STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155535	A. BUILDING 00 B. WING	09/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLOW CROSSING HEALTH & REHABILITATION CENTER	3550 CENTRAL AVE COLUMBUS, IN 47203

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00384291 and IN00387239. Complaint IN00384291 - Substantiated. Federal/state deficiencies related to the allegations are cited at F584. Complaint IN00387239 - Unsubstantiated due to lack of evidence. Unrelated deficiency cited. Survey dates: September 15 and 16, 2022 Facility number: 000572 Provider number: 155535 AIM number: 100267710 Census Bed Type: SNF/NF: 69 Total: 69 Census Payor Type: Medicare: 4 Medicaid: 63 Other: 2 Total: 69 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on September 23, 2022.	F 0000	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under the state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey. Due to the low scope and severity of the survey findings, please find the sufficient documentation providing evidence of compliance with the plan of correction. Should additional information be necessary to confirm said compliance, feel free to contact me.	
F 0584 SS=D Bldg. 00	483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment.			

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

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

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	The 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- §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.			

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	Based on observation, interview and record review, the facility failed to provide housekeeping services necessary to maintain a sanitary, orderly, and comfortable homelike environment for 3 of 16 resident rooms reviewed. (Residents E, R, G, and D) Findings include: 1. During an observation on 9/15/22 at 10:10 a.m., Resident R's room had black dirt debris under the bed next to the door. There was black dirt debris and dried black spots at the end of each bed. There was dirt and food debris around the perimeter of the room. There was dirt debris between the closets, walls, and along the front of the closets. 2. During an observation on 9/15/22 at 1:06 p.m., Resident G's room had dried food from breakfast and dirt debris throughout the floor. During an observation and interview on 9/15/22 at 1:06 p.m., Resident G's family member indicated he does not sit in a chair in his family member's room. "The staff never clean them." The resident's other family member indicated the room was always dirty when she came to visit. 3. During an observation and interview on 9/15/22 at 1:38 p.m., Resident D's bathroom toilet had dried stool on the back of the seat. The floor had multiple brown spots and dirt debris in the floor. The resident's family members indicated the bathroom "looked like that yesterday." A deep cleaning schedule for resident rooms was provided by the Administrator on 9/15/22 at 1:24 p.m. The schedule indicated Resident D's room had been deep cleaned from 9/11/22 through	F 0584	F584 The facility must provide housekeeping services necessary to maintain a sanitary, orderly, and comfortable homelike environment. 1. No residents were harmed. Resident R, G, D had their rooms deep cleaned. The dining room was deep cleaned. 2. All resident rooms and living areas have the potential to be affected. An initial facility observation was done by the Administrator or designee to identify any resident rooms or resident areas that were in need of a deep clean. Those areas were deep cleaned first in the facility. 3. The Policy and Procedure on deep cleaning resident rooms and resident areas was reviewed with no changes made to the policy. The facility housekeeping staff was re-educated on the policies/procedures and schedule for deep cleaning a resident room and other resident areas in the facility. (See attachment A). The other facility staff was educated on reporting and following up on any housekeeping concerns noted in the facility, or reported by residents or families (See attachment B). The facility will now use a housekeeping communicator to communicate housekeeping concerns that can't be handled by nursing personnel to the housekeeping department. (see attachment C)	10/13/2022

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	9/14/22. During an interview on 9/16/22 at 11:29 a.m. Resident D's family member indicated the room was cleaner today than yesterday, but she had to clean food and some dried brown spots from the floor where her family member sat. In an interview on 9/15/22 at 10:52 a.m., the Housekeeping Supervisor indicated she had one staff in at 6:00 a.m. and one staff in at 8:00 a.m. They usually cleaned the four bathrooms (two public and two employee), the breakroom, the front lobby, the nurses' station, and the pantry. Then when breakfast was done, they cleaned the dining room (wiped tables, swept, and mopped), before they cleaned the resident rooms. The Supervisor acknowledged there was dried food debris on the edges of the tables, food debris, dirt, and dead bugs in the corners and around the perimeter of room. There was no schedule for deep cleaning the dining room. Staff just deep cleaned when it needed done. At 2:03 p.m., the Housekeeping Supervisor indicated she was not sure if the deep clean procedure was on a document, but she tells staff to dust the light fixture, blinds, pull out the furniture, sweep and mop. During an interview on 9/15/22 at 1:52 p.m., Housekeeper 6 indicated she was still learning, but the daily cleaning routine in the residents rooms was to go in and spray the bathroom with a sanitizing cleaner. While the bathroom was soaking, she would wipe the door knobs; dust the window sill; dust the the heat and air vents, and the TV area. She would then clean the bathroom, and then sweep and mop the entire room. The current facility Deep Clean check off list and a		4. All resident rooms, care areas, and common areas will be observed by the Administrator or designee. The administrator or designee will observe all rooms that were scheduled for a deep clean to ensure appropriate completion. If there are noted to be any areas that need cleaned, or any area that needs service, the appropriate steps will be taken to correct the issue at the time of observation. The Administrator or designee will complete an observation tool to document the findings 5 times weekly for four weeks, then three times weekly for four weeks, then 2 times weekly for four weeks, then quarterly thereafter to ensure resident rooms and living areas are clean. (See attachment D) The observation tools will be reviewed during the facility Quality Assurance meetings and the plan of correction will be adjusted accordingly. 5. The above corrective measures will be completed on or before 10/13/2022	

