STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155022	A. BUILDING 00 B. WING	07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLOWS OF SHELBYVILLE	2309 S MILLER ST SHELBYVILLE, IN 46176

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00406333. Complaint IN00406333 - Federal deficiencies related to the allegations are cited at F550. Survey dates: July 20, 21, 24, 25, and 26, 2023 Facility number: 000009 Provider number: 155022 AIM number: 100274760 Census Bed Type: SNF/NF: 63 Total: 63 Census Payor Type: Medicare: 1 Medicaid: 47 Other: 15 Total: 63 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 3, 2023	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 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.			

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

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	§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on observation, interview, and record review, the facility failed to ensure a dignified environment for 2 of 2 residents reviewed for dignity. (Resident C and Resident D)	F 0550	**F550 Resident Rights/Exercise of Rights** **What corrective action (s) will be accomplished for those**	08/25/2023

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	Findings include: 1. An observation conducted of the memory care unit, on 7/24/23 at 12:37 p.m., noted Licensed Practical Nurse (LPN) 8 standing in front of Resident C. Resident C was yelling out loud and LPN 8 commented to Resident C "I'm gonna put you down". Resident C continued to yell, and LPN 8 then commented "let's put you to bed". Resident C was then assisted to lay down in his bed. An interview conducted with Housekeeping Staff 6, on 7/24/23 at 12:42 p.m., indicated it's common for Resident C to yell. She was unsure if it was related to his dementia or the fact that he was hard of hearing, or both. An interview conducted with LPN 8, on 7/24/23 at 12:50 p.m., indicated she would remove herself and reapproach a resident if they were difficult to redirect and then reapproach. 2. An observation of meal service was conducted on the memory care unit, on 7/25/23 at 12:00 p.m. LPN 8 was observed feeding Resident D his lunch. She was standing while assisting Resident D with his lunch. Resident D was sitting in his wheelchair and was at the height of LPN 8's hips. At 12:05 p.m., LPN 8 continued to stand while feeding Resident D. She would look down at Resident D while standing to his right side in an attempt to communicate with him. The clinical record for Resident D was reviewed on 7/26/23 at 3:10 p.m. The diagnoses included, but were not limited to, dementia, bipolar disorder, anxiety disorder, and arthritis.		**residents found to have been affected by the deficient practice?** Resident C and Resident D both had the potential to be affected by this alleged allegation, but no adverse effects were noted. LPN 8 was educated on the choice of words she chooses when speaking to residents. She works frequently with Resident C and can anticipate his wants and needs. He communicates in various ways d/t his cognition and staff must anticipate his wants and needs. After assisting him to bed he stopped yelling and was relaxing with his eyes closed. This was also observed by the state surveyor at the time of the incident. LPN 8 was also educated on the need to sit down to be at the level of the resident when assisting with meal consumption. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents residing in the facility have the potential to be affected by the alleged deficient practice. IDT met and reviewed behaviors for any patterns noted and for any psychosocial affects. No adverse effects were noted. **What measures will be put in**	

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	An admission minimum data set (MDS) assessment, dated 6/17/23, noted severe cognitive impairment and extensive assistance with one staff for eating. An interview conducted with the Director of Nursing (DON), on 7/26/23 at 1:42 p.m., indicated there was no facility policy for dignity. The expectations are for staff to be sitting down while assisting a resident with eating or whatever is comfortable for the resident or staff member. This Federal tag relates to Complaint IN00406333. 3.1-3(t)		**place or what systemic changes you will make to ensure the deficient practice does not occur.** The DON or designee will educate all nursing staff on or before 8/22/23 regarding the choice of words when speaking with residents and to ensure to be seated while assisting residents with meals in the dining room. **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?** DON or designee will do meal observations five times weekly for 2 weeks, biweekly for 6 weeks, and weekly for four months to ensure staff are seated at the level of resident when assisting with meals. Any identified deficiencies will be corrected upon discovery, ongoing education provided, and results reported to QA committee meeting overseen by the HFA. All recommendations by the committee are to be followed.	
F 0582 SS=D Bldg. 00	483.10(g)(17)(18)(i)-(v) Medicaid/Medicare Coverage/Liability Notice §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-			

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	(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice			

