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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155158	A. Building B. Wing	11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of the Willows	1000 Elizabeth Dr Valparaiso, IN 46383

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 32582 Based on observation and interview, the facility failed to ensure resident's privacy was maintained related to the electronic medication record left open and unlocked in the hallway during medication pass for 2 of 5 residents observed during medication pass. (Residents 113 and 6) Finding includes: On 11/8/24 at 8:15 a.m., LPN 1 was observed passing medications to Resident 113. She prepared the medications in the hallway on the East Hall cart using the electronic medication record on the computer. She then took the medications to the resident in his room. The computer screen was left open and on, leaving the residents medications and personal information available to view. At 8:25 a.m., LPN 1 returned to the East Hall cart and prepared medications for Resident 6. She then took the medications to the resident in his room and again left the computer screen open and unlocked with personal information available to view in the hallway. During an interview on 11/8/24 at 8:37 a.m., LPN 1 indicated she should have locked the screen but didn't know how to unlock it. During an interview on 11/8/24 at 8:44 a.m., the Director of Nursing indicated that computer screens should be locked when the nurse walked away and she would speak to the nurse. 3.1-3(p)(2)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 45666 Based on record review and interview, the facility failed to ensure care plans were implemented for 1 of 19 resident care plans reviewed. (Resident 9) Finding includes: Resident 9's record was reviewed on 11/8/24 at 10:20 a.m. Diagnoses included, but were not limited to, senile degeneration of the brain and dementia. The Quarterly Minimum Data Set (MDS) assessment, dated 10/14/24, indicated the resident was severely cognitively impaired for daily decision making. She required maximal to total dependence on staff for activities of daily living (ADL) care. She received antipsychotic, anti-anxiety, antidepressant, and opioid medications. She was on hospice care. The November 2024 Physician Order Summary indicated Resident 9 received morphine sulfate (opioid pain medication) 20 milligram/milliliter (mg/ml), 5 mg by mouth every two hours as needed. The resident was to be observed for opioid medication side effects every shift. There were no care plans related to pain and opioid use. During an interview on 11/12/24 at 3:50 p.m., the Director of Nursing indicated there were no care plans for pain and opioid use in the current care plan for the resident. 3.1-35(c)(1)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 32582 Based on observation, record review, and interview, the facility failed to ensure a resident with a pressure ulcer received the necessary treatment and services to promote healing related to a treatment not provided as ordered for 1 of 3 residents reviewed for pressure ulcers. (Resident 39) Finding includes: On 11/8/24 at 10:40 a.m., wound care for Resident 39 was observed with the Infection Prevention (IP) Nurse. The resident had a stage 4 pressure ulcer to her sacrum. She was in bed and turned onto her right side. The nurse removed the old dressing and cleansed the wound with wound wash, patted the area dry and checked measurements. She then applied skin prep to the skin surrounding the wound and applied an antimicrobial gel to the wound bed. She then packed the wound with calcium alginate and covered the area with an island border dressing. The resident's record was reviewed on 11/7/24 at 3:31 p.m. Diagnoses included, but were not limited to, diabetes mellitus, adult failure to thrive, and a stage 4 pressure ulcer to sacral region. The Quarterly Minimum Data Set assessment, dated 8/1/24, indicated the resident had significant cognitive impairment, required substantial assistance for bed mobility, and had a stage 4 pressure ulcer present on admission. A Physician's Order, dated 7/18/24, indicated wound care to coccyx was to be provided three times weekly. Cleanse coccyx with wound wash and pat dry. Apply skin prep to periwound. Apply a thin layer of germ shield to the wound bed, apply one packet of collagen to wound bed, cover wound bed with silver alginate, and apply a small foam dressing. During an interview on 11/8/24 at 11:14 a.m., the IP Nurse indicated she had just reviewed the Physician Orders and she would redo the treatment for the resident. 3.1-40(a)(2)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 32664 Based on observation, record review, and interview, the facility failed to ensure a nutritional supplement was offered during meal service and food consumption logs were completed for a resident with a history of weight loss for 1 of 2 residents reviewed for nutrition. (Resident 5) Finding includes: On 11/13/24 at 1:07 p.m., Resident 5 was seated at a table in a wheelchair in the Assisted Dining Area. The resident had a meal tray in front of her which included mashed potatoes, ground meatballs with gravy, vegetables, and ice cream. There was no bowl of soup observed. The resident's meal ticket had Super Soup written on the ticket. Record review for Resident 5 was completed on 11/12/24 at 10:45 a.m. Diagnoses included, but were not limited to, stroke, diabetes mellitus, hypertension, dementia, and end stage renal disease. The Quarterly Minimum Data Set (MDS) assessment, dated 8/1/24, indicated the resident was cognitively impaired. The resident had an impairment on one side of her upper and lower extremities for a functional limitation in range of motion. The resident required a partial moderate assistance with eating. The resident also had a feeding tube and a mechanical therapeutic diet. A Care Plan, dated 1/10/24 and revised 8/2/24, indicated the resident was a nutritional risk due to hypertension, diabetes mellitus, anemia, depression, and dementia. The resident received tube feeding for nutrition and hydration. The resident received a therapeutic mechanically altered diet. Interventions included to provide supplements and diet as ordered to promote better nutritional value and to monitor intake and record every meal. The November 2024 Physician's Order Summary indicated the following orders: - Glucerna (diabetic nutritional supplement) via enteral feed, on at 8:00 p.m. and off at 8:00 a.m. - mechanically altered diet - fortified (nutrients added to them that don't naturally occur in the food) soup at lunch and supper The resident's weight on 5/1/24 was 136.2 lbs (pounds). On 11/4/24, the resident weighed 120.2 lbs. This was a weight loss of 11.75% (percent) in 6 months. A Nutrition/Dietary Note, dated 11/12/24, indicated the resident's weight was stabilizing for the past 3 weeks. The resident recently had fortified soup added for lunch and supper meals. The Task Meal Consumption Logs were documented with percentage of meals eaten. The last 30 days lacked documentation for the following meals: - Breakfast on 10/31/24 (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Lunch on 10/21, 10/31, and 11/7/24 During an interview on 11/13/24 at 1:07 p.m., CNA 1 indicated the resident did not normally receive soup at meal times that she was aware of. During an interview on 11/13/24 at 1:08 p.m., LPN 1 indicated she was unaware if the resident was supposed to receive any fortified soup and would look up the orders. She proceeded to look up the resident's order and indicated the resident did have an order for fortified soup at lunch and should have received it. During an interview on 11/13/24 at 1:14 p.m., the Dietary Manager indicated she would review the resident's meal consumption logs to see the percentage of meals the residents ate. The staff were expected to document percentages of every meal eaten. The meal percentages eaten were important to review to decide if the resident's enteral feeding would need to be adjusted. The resident had an order change recently for fortified soup at lunch and supper. She had hand written Super Soup on the resident's meal ticket. The cook should have put the fortified soup on the resident's meal tray for lunch and did not. 3.1-46(a)(1) 3.1-46(a)(2)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 32582 Based on observation, record review, and interview, the facility failed to ensure infection control measures were implemented related to hand hygiene during medication pass for 2 of 5 residents observed during medication pass. (Residents 113 and 6, and LPN 1) Finding includes: On 11/8/24 at 8:15 a.m., LPN 1 was observed passing medications to Resident 113. There was no hand hygiene observed prior to medication preparation. She gave the medications to the resident in his room and returned to the medication cart to prepare medications for Resident 6. There was no hand hygiene observed. After the medications had been poured into the medication cup, she used hand sanitizer. The nurse then took the medications to Resident 6 in his room. She returned to the medication cart and did not perform hand hygiene. During an interview on 11/8/24 at 8:37 a.m., LPN 1 indicated she thought she only had to wash her hands after every third resident. During an interview on 11/8/24 at 8:44 a.m., the Director of Nursing indicated the nurses had hand sanitizer that should be used and they should wash their hands after every third resident unless they touched something. The policy, Hand Hygiene, dated 7/15/22, indicated, . Associates perform hand hygiene (even if gloves are used) in the following situations: a. Before and after contact with the resident . c. After contact with objects and surfaces in the resident's environment 3.1-18(l)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. 32582 Based on record review and interview, the facility failed to promote antibiotic stewardship by ensuring the appropriate use of antibiotic therapy to reduce antibiotic resistance related to not following up on urine culture results in a timely manner for 1 of 2 residents reviewed for urinary tract infections. (Resident 40) Finding includes: Resident 40's record was reviewed on 11/12/24 at 1:11 p.m. Diagnoses included, but were not limited to, vascular dementia, major depression, and a history of urinary tract infections (UTIs). The Quarterly Minimum Data Set assessment, dated 9/23/24, indicated the resident was cognitively intact and was dependent on staff for toileting assistance. The resident had been on antibiotics during the assessment period. A Health Status Note, dated 10/14/24, indicated the resident was sent to the hospital to be evaluated for vaginal bleeding. The resident returned to the facility later that day with an order for an antibiotic related to a UTI. A Physician's Order, dated 10/14/24, indicated to give ciprofloaxin (an antibiotic) 500 milligrams (mg), twice daily for seven days for a UTI. A Request for Hospital Records had been faxed to the hospital on 10/16/24 requesting the results of the urine culture and sensitivity (a report that indicates which antibiotics are effective). There were no additional requests for the test results or documentation the hospital had been contacted regarding the test results. The Medication Administration Record indicated the resident began ciprofloaxin on 10/14/24 and completed the medication on 10/21/24. A Health Progress Note, dated 10/22/24, indicated an order had been received from the hospital for cefuroxime 500 mg twice daily for seven days. The urine culture and sensitivity results indicated the infection was resistant to ciprofloaxin. The resident complained of pain to the right side and her urine was dark amber colored. The Urine Culture results, dated 10/17/24, indicated the infection was resistant to ciprofloaxin and susceptible to cefuroxime. The results were not faxed to the facility until 10/22/24. During an interview on 11/12/24 at 2:30 p.m., the Infection Prevention Nurse indicated they did not have access to the hospitals records or test results and had to request them by fax. It would often take several requests to get the results sent over. There was no additional information provided related to additional requests made or follow up related to the test results. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The policy, Antibiotic Stewardship, dated 5/16/24, indicated, .The antibiotic stewardship program promotes the appropriate use of antibiotics and includes a system of monitoring to improve resident outcomes and reduce antibiotic resistance. This means that the antibiotic is prescribed for the correct indication, dose and duration to appropriately treat the resident while also attempting to reduce the development of antibiotic resistant organisms