STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155089	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willows of New Castle	1023 N 20th St New Castle, IN 47362

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28309 Based on interview and record review, the facility failed to ensure 2 of 2 residents diagnosed with Clostridium difficile infection (c-diff) were receiving care which included thorough and accurate assessments on a routine basis and the documentation of the assessments reflected the thorough assessments and resident status. (Residents B and C) Findings include: 1. The clinical record of Resident B was reviewed on 1-7-25 at 2:32 p.m. Her diagnoses included, but were not limited to, a history of urinary tract infections (UTI), systemic inflammatory response syndrome (SIRS), Alzheimer's disease and generalized muscle weakness. A hospital discharge summary, dated 11-12-24, indicated she was diagnosed with a c-diff infection upon admission to the hospital on 11-7-24. She returned to the facility on [DATE]. A review of the progress notes and Nursing Infection Charting ATB [antibiotic] daily assessments, dated 11-12-24 through 11-19-24, was conducted. The documentation failed to address the stooling status, such as the presence of watery type diarrhea, foul-smelling or mucous-type stools or presence of abdominal pain, nausea, vomiting or change in appetite for Resident B on 11-12-24 at 11:03 p.m., 11-13-24 at 1:40 a.m., 11-13-24 at 11:51 a.m., 11-17-24 at 5:19 p.m., 11-18-24 at 1:56 p.m., 11-18-24 at 9:28 p.m., and 11-19-24 at 12:57 a.m. Additionally, the clinical record documentation failed to identify Resident B was in contact isolation, related to c-diff, on 11-13-24 at 1:40 a.m., 11-16-24 at 4:58 p.m., 11-17-24 at 5:19 p.m., 11-18-24 at 6:23 a.m., 11-18-24 at 9:28 p.m. and 11-19-24 at 12:57 a.m. The clinical record failed to identify the date of the initiation of contact isolation or the date it ended. A review of the Infection Control Surveillance, information for November 2024, indicated Resident B was started on an antibiotic for c-diff on 11-13-24, but did not specify she was on isolation of any type. During an interview with the Director of Nursing (DON) on 1-8-25 at 12:18 p.m., she indicated the documentation from the nursing staff, related to Resident B's c-diff, appeared to be put in briefly and was more hit and miss. I would expect the documentation to be detailed. (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the DON on 1-9-25 at 11:19 a.m., she indicated the Infection Preventionist's (IP) notation for Resident B indicated the resident was identified with c-diff, on 11-13-24, upon her return from the hospital and was placed in isolation on that date; isolation was discontinued on 11-18-24, per physician orders. The facility's guidelines for continuation of isolation were until the antibiotic was completed. It is a case-by-case basis from the facility's doctors as to how long the person stays in isolation, based on the status of their stools being solid and their antibiotic. Generally, they error on the side of caution. The DON indicated the former IP left employment about a week before Christmas, with no notice. Additionally, the DON indicated she was out for surgery around the same time the former IP left employment and was trying to get some of the paperwork done from home. In an interview with the DON on 1-9-25 at 3:50 p.m., she indicated her expectations for the assessments for c-diff to be thorough and conducted at least daily. 2. The clinical record of Resident C was reviewed on 1-8-25 at 2:17 p.m. His diagnoses included, but were not limited to, unspecified dementia, ulcerative colitis, diabetes, a history of severe sepsis with septic shock, gastrointestinal hemorrhage, noninfective gastroenteritis and colitis, and prior noncompliance with other medical treatment regimen due to an unspecified reason. A progress note, dated 12-21-24, indicated Resident C had experienced frequent, loose, watery, and foul smelling stools, and a stool sample was sent out to determine if he had c-diff. He was placed in contact isolation, pending the results of the stool sample. A notation the following day, 12-22-24, indicated the stool sample was positive for c-diff and the resident remained in contact isolation. It indicated Resident C was placed on an oral medication for 14 days to treat the c-diff infection. A review of the progress notes and Nursing Infection Charting ATB [antibiotic] daily assessments, dated 12-22-24 through 1-7-25, was conducted. The documentation failed to address the stooling status, such as the presence of watery type diarrhea, foul-smelling, or mucous-type stools, or presence of abdominal pain, nausea, vomiting or change in appetite for Resident C on 12-23-24 and 1-6-25. Additionally, the clinical record documentation failed to identify Resident C was in contact isolation, related to c-diff on 12-23-24. A progress note, dated 1-7-25, indicated the contact isolation had been discontinued. A review of the Infection Control Surveillance, information for December 2024, indicated Resident C's c-diff infection was not located on the Monthly Infection Surveillance Report. In an interview with the DON on 1-9-25 at 11:19 a.m., she indicated Resident C's c-diff diagnosis was not added to the infection surveillance log like it should have been. During an interview with the DON on 1-9-25 at 9:30 a.m., she indicated it appeared as if Resident C's clinical record documentation, related to the c-diff infection started out pretty good, but the quality of the documentation and frequency of the documentation of the assessments went downhill. I would expect the documentation, and assessments should remain of a high quality throughout the resident's care needs. The assessments should be at least twice daily for c-diff and address the number and quality of the stooling, as well as any abdominal pain or discomfort. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the DON on 1-9-25 at 11:19 a.m., she indicated the facility's guidelines for continuation of isolation was until the antibiotic was completed. It is a case-by-case basis from our doctors as to how long the person stays in isolation, based on the status of their stools being solid and their antibiotic. Generally, they error on the side of caution. The DON indicated the former Infection Preventionist (IP) left employment about a week before Christmas, with no notice. Additionally, the DON indicated she was out for surgery around the same time the former IP left employment and was trying to get some of the paperwork done from home. In an interview with the DON on 1-9-25 at 3:50 p.m., she indicated her expectations for the assessments for c-diff infections are they will be thorough and conducted at least daily. On 1-9-25 at 9:15 a.m., the Administrator provided a copy of an undated policy entitled, Management of C. Difficile Infection. It indicated, This facility implements facility-wide strategies for the prevention and spread of Clostridium difficile (C. difficile) infections .Licensed nurses may implement preemptive contact precautions when C. difficile infection is suspected, pending results of testing. Once confirmed, contact precautions shall be implemented in accordance with a physician order and facility policy for transmission-based precautions . This citation relates to Complaint IN00449670. 3.1-37(a)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28309 Based on interview and record review, the facility failed to ensure 2 of 2 residents reviewed for urinary tract infections (UTI), received prompt treatment for complaints of dysuria (painful urination), urine culture and sensitivity reports be reviewed with the medical provider for accuracy related to the proper medications be ordered to treat the identified organisms, and their daily nursing assessments related to their diagnosis are thorough and accurate. (Resident B and D) Findings include: 1. The clinical record of Resident B was reviewed on 1-7-25 at 2:32 p.m. Her diagnoses included, but were not limited to, a history of urinary tract infections (UTIs), systemic inflammatory response syndrome (SIRS), Alzheimer's disease and generalized muscle weakness. 1.a. A review of the progress notes, dated 12-19-24 at 10:42 p.m., indicated a urinalysis with a culture and sensitivity (C&S) request was obtained from Resident B and sent to the lab for analysis on 12-20-24 at 5:58 a.m. An entry, dated 12-22-24 at 8:49 a.m., indicated the facility had received a new physician's order for Cipro (antibiotic) 500 milligrams (mg) to be administered twice daily for seven days for a UTI. The corresponding urinalysis report, including the C&S report, indicated the urine sample had been received by the laboratory on 12-21-24 at 5:21 a.m. The C&S report indicated the urine sample analysis identified the organisms present were a high level of Escherichia coli (e-coli) and low level of Enterococcus faecalis. It indicated these organisms were resistant to Ciprofloxacin, Levofloxacin and Trimethoprim/Sulfamethoxazole. It indicated these organisms were susceptible to 14 common antibiotics. During an interview with the Director of Nursing (DON) on 1-9-25 at 2:20 p.m., she indicated she was unable to address why the Cipro was started for this resident's UTI when the C&S showed it was resistant to Cipro. She indicated one of the nurses should have caught this and notified the doctor or NP (nurse practitioner) of this. I will check with the doctor to see how he wants to handle this. The DON indicated this occurred around the time she was off work for surgery and the Infection Preventionist (IP) and the Assistant Director of Nursing (ADON) had left employment. 1.b. A hospital discharge summary, dated 11-12-24, indicated Resident B was diagnosed with a UTI upon admission to the hospital on 11-7-24. She returned to the facility on [DATE]. A review of the progress notes and Nursing Infection Charting ATB [antibiotic] daily assessments, dated 11-12-24 through 11-19-24, was conducted. The documentation failed to address the urinary status, such as the color and shade of the urine, any urinary odors, clarity of the urine, presence of blood, mucus, or sediment in Resident B's urine on 11-12-24 at 11:03 p.m., 11-13-24 at 1:40 a.m. and 11-18-24 at 9:28 p.m. During an interview with the DON on 1-9-25 at 3:50 p.m., she indicated her expectations for the assessments for UTI's to be thorough and conducted at least daily. 2. The clinical record of Resident D was reviewed on 1-9-25 at 11:05 a.m. Her diagnoses included, but were not limited to, diabetes with neuropathy, unspecified mild dementia, and a history of urinary tract infections (UTIs). (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident D's progress notes reflected she had completed intravenous antibiotic therapy on 12-22-24 for a UTI. It indicated, on 12-26-24, Resident D was reporting blood in her urine and the attending physician ordered for a urinalysis with culture and sensitivity (C&S) testing to be obtained. A notation, on 12-31-24, indicated a urine sample had been obtained and was awaiting the laboratory to pick up the sample. Another entry, dated 12-31-24, indicated Resident D had tested positive for Covid-19 and was ordered to begin a regimen of the anti-viral medication, Paxlovid. Another entry, dated 1-1-25, indicated a second urine sample had been obtained for this resident and was to be sent to the laboratory for analysis. It did not indicate the reason for a second sample. During an interview with the DON on 1-9-25 at 2:20 p.m., she indicated the attending physician for Resident D, does not like to order any antibiotics when someone is on Paxlovid. That is my guess as to why he wouldn't have ordered an antibiotic for the UA [urinalysis] of 1-1-25. The lab had requested a repeat urine from the 12-31-24 urine sent to them as to why it was repeated on 1-1-24. I can't answer as to why there was a delay in getting her urine, from 12-26-24 until 12-31-24. Again, this was during the time frame that I was out of the office, and we had recently had the ADON [Assistant Director of Nursing] and IP [Infection Preventionist] leave employment. Again, one of the nurses should have caught this and gotten it done. It looks like there was a lapse in documentation, so have no idea if she was having blood in her urine or dysuria. During an interview with the DON on 1-9-25 at 3:50 p.m., she indicated the facility does not have a specified policy on documentation. She indicated her expectations for the assessments for UTI's to be thorough and conducted at least daily. This citation relates to Complaint IN00449670. 3.1-41(a)(2)