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	requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. Based on interview and record review, the facility failed to provide beneficiary notices for 1 of 3 residents reviewed. (Resident 8) Findings include: Beneficiary notifications were reviewed on 7/24/23 at 1:30 p.m. Resident 8's documentation indicated his Medicare part A skilled services began on 4/20/23 and the last day covered, of his part A services was 6/22/23. There was no explanation of how the Medicare part A was terminated. There was no indication a Notice of Medicare Non-Coverage or a Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage had been provided, or that a two day notice had been given. On 7/24/23, at 2:06 p.m., the Bookkeeper indicated she had taken his letters of the Notice of Medicare Non-Coverage and Skilled Nursing Facility Advanced Beneficiary to him, to explain it, and he was asleep so she never went back to talk to him. He was his own responsible person and he didn't receive either the Notice of Medicare Non-Coverage or a Skilled Nursing Facility Advanced Beneficiary. On 7/24/23 at 3:40 p.m., the Director of Nursing	F 0582	**F582 Medicaid/Medicare coverage/Liability Notice** **What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice.** Resident 8 had potential to be affected by the alleged allegation, but no adverse effects were noted. The bookkeeper was educated on the need to provide notification of termination of benefits two days prior to termination. If, resident is resting it is imperative to return to the resident later to notify of termination. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents who have Medicare Part A services in the facility have the potential to be affected by the alleged deficient practice. Medicare Part A liability notices were reviewed.	08/25/2023

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	indicated they don't have a policy for providing beneficiary notices, they follow the regulations. 3.1-4(f)(1)(3)		**What measures will be put into place or what systemic changes you will make to ensure the deficient practice does not occur?** The HFA or designee will educate bookkeepers on the regulation to notify of Medicare coverage termination. **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 into place?** HFA or designee will ensure that proper notification was given to each person whose coverage changes from Medicare A for 6 months. Any identified deficiencies will be corrected upon discovery, ongoing education provided, and results reported to QA committee meeting overseen by the HFA. All recommendations by the committee are to be followed.	
F 0584 SS=E Bldg. 00	483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide-			

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	§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. Based on observation and interview, the facility failed to ensure overhead light fixtures were free of dead insects for all 4 hallways in the facility. This had the potential to affect all 63 residents who resided in the facility.	F 0584	**F584** **Safe/Clean/Comfortable/Homelike Environment** **What corrective action (s) will be accomplished for those**	08/25/2023

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	Findings include: On 7/21/23, at 2:02 p.m., numerous dead insects were observed in 7 of the 8 overhead light fixtures on the Shelby hall. All 8 light fixtures on the Reed hall, and all 8 light fixtures on the Grover hall had numerous dead insects on the light covers. On 7/24/23 at 10:02 a.m., all the light fixtures on Shelby, Reed, and Grover, continued to have numerous dead insects on the light covers, On 7/25/23, at 10:03 a.m., all 3 halls continued to have numerous dead insects in the light fixtures. On 7/25/23 at 12:17 p.m., all the light fixtures on the memory care hallway had numerous bugs/pests located within each light. On 7/26/23, at 2:13 p.m., the Administrator indicated the light fixtures are typically cleaned when they see something in the light fixtures. On 7/26/23 at 3:40 p.m., the Director of Nursing indicated they don't have a policy for environment, that included cleaning light fixtures. 3.1-19(e)		**residents found to have been affected by the deficient practice?** The administrator removed the light fixtures that were noted to have dead insects in them and cleaned sconces prior to state surveyors exiting the building. Due to shadow effect of lighting the dead insects appeared to be much larger or numerous than what was actually in the light fixtures. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents residing in the facility have the potential to be affected by the alleged deficient practice. There were no residents with adverse effects from alleged deficient practice. All light fixtures in the facility were inspected and if found with dead insects they were removed and cleaned as appropriate. **What measures will be put into place or what systemic changes you will make to ensure the deficient practice does not occur?** HFA or designee will in service Maintenance staff on or before 8/22/23 of the importance of checking light fixtures on a routine basis for insects/pests.	

