STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155210	A. Building B. Wing	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willows of Greensburg	410 Park Rd Greensburg, IN 47240

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. 38239 Based on observation, interview, and record review, the facility failed to follow manufacturer's guidelines related to insulin pen usage (Residents 35), and failed to follow physician's orders related to hold parameters for a blood pressure medication (Resident 52) for 2 of 7 residents reviewed for quality of care. Findings include: 1. Medication administration was observed on 05/29/24 at 9:03 A.M., with RN 3. The RN retrieved an Insulin Aspart pen and a Basalgar insulin pen from a plastic bag and indicated Resident 35 was to receive 15 units of the Aspart (a short-acting insulin) and 30 units of Basalgar (a long-acting insulin). The nurse applied needles to both pens but did not cleanse the rubber seals with an alcohol wipe before attaching the needles. She turned the dials at the end of the pens to the appropriate doses and then dialed up an additional 3 units per pen to prime the pens. The RN held the pens sideways and primed both pens, cleansed the resident's skin and administered the insulin. During an interview following the medication administration, the RN indicated she should have cleansed the pens with alcohol before attaching the needles. She usually held the insulin pens sideways when she primed them. The clinical record for Resident 35 was reviewed on 05/29/24 at 9:45 A.M. A Quarterly MDS (Minimum Data Set) assessment, dated 03/18/24, indicated the resident was moderately cognitively impaired. The resident's diagnoses included, but were not limited to, diabetes and stroke. The current facility policy, titled Insulin Pen, and dated 07/23, was provided by the DON (Director of Nursing) on 05/30/24 at 10:40 A.M. The policy indicated, .Insulin pens will be primed prior to each use to avoid collection of air in the insulin reservoir .wipe the rubber seal with an alcohol pad .With the needle pointing up, push the plunger, and watch to see that at least one drop of insulin appears on the tip of the needle . 2. The clinical record for Resident 52 was reviewed on 05/28/24 at 10:53 A.M. An Admission MDS assessment, dated 03/19/24, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, stroke, hypertension, and diabetes. The resident's current physician's orders included an opened-ended order, with a start date of 03/22/24, for lisinopril (a blood pressure medication), 10 mg (milligrams) once a day. The medication was to be held if the resident's SBP (Systolic Blood Pressure) was less than 110. (continued on next page)

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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NAME OF PROVIDER OR SUPPLIER Willows of Greensburg		STREET ADDRESS, CITY, STATE, ZIP CODE 410 Park Rd Greensburg, IN 47240	

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The March, April, and May 2024 EMARs (Electronic Medication Administration Records) were reviewed and indicated the medication was administered daily. The resident's record lacked documentation of the resident's blood pressure prior to the medication administration for 52 of 69 days reviewed: - 03/22/24, - 03/25/24 through 04/01/24, - 04/05/24 through 04/07/24, - 04/10/24, - 04/12/24 through 04/14/24, - 04/16/24, - 04/19/24 through 05/01/24, - 05/03/24 through 05/08/24, - 05/10/24 through 05/13/24, - 05/15/24, - 05/17/24 through 05/22/24, and - 05/24/24 through 05/29/24. During an interview on 05/30/24 at 8:36 A.M., QMA (Qualified Medication Aide) 4 indicated if a resident had a hold parameter ordered for a medication, they were to check the resident's blood pressure or heart rate before they gave the medication. If the blood pressure or heart rate was too low, they were to hold the medication and document it in the EMAR. The current facility policy, titled Medication Administration, dated 07/2023, was provided by the DON on 05/30/24 at 2:04 P.M. The policy indicated, .Obtain and record vital signs, when applicable or per physician's orders. When applicable, hold the medication for those vital signs outside the physician's prescribed parameters . 3.1-37(a) 3.1-48(a)(3)

