C) Finding includes: 1. During an interview on 10/3/22 at 11:25 A.M., Resident B indicated the meals were, at times, served cold. 2. During an interview on 10/4/22 at 9:55 A.M., Resident C indicated the room trays sit on the food cart for too long before they are passed to residents, and that the food is served warm, not hot. 3. During an observation on 10/3/22 at 12:20 P.M., a sample tray from the Locked Unit cart was sampled. The sample tray food temperatures were as follows: Meat (pork) - 100 degrees Fahrenheit Beans - 115 degrees Fahrenheit	F 0804	**F804** **What Corrective Action(s) Will Be Accomplished for Those Residents Found to Have Been Affected by The Deficient Practice:** Resident's B & C had no noted adverse effects related to this alleged deficient practice. Resident's B & C will receive a meal tray with acceptable food temperatures. **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 receiving meal trays have the potential to be affected, no other residents were affected by this alleged deficient practice. **What Measures Will Be Put into Place and What Systemic**	11/03/2022

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	Tomatoes - 110 degrees Fahrenheit During an interview on 10/4/22 at 11:15 A.M.., the Dietary Manager (DM) indicated the facility was trying to get new carts to deliver the food trays to resident units. On 10/4/22 at 11:15 A.M., the DM supplied a facility policy titled Holding Hot & Cold Foods on Service Line, dated 6/2018. The policy included, "Foods will be held at proper temperature to ensure food safety. When holding foods for service... always remember to keep hot foods hot and cold foods cold. Hot-holding equipment must be able to keep foods at a temperature of 135 (degrees Fahrenheit) or higher..." This Federal tag relates to Complaint IN00389593. 3.1-21(a)(2)		**Changes Will Be Made to Ensure That the Deficient Practice Does Not Recur:** Food temperatures will be recorded at the beginning of tray line and the end of tray line. A test tray will be sent on each meal cart and tested at the end of passing meal trays. All nursing staff and dietary staff will be in-serviced over taking and recording food temperature and to not let trays sit on the food cart for to long before they are passed out. **How The Corrective Action(s) Will Be Monitored to Ensure the Deficient Practice Will Not Recur:** Dietary Manager/Designee will monitor food temperature logs at the beginning and end of tray line for 2 meals daily on scheduled workdays times 4 weeks, then 2 times per week times 4 weeks, then weekly times 2 months, then monthly times 2 months. Nurse/Designee will take and log food temperature of test tray of 2 meals daily on scheduled workdays times 4 weeks, then times per week times 4 weeks, then weekly times 2 months, then monthly times 2 months. Any negative findings will be forwarded to the Administrator and corrected immediately and will result in re-education and/or disciplinary action. A report of progress will be	

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			forwarded to the QAPI committee monthly for a minimum of 6 months and plan adjusted accordingly. **Date of Completion:** **11-03-2022**	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or			

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	infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			

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	Based on observation, interview, and record review, the facility failed to maintain infection control practices to mitigate the spread of COVID-19 during 1 of 2 observations of care, and during one random observation. Staff failed to remove a contaminated glove while providing care and a staff member failed to put on (don) the required personal protective equipment (PPE) prior to entering an isolation room. (Resident D, Resident K) Findings include: 1. During an observation on 10/3/22 at 12:15 PM., CNA 4 was assisting Resident D back to his contact/droplet isolation room. Prior to entering the room, CNA 4 donned a gown, gloves, and was already wearing an N95 mask. CNA 4 then entered the room without eye protection. During record review on 10/3/22 at 1:40 P.M., Resident D's physician orders included, but were not limited to; Strict Contact/Droplet Isolation due to COVID positive (started 9/23/22 with an end date of 10/4/22). During an interview on 10/3/22 at 12:25 P.M., RN 9 indicated that prior to entering a contact/droplet isolation room, staff should don a gown, gloves, an N95 facemask, and eye protection that forms a seal above the eyes. During an interview on 10/4/22 at 11:05 A.M., the Facility Administrator indicated they did not have a facility policy specific to donning PPE for isolation rooms, but that the facility followed the IDOH (Indiana Department of Health) COVID-19 toolkit. 2. During an observation on 10/4/22 at 9:45 A.M.,	F 0880	**F880** **What Corrective Action(s) Will Be Accomplished for Those Residents Found to Have Been Affected by The Deficient Practice:** Resident D is no longer on TBP and the facility has no current residents with COVID-19 at this time. Resident K now receives peri-care with proper infection control practices (i.e. hand hygiene) being followed. In-services held and staff educated on the proper PPE to wear, donning & doffing, isolation precautions and proper hand hygiene during peri care. Resident D and Resident K have not had any negative affects related to this 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:** Any residents with Covid and/or receiving peri-care from staff have the potential to be affected, no other residents were affected by this alleged deficient practice. In-services held and staff educated on the proper PPE to wear, donning & doffing, isolation precautions and proper hand hygiene during peri care.	11/04/2022

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	CNA 6 assisted Resident K to the restroom. CNA 6 donned gloves, assisted the resident with peri care, then without removing the gloves, assisted the resident back to his bed. CNA 6 then applied Resident K's oxygen by placing the oxygen tubing into the residents nares and around his ears still wearing the same gloves. During an interview on 10/4/22 at 10:30 A.M., the Infection Preventionist (IP) indicated staff should change gloves and perform hand hygiene following peri care. On 10/4/22 at 10:35 A.M., the DON (Director of Nursing) supplied a facility policy titled, Handwashing/Hand Hygiene, dated 8/2015. The policy included, "7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: ...h. Before moving from a contaminated body site to a clean body site during resident care..." This Federal tag relates to Complaint IN00390618. 3.1-18(b)(1) 3.1-18(l)		**What Measures Will Be Put into Place and What Systemic Changes Will Be Made to Ensure That the Deficient Practice Does Not Recur:** In-services held by Infection Preventionist, and staff educated on proper PPE with return demonstration, and isolation precautions along with proper signage and proper hand hygiene during peri care. A root cause analysis was completed. The LTC infection control self-assessment has been updated to reflect current status of facility. Staff will be educated regarding any area indicated on the facility assessment as an area of needed improvement. QIO (Indiana Q-Source) is being used as a resource/intervention. All newly hired staff will receive Infection Control Training during job orientation and all current staff will receive education on an ongoing quarterly basis and as needed. **How The Corrective Action(s) Will Be Monitored to Ensure the Deficient Practice Will Not Recur:** DON/Infection Preventionist/Designee will complete daily IC rounds. Non-compliance will be corrected immediately, and staff will be re-educated at that time. Staff found to repeatedly be out of compliance with infection control	

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			policies and procedures will receive disciplinary actions, up to termination, as deemed appropriate. The Infection Preventionist/Designee will report findings to the QAPI committee for 6 months. **Date of Completion: 11-04-2022**	