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			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 into place? HFA or designee will audit six light fixtures biweekly for 6 weeks and monthly for four months to ensure that insects are not in light fixtures. Any identified deficiencies will be corrected upon discovery, ongoing education provided, and results reported to QA committee meeting overseen by the HFA. All recommendations by the committee are to be followed.	
F 0585 SS=D Bldg. 00	483.10(j)(1)-(4) Grievances §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make			

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	information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal			

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	agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.	F 0585	**F585 Grievances**	08/25/2023

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	Based on interview and record review, the facility failed to file a grievance for a resident voicing missing items for 1 of 2 residents reviewed for missing personal property. (Resident 5) Findings include: The clinical record for Resident 5 was reviewed on 7/24/2023 at 11:15 a.m. The medical diagnosis included glaucoma. A Quarterly Minimum Data Set Assessment, 7/8/2023, indicated that Resident 5 had a cognitive impairment and did not hallucinate or have delusions. An interview with Resident 5 on 7/20/2023 at 11:45 a.m. indicated she had multiple missing items that included three pairs of missing socks and a pair of pajama bottoms. She stated they have been missing for at least a few weeks. She stated she had reported them to the housekeeping staff and during the most recent resident council. Review of resident council minutes, dated 7/3/2023, indicated that multiple residents indicated they had missing clothing items, included Resident 5 reporting she had missing cheetah print pants. This was listed as "found 7/6". An interview and observation on 7/24/2023 at 1:55 p.m. with CNA 3 indicated there were no cheetah print pants in Resident 5's room. An interview with Resident 5 on 7/26/2023 at 11:35 a.m. indicated they never found her cheetah print pants and never followed up with her after voicing her concern during the resident council meeting. She was never offered to file a grievance or		**What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident 5 had the potential to be affected by the alleged deficient practice, but no adverse effects were noted. A grievance form was filed for missing cheetah print pants and socks when surveyor mentioned to the facility staff. Resident did have a pair of cheetah print pants and socks found and returned to her previously. Resident now states it is a different pair of cheetah print pants and socks. The socks were located and returned to the resident. There is no note of the cheetah print pants on the inventory sheet. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents in the facility have the potential to be affected by the alleged deficient practice if they voice concern of missing items, no residents were found to have been affected by the alleged deficient practice. IDT met and reviewed the last resident council meeting notes to review any concerns with missing items. All items from the previous	

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	missing item report, but she would need assistance to do so due to her eyesight being poor from "glaucoma". A policy entitled, "Concern / Grievance Policy", was provided by the DON on 7/25/2023 at 3:05 p.m. The policy indicated, " ...If the resident verbally notifies a staff member of their concern/grievance, when possible, the staff will try to resolve the concern/grievance immediately. If due to the nature of the concern/grievance, it may not be resolved immediately by the staff member, the staff member should either fill out a grievance form for the resident or assist the resident in filling out the form..." 3.1-7(a)(2)		council meeting were found or replaced following the meeting. No further concerns were noted. **What measures will be put into place or what systemic changes you will make to ensure the deficient practice does not occur?** All staff will be in-serviced on the need to offer assistance in filing a grievance or filing one for the resident if they voice a concern of missing items. Resident council meetings are held monthly. The minute taker will notify the housekeeping supervisor of missing items immediately following the meeting. If, these items are not found after review of inventory sheet and initial search of items, housekeeping supervisor will notify administrator of need for grievance to be filed and state reportable. **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 into place?** DON or designee will do an audit after each resident council meeting to ensure that concerns are immediately addressed and that a grievance is filed as necessary for 6 months. Any identified deficiencies will be corrected upon discovery, ongoing	

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			education provided, and results reported to QA committee meeting overseen by the HFA. All recommendations by the committee are to be followed. The facility respectfully appeals this finding. Resident had a matching pair of cheetah print pajamas in her drawer. When facility was notified of missing pants the facility found matching set that were in drawer. Subsequently, facility was notified by surveyor of complaint of additional pair of missing pants. Upon notification facility initiated grievance form and attempted to located pants. Pants were not on resident inventory sheet to know if they were ever in the facility. Facility offered to buy resident a pair of pants as an act of goodwill. At all times facility followed grievance policy.	
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -			

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	(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on observation, interview, and record review, the facility failed to ensure a care plan was initiated for the utilization of a splint for 1 of 1	F 0656	**F656 Develop/Implement Comprehensive Care Plan** **What corrective action (s) will**	08/25/2023