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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. 50498 Based on observation, interview, and record review, the facility failed to provide resident education related to urinary catheter care related to risk of placement for 1 of 2 residents reviewed for urinary catheters. (Resident 29) Findings include: During an observation on 05/29/24 at 12:48 P.M., Resident 29 was self-transferring to their wheelchair in their room. The urinary catheter bag was hanging on the right side of the wheelchair under the arm rest above the resident's waist. During an observation on 05/29/24 at 1:14 P.M., the resident was sitting in her wheelchair with her urinary catheter bag hanging off the right side of the wheelchair under the arm rest above the resident's waist in the main dining room. During an observation 05/29/24 at 3:35 P.M., the resident was in the public bathroom by the main entrance doors, emptying her urinary catheter bag into the toilet while she was sitting in her wheelchair. During an observation on 05/30/24 at 10:08 A.M., the resident was sitting at the nurse's station in their wheelchair with their urinary catheter bag under the right-side arm rest of the wheelchair. During an interview on 05/23/24 at 2:04 P.M., the resident indicated she had a urinary catheter. The urinary catheter bag was usually placed on the side of wheelchair under the right-side handle. During an interview on 05/30/24 at 3:18 P.M., the resident indicated she did their own urinary catheter care. During an interview with CNA (Certified Nurse Aide) 2 on 05/30/24 at 2:40 P.M., she indicated Resident 29 usually provided her own urinary catheter care and would call for assistance with getting dressed as needed. The resident usually needed help to complete her shower. Usually, the staff would ask the resident if she needed help with catheter care and the resident had already done it. The staff had gone in the resident's room today to empty the urinary catheter bag and she had already emptied it herself. The CNA indicated the typical placement of the resident's urinary catheter bag was clipped onto the side under her armrest. The urinary catheter bags were supposed to be hung underneath the wheelchair, but the resident liked it on the side of her wheelchair because it was easier for her to access. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the DON (Director Of Nursing) on 05/30/24 at 2:54 P.M., she indicated therapy usually worked with the residents for providing their own urinary catheter care. They would educate the residents on admission related to the urinary catheter care and placement of the urinary catheter bag. She had not documented education with the resident related to her urinary catheter care or placement of the urinary catheter bag, it was usually something they just went over with them verbally. She was unsure if the residents would be care planned for the education and providing their own urinary catheter care. She indicated residents that provide their own catheter care should have been educated on the proper placement or risk of placement of the catheter bag. During an interview with the DON 05/30/24 at 3:41 P.M., she indicated she could not provide any documentation for the resident's education related to urinary catheter care and urinary catheter bag placement. The clinical record for the resident was reviewed on 05/28/24 at 9:32 P.M. The Quarterly MDS (Minimum Data Set) assessment, dated 02/26/24, indicated the resident was moderately cognitively impaired. The resident's diagnoses included, but were not limited to, neuromuscular dysfunction of bladder and diabetes. The resident required staff supervision with toileting. The facility's Infection tracking and trending documents were reviewed on 05/30/24 at 9:36 A.M. The documents indicated the resident had a confirmed UTI on 02/12/24 and 12/06/23. A Progress Note, dated 02/29/24 at 11:09 P.M., indicated the resident had reported a significant amount of leakage from the urinary catheter. There was a large amount of sediment in the tubing and entry holes at the tip of the catheter when changed. A current physician's order, with the start date of 12/13/23, indicated that staff were to provide Foley catheter care every shift. A current physician's order, with the start date of 05/12/24, indicated the resident had a Foley catheter due to neuromuscular dysfunction of the bladder. The clinical record lacked documentation that the resident was educated on proper urinary catheter bag placement related to bladder level. The resident lacked a care plan for self-catheter bag placement and self-catheter care. The current facility policy titled Catheter Care dated 07/23 was provided by DON on 5/30/24 at 2:04 P.M. The policy indicated, .is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care . 3.1-41(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. 38239 Based on observation, interview, and record review, the facility failed to follow infection control guidelines related to indwelling urinary catheters for 1 of 2 residents reviewed for urinary catheters. (Resident 51) Findings include: On 05/23/24 at 11:43 A.M., Resident 51 was observed in his wheelchair in the main dining room. The resident's urinary catheter drainage bag was in a dignity pouch. The drainage bag and pouch were hanging from his wheelchair, with the bottom of the pouch resting on the dining room floor. On 05/24/24 at 10:01 A.M., the resident was in his room sitting in a recliner. The resident's catheter drainage bag was hanging from his wheelchair and not in a dignity pouch. The bottom of the residents catheter drainage bag was resting directly on the floor. The resident indicated he had not had the urinary catheter for very long. On 05/28/24 at 10:41 A.M., the resident was in his room in bed. The resident's catheter drainage bag was in a dignity pouch. The bag and pouch were laying in a plastic wash basin on the floor. The resident's record was reviewed on 05/28/24 at 11:57 A.M. An Admission MDS (Minimum Data Set) assessment, dated 02/19/24, indicated the resident was moderately cognitively impaired. The resident's diagnoses included, but were not limited to, Parkinson's disease, dementia, diabetes, BPH (benign prostatic hyperplasia) and history of bladder cancer. The resident's current physician's orders included an open ended order, with a start date of 05/12/24, for the resident to utilize an indwelling urinary catheter for obstructive uropathy. On 05/30/24 at 10:59 A.M., the resident was observed with CNA (Certified Nurse Aide) 2. The resident was in his room in bed. The bed was in a lower position, and the catheter drainage bag and dignity pouch were hanging on the side of his bed, with the bottom of the drainage bag hanging out of the dignity pouch and resting directly on the floor mat. CNA 2 indicated the drainage bag and pouch should not touch the floor. She adjusted the bag on the bed so that it didn't touch the floor or the floor mat. During an interview on 05/30/24 at 2:54 P.M., the DON (Director of Nursing) indicated the facility did not have a policy on catheter bag placement, but staff knew that catheter bags should be off the floor. 3.1-18(b)