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	Daily Cleaning Check Off List and not dated was provided by the Housekeeping Supervisor on 9/15/22 at 2:24 p.m. The Deep Clean list indicated, " ...Bedroom ...move bed and sweep behind ...move dressers and sweep behind ...Bathroom ...clean toilet." The Cleaning Check Off List indicated, " ...Room ...Dust blinds ...sweep/Dust Mop Floors ...Wet Mop Floors & Under Bed ...Bathroom ...Clean/Disinfect Toilets Inside & Out ...Dust mop floors ...Wet mop floors ..." This Federal tag relates to Complaint IN00384291. 3.1-19(f)			
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			

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	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 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			

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	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. Based on observation and interview, the facility failed to ensure appropriate infection control guidelines were followed related to TBP (Transmission Based Precautions) for 4 of 8 staff observed for Infection Control. (CNA 2, CNA 3, CNA 4, and Receptionist) Findings include: 1. a. During an observation and interview on 9/15/22 at 10:02 a.m., Certified Nurse Aide (CNA) 2 entered Resident E's room without donning Personal Protective Equipment (PPE). At 10:06 a.m., CNA 2 was providing care for Resident E and she had her mask under her nose. She was observed without a N95, gown, gloves, or eye protection. CNA 2 indicated she did not know why the resident was on isolation. An interview on 9/15/22 at 10:06 a.m., with the Administrator she indicted the resident was on isolation since she was a new admit and not up to date with her vaccines. All staff were to follow the appropriate PPE for TBP posted on the isolation room doors. b. During an observation and interview on 9/15/22 at 10:08 a.m., CNA 3 entered Resident E's room without donning Personal Protective Equipment PPE. CNA 3 indicated staff were to don a gown and gloves when entering an isolation room.	F 0880	F880 Requires that the facility ensures appropriate infection control guidelines are followed related to TBP for Infection Control. 1. No residents were harmed. Resident E had no negative outcome. The CNAs were re-educated on proper PPE at the time of awareness. 2. All residents have the potential to be affected. All residents who were in isolation were reviewed with no problems observed. A root cause analysis was conducted with the IP with input from the facility's medical director, IP and DON. The facility LTC infection control assessment was reviewed. 3. The facility policy and procedure on Isolation and PPE were reviewed with no changes made to the policy. The facility staff was re-educated with information on the policy provided by the IP on PPE usage, handwashing, make use and return demonstration on DON and Doff PPE was completed. (See attachment B). 4. All residents who are in isolation will be observed by the	10/13/2022

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	c. During an observation and interview on 9/15/22 at 10:11 a.m., CNA 4 entered Resident E's room without donning PPE. CNA 4 indicated she did not know the reason the resident was on isolation. 2. During an observation on 9/15/22 at 12:45 p.m., the receptionist was sitting at the screen-in table at the entrance to the facility. Her mask was under her nose. An interview on 9/15/22 at 12:46 p.m., with the Receptionist she indicated the facility policy was to wear the mask over the nose and staff were to use hand sanitizer after touching their mask. Centers for Disease Control and Prevention. Infection Control: Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html. Accessed September 19, 2022. Personal Protective Equipment: "Health Care Providers (HCP) who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a NIOSH-approved N95 or equivalent or higher-level respirator, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face).		Administrator or designee to ensure that staff are wearing proper PPE in resident rooms requiring isolation, that masks are being worn appropriately, and that proper sanitization is occurring when a staff touches their mask. The Administrator or designee will complete an observation monitoring tool to ensure this is occurring. The tool will be completed five times weekly for four weeks, then twice weekly for four weeks, then every week for two months, then monthly thereafter to ensure compliance. (See attachment E). The audit will be reviewed during the facility Quality Assurance meetings and the plan of correction will be adjusted accordingly. 5. The above corrective measures will be completed on or before 10/13/2022.	