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	resident reviewed for range of motion. (Resident 37) Findings include: An observation was conducted of Resident 37, on 7/20/23 at 12:26 p.m., to where no splint was in place to either hand. An observation, on 7/21/23 at 11:12 a.m., noted a splint to Resident 37's left hand. An observation, on 7/24/23 at 12:44 p.m., noted a splint to Resident 37's left hand. An observation, on 7/24/23 at 3:42 p.m., noted a splint to left hand. An interview conducted with Licensed Practical Nurse (LPN) 9, on 7/24/23 at 3:44 p.m., indicated Resident 37 has had the device on her left hand "for a while". Resident 37 wears the device so her hand doesn't close up. The resident would not open her left hand. An observation, on 7/25/23 at 9:24 a.m., noted no splint device to either hand. An observation, on 7/25/23 at 10:10 a.m., noted no splint device to either hand. The clinical record for Resident 37 was reviewed on 7/24/23 at 2:32 p.m. The diagnoses included, but were not limited to, dementia, impulse disorder, anxiety disorder, and delusional disorder. There were no physician orders for the utilization of a splint device for Resident 37's hand.		**be accomplished for those residents found to have been affected by the deficient practice?** Resident 37 had the potential to be affected by the alleged allegation, but no adverse effects were noted. A care plan was initiated for Resident 37 regarding a splint to her left hand. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents who utilize the use of splints have potential to be affected by the alleged deficient practice. 100% audit of care plans for all residents who utilize splints. If a resident who utilizes splints was found to not have a care plan in place the care plan was initiated or revised to reflect the use of a splint. **What measures will be put into place or what systemic changes you will make to ensure the deficient practice does not occur?** The ADON was educated on initiating a care plan for each new order of a splint. **How the corrective action (s) will be monitored to ensure the**	

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	There were no care plans in place for the utilization of a splint device to Resident 37's hand. A quarterly minimum data set (MDS) assessment, dated 6/12/23, indicated no impairment to the upper and lower extremities. An interview conducted with the Director of Nursing (DON), on 7/26/23 at 2:35 p.m., indicated there were no therapy notes for the utilization of a splint device for Resident 37. The device should have been initiated on a care plan. She believed Resident 37 has had the device for a "couple of months". A policy titled "COMPREHENSIVE CARE PLANNING", REVISED 7/24/19, was provided by the DON on 7/26/23 at 12:08 p.m. The policy indicated the following, "...a comprehensive person-centered care plan will be developed for each resident consistent with the Resident Rights...that meets his/her preferences, goals and addresses the resident's medical, physical, mental and psychosocial needs...." 3.1-35(a) 3.1-35(b)(1)		**deficient practice will not recur, i.e., what quality assurance program will be put into place?** DON or designee will do care plan audits on each new resident with a splint order for 6 months. Any identified deficiencies will be corrected upon discovery, ongoing education provided, and results reported to QA committee meeting overseen by the HFA. All recommendations by the committee are to be followed.	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on interview, observation, and record review, the facility failed to provide supervision and/or assistance for 3 of 3 residents observed for eating activities of daily living. (Resident 61,	F 0677	**F677 ADL care Provided for Dependent Residents.** **What corrective action (s) will be accomplished for those**	08/25/2023

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	Resident 31, and Resident 33). Findings include: 1. The clinical record for Resident 61 was reviewed on 7/24/2023 at 1:55 p.m. The medical diagnoses included acute kidney failure and obstructive uropathy. An Admission Minimum Data Set Assessment, dated 6/8/2023, indicated Resident 61 was cognitively impaired and was supervision for eating task. An activities of daily living care plan, dated for 6/2/2023, indicated that Resident 61 needed limited to extensive assistance of one staff member to eat. An observation on 7/21/2023 at 12:45 a.m. indicated Resident 61 was sitting in the main dining room with his meal tray in front of him. No staff were present in the dining room. He was attempting to eat his lunch, including a taco and ice cream. Resident 61 was trying to eat his taco with a spoon and dropped it on his shirt before attempting to eat his ice cream, which he also dropped upon his shirt. CNA 4 entered the dining room at 12:48 p.m. time and offered help to Resident 61 but he shook his head and began pushing himself away from the table. 2. The clinical record for Resident 31 was reviewed on 7/25/2023 at 11:33 a.m. The medical diagnoses included heart failure and dementia. A Quarterly Minimum Data Set Assessment, dated for 5/24/2023, indicated that Resident 31 was cognitively impaired and needed extensive assistance of one person for eating.		**residents found to have been affected by the deficient practice?** Residents 61, 31, and 33 had the potential to all be affected by the deficient practice, but no adverse effects were noted. The nursing staff were assisting other residents out of the dining room and helping those residents that need up to extensive assistance after attempting to consume their meal themselves and to maintain any independence that they may have left. Nursing staff offered assistance to all residents involved after the residents were done attempting to consume meal on their own. Resident 61 was finished eating, Resident 31 was assisted after he completed all he could, and Resident 33 was feeding herself. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents residing in the facility that need assistance with consuming meals have potential to be affected by the alleged deficient practice. All ADL care plans were reviewed for eating assistance and updated as needed. **What measures will be put into place or what systemic changes you will make to**	

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	An activities of daily living care plan, dated 4/8/2023, indicated that Resident 31 needed extensive assistance of one staff for eating. An observation on 7/21/2023 at 12:45 p.m. indicated Resident 31 was sitting in the back of the main dining room with an over the bed table with his lunch on it. No staff were present in the dining room. Resident 31 was not attempting to eat at this time. At 12:48 p.m., CNA 4 came into the dining room and went to Resident 61 before coming back to Resident 31. CNA 4 asked Resident 31 if he would like assistance eating. He nodded his head slightly and CNA 4 stood to the right of Resident 31 and began to assist him with eating. Resident 31 tolerated over 75% of his meal once he was assisted to eat. During an interview with the Director of Nursing on 7/26/2023 at 3:05 p.m., she indicated that at least one staff member should be in the dining room when residents are eating and residents should receive assistance with eating as needed. 3. An observation was conducted of meal service on 7/24/23 at 12:40 p.m. There were no nursing staff in the dining room and Resident 33 was consuming lunch by herself by utilizing her hands. An interview conducted with Housekeeping Staff 6, on 7/24/23 at 12:42 p.m., indicated she primarily works on the memory care unit. She indicated she will try to "keep an eye" on the residents during meal service if there are no nursing staff in the dining room. She understood she couldn't do anything "hands on" but just to lookout. The clinical record for Resident 33 was reviewed on 7/25/23 at 2:21 p.m. The diagnoses included, but were not limited to, dementia, multiple		**ensure the deficient practice does not occur?** An RN/LPN/QMA will be assigned to the dining room for each meal on the daily assignment sheet to ensure that supervision is maintained and that residents are assisted as needed with meals. All nursing staff will be educated on or before 8/22/23 on the need for someone to be in the dining room assisting residents with meal consumption and the assigned staff on the daily assignment sheet. **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 into place?** DON or designee will do meal observations five times weekly for 2 weeks, biweekly for 6 weeks, and weekly for four months to ensure dining room supervision and residents are being assisted with meals as needed. Any identified deficiencies will be corrected upon discovery, ongoing education provided, and results reported to QA committee meeting overseen by the HFA. All recommendations by the committee are to be followed.	

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	sclerosis, anorexia, and chronic pain. A quarterly minimum data set (MDS) assessment, dated 5/16/23, noted Resident 33 with severe cognitive impairment and the need for extensive assistance of one staff person with eating. An ADL care plan, revised 9/22/22, indicated Resident 33 was limited assist with eating. A nutrition care plan, revised 7/17/23, indicated to assist, as needed, for eating and drinking. An interview conducted with the Director of Nursing (DON), on 7/26/23 at 2:35 p.m., indicated the Activities Director does go to the memory care unit to assist with meals. Her expectations are for someone to be in the dining room when residents are eating. 3.1-38(a)(2)(D)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure the utilization of a gait belt during a transfer for 1 of 1 resident randomly observed. (Resident 30)	F 0689	**F689 Free of Accidents Hazards/supervision/devices** **What corrective action (s) will be accomplished for those residents found to have been**	08/25/2023

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	Findings include: A random observation was conducted of dining service on 7/24/23 at 12:46 p.m. Licensed Practical Nurse (LPN) 8 and Certified Nursing Assistant (CNA) 10 were present in the dining room. Resident 30 was assisted in her wheelchair to the lounge area, off of the dining room, and was assisted to a standing position by LPN 8 and CNA 10. One staff person had their arm going underneath Resident 30's left arm while the other staff was holding onto the back of Resident 30's pants during the transfer to a recliner. There was no gait belt utilized during the transfer for Resident 30 from wheelchair to bed. The clinical record for Resident 30 was reviewed on 7/26/23 at 11:24 a.m. The diagnoses included, but was not limited to, hypertension, dementia, and diabetes mellitus. A quarterly minimum data set (MDS) assessment, dated 4/20/23, indicated severe cognitive impairment along with extensive assistance for transfers with 2 staff persons. A care plan for fall risk, revised 5/9/23, indicated to assist resident, as needed, with care, transfers, and ambulation. A care plan for activities of daily living (ADLs), revised 5/9/23, indicated Resident 30 was extensive assist with one staff person for transfer status. An interview with the Director of Nursing (DON), on 7/26/23 at 2:35 p.m., indicated nursing staff should utilize a gait belt as needed. A policy titled "Gait Belt Policy and Procedure",		**affected by the deficient practice?** Resident 30 had the potential to be affected by the alleged deficient practice, but no adverse effects were noted. DON spoke with LPN 8 and CNA 10 regarding the surveyor's desire for a gait belt to be utilized for the transfer of Resident 30. The staff believe that they followed facility protocol. Resident 30 is an extensive assistance of 1 staff member for transfers. LPN 8 and CNA 10 utilized 2 staff members for an extensive transfer of the resident. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents residing in the facility have the potential to be affected by the alleged deficient practice, no residents were found to be affected by the alleged deficient practice. Care plans were reviewed and updated as needed for transfers. **What measures will be put into place or what systemic changes you will make to ensure the deficient practice does not occur?** All nursing staff will be in-serviced on or before 8/22/2023 regarding the need to utilize a gait belt for	

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	undated, was provided by the DON on 7/26/23 at 12:08 p.m. The policy indicated the following, "...The Gait Belt may be used when lifting, ambulating, or transferring residents. It is not to be used as a restraint in the wheelchair, chairs of any kind or in bed...." 3.1-45(a)(1) 3.1-45(a)(2)		transfers as needed. **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 into place?** DON or designee will observe 2 transfers 5 times weekly for two weeks, biweekly for 6 weeks, and weekly for four months. Any identified deficiencies will be corrected upon discovery, ongoing education provided, and results reported to QA committee meeting overseen by the HFA. All recommendations by the committee are to be followed. The Facility respectfully appeals this finding. The MDS assessment cited in the 2567 showed one time that an assist of two was needed when transferring the resident within the seven day look back period. The resident required an equal amount of assistance in the look back of limited and extensive. As mentioned in the 2567 the resident was care planned for extensive assistance of one person. This transfer actually occurred with two people, providing additional assistance and safety than what the resident was care planned for. The only mention of gait belts in the state operations manual says in pertinent part, "*Assistive*	

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			Devices for Transfer - Mechanical assistive devices for transfer include, but are not limited to, portable and stationary total body lifts, sit-to-stand devices, and transfer or gait belts. The resident assessment helps to determine the resident's degree of mobility and physical impairment and the proper transfer method; for example, whether one or more caregivers or a mechanical device is needed for a safe transfer". The most recent assessment does not indicate a need for a gait belt for transfer, nor is the resident care planned for one or the facility policy indicating its need. The resident has had one fall in the previous twelve months with the only fall occurring during a self-transfer.	
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized			

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WILLOWS OF SHELBYVILLE	2309 S MILLER ST SHELBYVILLE, IN 46176

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	unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on interview and record review, the facility failed to document the outputs as careplanned for a resident with an indwelling urinary catheter for 1 of 1 residents reviewed for urinary catheters. (Resident 61) Findings include: The clinical record for Resident 61 was reviewed on 7/24/2023 at 1:55 p.m. The medical diagnoses included acute kidney failure and obstructive uropathy. An Admission Minimum Data Set Assessment, dated 6/8/2023, indicated Resident 61 was cognitively impaired and had an indwelling urinary catheter.	F 0690	**F690 Bowel/Bladder Incontinence, catheter, UTI** **What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident 61 had the potential to be affected by the deficient practice, but no adverse effects were noted. Resident outputs were reviewed, and output documentation was placed on EMAR. **How will you identify other residents having the potential to be affected by the same deficient practice and what**	08/25/2023

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	A catheter care plan, dated for 6/2/2023, indicated for Resident 61 to have his urinary catheter bag emptied every shift and as needed and to document the output. Review of the outputs for Resident 61 for 7/11/2023 through 7/15/2023, indicated outputs were only documented once on 7/11/2023 for a volume of 400 ml, twice on 7/12/2023 with a combined 900 ml, once on 7/13/2023 with a volume of 100 ml, documented three times for 7/14/2023 for a total of 900 ml, and twice on 7/15/2023 for a total of 2925 ml. An interview with CNA 5 on 7/21/2023 at 2:01 p.m. indicated that they are supposed to empty Resident 61's catheter at the end of every shift and document it. If he doesn't have much output, they are supposed to tell the nurse. She stated they do not always get the chance to document because they are busy with other things like resident care. During an interview with the DON on 7/26/2023 at 1:45 p.m., she indicated they do not have a policy for documenting urinary outputs for a resident with a catheter. 3.1-41(a)(2)		**corrective action will be taken?** All residents residing in the facility who have an indwelling catheter have the potential to be affected by the alleged practice, no residents were affected by the alleged deficient practice. All residents with an indwelling catheter were reviewed and output documentation was placed on EMAR for RN/LPN/QMA to document outputs. **What measures will be put into place or what systemic changes you will make to ensure the deficient practice does not occur?** The DON or designee will educate all nursing staff on or before 8/22/23 regarding documenting urinary outputs from an indwelling urinary catheter Q shift. **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 into place?** DON or designee will audit those residents with indwelling catheters 5 times weekly for two weeks, biweekly for 6 weeks, and weekly for four months for documentation of urinary outputs Q shift. Any identified deficiencies will be corrected upon discovery, ongoing education provided, and results reported to QA committee meeting	

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			overseen by the HFA. All recommendations by the committee are to be followed.	
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on observation, interview, and record review, the facility failed to ensure water pitchers were available for resident utilization for 2 of 3 residents reviewed for hydration. (Resident 52 and Resident D) Findings include: 1. The following observations were conducted of Resident 52 not having a water pitcher available for use:	F 0692	**F692 Nutrition/Hydration Status Maintenance** **What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident 52 and Resident D had the potential to be affected by the alleged deficient practice, but no adverse effects were noted.	08/25/2023

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	7/20/23 at 11:51 a.m., 7/21/23 at 11:16 a.m., 7/24/23 at 12:40 p.m., 7/24/23 at 3:38 p.m., & 7/25/23 at 10:11 a.m. The clinical record for Resident 52 was reviewed on 7/26/23 at 3:00 p.m. The diagnoses included, but were not limited to, dementia, schizophrenia, edema, major depressive disorder, and cerebrovascular disease. A significant change minimum data set (MDS) assessment, dated 5/17/23, noted Resident 52 with severe cognitive impairment along with the need for extensive assistance with one staff for eating. A constipation care plan, revised 6/5/23, indicated to offer and encourage fluids for an intervention. An activities of daily living (ADL) care plan, revised 6/5/23, indicated Resident 52 required extensive assistance with one staff for eating. 2. The following observations were conducted of Resident D not having a water pitcher available for use: 7/20/23 at 2:30 p.m., 7/21/23 at 11:19 a.m., 7/24/23 at 12:47 p.m., 7/24/23 at 3:40 p.m., & 7/25/23 at 10:12 a.m. The clinical record for Resident D was reviewed on 7/26/23 at 3:06 p.m. The diagnoses included, but were not limited to, dementia, bipolar disorder, anxiety disorder, and arthritis.		Resident 52 has a hoarding behavior, and she tends to hide and or move her water pitcher in her bathroom and her drawers. Resident D's family brings in certain water cups for him and he will take the cup to the dining area and common areas with him. Fresh water pitchers were given to each resident. Cameras were viewed of hallways and water pitchers had been replenished during the night and dayshift hours. These residents both move independently and can move their pitchers on their own. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents residing in the facility have the potential to be affected by the alleged deficient practice, no residents were found to be affected by the alleged deficient practice. All nursing staff will be educated on or before 8/21/23 for passing water pitchers nightly and replenishing water pitchers during the day and evening shifts. **What measures will be put into place or what systemic changes you will make to ensure the deficient practice does not occur?** Fresh water pitchers will be	

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	An admission MDS assessment, dated 6/17/23, noted Resident D with severe cognitive impairment along with the need for extensive assistance with one staff for eating. A nutrition care plan, revised 7/17/23, indicated the intervention for assistance with eating and drinking as needed. A care plan for constipation, revised 7/13/23, indicated the intervention to offer and encourage fluids. An activities of daily living (ADL) care plan, revised 7/13/23, indicated the following, "Interventions...Eating: Resident is able to feed self or requires to be fed by staff...." An interview conducted with Licensed Practical Nurse (LPN) 9, on 7/24/23 at 3:36 p.m., indicated the water pitchers are located in the staff breakroom. The pitchers are cleaned daily and exchanged out every night. There were no residents currently that were on thickened liquids that would be a consideration on not leaving water pitchers in their rooms. An interview conducted with the Director of Nursing (DON), on 7/26/23 at 2:35 p.m., indicated Resident D's family will come in and give certain cups and Resident 52 does take her water pitcher and move it. A policy titled "HYDRATION OF RESIDENTS POLICY", undated, was provided by the DON on 7/26/23 at 12:08 p.m. The policy indicated the following, "...All residents will be assessed regularly for risk of dehydration. Hydration will be maintained by provision of fluids through meal service, juice and/or what given with		passed nightly, and a CNA will be assigned, on the CNA daily assignment sheet, to pass ice on both dayshift and evening shift. **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 into place?** DON or designee will ensure that ice has been passed 5 times weekly for two weeks, biweekly for 6 weeks, and weekly for four months. Any identified deficiencies will be corrected upon discovery, ongoing education provided, and results reported to QA committee meeting overseen by the HFA. All recommendations by the committee are to be followed. The facility respectfully appeals this finding. Both residents are mobile and capable of moving their own water pitchers as explained to state surveyor. Facility reviewed hallway cameras to ensure that ice and water was being passed. As shown in the exhibits 1, 2, 3, and 4 staff member was passing ice and water, specifically showing to Resident 52's room on 7/20 at a time of 15:45, 7/21 at 11:22, 7/24 at 10:38, and 7/25 at 14:47. Facility camera system was one hour ahead so the times water was being passed were 14:45,	

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	administration of medication, replenishing water pitchers on each tour of duty and offering juice or water throughout the day...PROCEDURE...Place water carafe and drinking glass by bedside (unless contraindicated by physician order) and encourage resident to drink frequently...." 3.1-46(b)		10:22, 9:38, and 13:47 respectively. All showing the residents cited were in fact receiving hydration as required.	
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			

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	identify possible communicable diseases or 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			

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	necessary. Based on observation, interview, and record review, the facility failed to ensure hand hygiene was performed between contact with multiple residents during dining service. (Resident D and Resident 11) Findings include: A dining observation was conducted on the memory care unit on 7/25/23 at 12:00 p.m. Licensed Practical Nurse (LPN) 8 was observed assisting Resident D with consuming his lunch. LPN 8 then went to encourage and assist Resident 11 with taking bites of food without performing hand hygiene before or after. LPN 8 then proceeded to return back to Resident D to continue to assist with his lunch by giving him bites of food. No hand hygiene was performed before returning to Resident D to assist with consuming lunch. An interview conducted with the Director of Nursing (DON), on 7/26/23 at 2:35 p.m., indicated the expectations are for nursing staff to perform hand hygiene between contact with other residents. A policy titled "HANDWASHING POLICY", undated, was provided by the DON on 7/26/23 at 2:34 p.m. The policy indicated the employee should wash his/her hands routinely after each direct resident contact. 3.1-18(l)	F 0880	**F880 Infection Prevention and Control** **What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident D and Resident 11 both had the potential to be affected by the alleged deficient practice, but no adverse effects were noted. LPN 8 was educated on the need to perform hand hygiene between assisting residents with meal consumptions. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents residing in the facility have the potential to be affected by the alleged allegations if he/she is assisted in consuming meals at mealtimes, no residents were found to been affected by the alleged deficient practice. IDT reviewed the hand washing monitoring tool. to verify if patterns were noted. No patterns noted during review. **What measures will be put into place or what systemic changes you will make to ensure the deficient practice does not occur?**	08/25/2023

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			The DON or designee will educate all nursing staff on or before 8/22/23 of the Handwashing Policy that states that the employee should wash his/her hands routinely after each direct resident contact. **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 into place?** DON or designee will observe a meal 5 times weekly for two weeks, biweekly for 6 weeks, and weekly for four months. Any identified deficiencies will be corrected upon discovery, ongoing education provided, and results reported to QA committee meeting overseen by the HFA. All recommendations by the committee are to be followed.	