STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155228	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willows of Richmond	2070 Chester Blvd Richmond, IN 47374

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28309 Based on interview and record review, the facility failed to maintain resident records that were accurately documented for each resident's oral hygiene and meal intakes for 3 of 3 residents reviewed for Activities of Daily Living (ADL's), specific to meal intakes and oral hygiene. (Residents B, C and D) Findings include: 1.a. The clinical record of Resident B was reviewed on [DATE] at 9:32 a.m. Her diagnoses included, but were not limited to, high blood pressure, age-related debility, lung cancer, a history of bladder cancer and pulmonary emboli (blood clots in the lungs) and chronic pain syndrome. It indicated she did not leave the facility during her admission, until her death on [DATE]. A review of her meal intakes indicated the facility utilized an electronic health record (EHR) to document the meal intakes for Resident B. The documentation for [DATE], through 28, 2024, indicated the following dates and meals were undocumented, as represented by a blank block in the EHR: -[DATE]: dinner. -[DATE]: dinner. -[DATE]: dinner. The documentation for [DATE], through 28, 2024, for meal intakes for Resident B had multiple choices in the EHR. The legend provided by the EHR for meal intakes were identified as the following: -0, or intake of ,d+[DATE] percent (%) of meal intake. -1, or ,d+[DATE]% of meal intake. -2, or ,d+[DATE]% of meal intake. -3, or ,d+[DATE]% of meal intake. -97, reflected, Not Available. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155228	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willows of Richmond	2070 Chester Blvd Richmond, IN 47374

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-98, reflected Resident Refused. -99 which indicates Resident Not Available. The following meal intakes were identified as, 97, or not available: -[DATE]: breakfast and lunch. -[DATE]: breakfast and lunch. -[DATE]: breakfast and lunch. -[DATE]: breakfast, lunch and dinner. -[DATE]: breakfast and lunch. -[DATE]: breakfast and lunch. -[DATE]: breakfast. -[DATE]: breakfast and lunch. -[DATE]: dinner. -[DATE]: dinner. -[DATE]: breakfast and lunch. -[DATE]: breakfast. -[DATE]: dinner. -[DATE]: breakfast and lunch. In an interview with the Regional Nurse Consultant on [DATE] at 4:34 p.m., she indicated if a resident refuses a meal or declines a meal, meal documentation in the EHR should reflect this as a refusal. She indicated each resident is offered three meals daily. In an interview on [DATE] at 10:30 a.m., with the MDS (Minimum Data Set) Coordinator, she indicated for the graph that depicts the meal intakes for each resident, she identified the first section represented breakfast, the second section represented lunch and the third section represented dinner, with the remaining sections, she did not know what those represented. The sections for breakfast, lunch and dinner were not identified on the actual graph. 1.b. The EHR indicated three (3) choices of yes, no, or Resident Refused, for oral care provision by facility staff, related to, Task [oral care] Completed. In an interview with the Regional Nurse Consultant on [DATE] at 4:36 p.m., she indicated the frequency in which oral care should be offered is three (3) times a day or on each shift. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155228	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willows of Richmond	2070 Chester Blvd Richmond, IN 47374

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident B's oral care provision, as documented in the EHR, for [DATE], through 28, 2024, was as follows: -[DATE]: received 2 times. -[DATE]: received once. -[DATE]: received 2 times. -[DATE]: received once with one resident refusal. -[DATE]: received 2 times with one resident refusal. -[DATE]: received 2 times. -[DATE]: received 2 times. -[DATE]: received once. -[DATE]: received once. -[DATE]: received 2 times. -[DATE]: received once with one resident refusal. -[DATE]: received once. -[DATE]: nothing documented. -[DATE]: nothing documented. -[DATE]: received 2 times. -[DATE]: received 2 times. -[DATE]: received 2 times. -[DATE]: received once with one resident refusal. -[DATE]: received 2 times. -[DATE]: received 2 times. -[DATE]: received 2 times. -[DATE]: received 2 times. -[DATE]: received 2 times. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155228	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willows of Richmond	2070 Chester Blvd Richmond, IN 47374

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-[DATE]: received once with one resident refusal. -[DATE]: received 0 times with two resident refusals. -[DATE]: received 2 times. -[DATE]: received 2 times. -[DATE]: received 2 times. 2.a. The clinical record of Resident C was reviewed on [DATE] at 11:19 a.m. Her diagnoses included, but were not limited to, fracture of the left humerus (arm bone), chronic pain syndrome, high blood pressure, atrial fibrillation (irregular heart rhythm), cerebral infarction (stroke) and schizoaffective disorder bipolar type. A review of her meal intakes indicated the facility utilized an electronic health record (EHR) to document the meal intakes for Resident C. The documentation for [DATE] through 30, 2024, indicated the following dates and meals were undocumented, as represented by a blank block in the EHR: -[DATE]: lunch. -[DATE]: dinner. The documentation for [DATE] through 30, 2024, for meal intakes for Resident C had multiple choices in the EHR. The legend provided by the EHR for meal intakes were identified as the following: -0, or intake of ,d+[DATE] percent (%) of meal intake. -1, or ,d+[DATE]% of meal intake. -2, or ,d+[DATE]% of meal intake. -3, or ,d+[DATE]% of meal intake. -97, reflected, Not Available. -98, reflected Resident Refused. -99 which indicates Resident Not Available. The following meal intakes were identified as, 97, or not available: -[DATE]: breakfast. -[DATE]: breakfast. -[DATE]: breakfast. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155228	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willows of Richmond	2070 Chester Blvd Richmond, IN 47374

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-[DATE]: breakfast. -[DATE]: breakfast and lunch. -[DATE]: breakfast. -[DATE]: breakfast. -[DATE]: breakfast and lunch. -[DATE]: breakfast. In an interview with the Regional Nurse Consultant on [DATE] at 4:34 p.m., she indicated if a resident refuses a meal or declines a meal, meal documentation in the EHR should reflect this as a refusal. She indicated each resident is offered three meals daily. In an interview on [DATE] at 10:30 a.m., with the MDS Coordinator, she indicated for the graph that depicts the meal intakes for each resident, she identified the first section represented breakfast, the second section represented lunch and the third section represented dinner, with the remaining sections, she did not know what those represented. The sections for breakfast, lunch and dinner were not identified on the actual graph. 2.b. The EHR indicated three (3) choices of yes, no, or Resident Refused, for oral care provision by facility staff, related to, Task [oral care] Completed. In an interview with the Regional Nurse Consultant on [DATE] at 4:36 p.m., she indicated the frequency in which oral care should be offered is three (3) times a day or on each shift. Resident C's oral care provision, as documented in the EHR, for [DATE], through [DATE], was as follows: -[DATE]: received 2 times. -[DATE]: received 2 times. -[DATE]: received 2 times. -[DATE]: received 2 times. -[DATE]: received once. -[DATE]: received 2 times. -[DATE]: received 2 times. -[DATE]: received 2 times. -[DATE]: received 4 times. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155228	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willows of Richmond	2070 Chester Blvd Richmond, IN 47374

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-[DATE]: received 2 times. -[DATE]: received 3 times. -[DATE]: received 2 times. -[DATE]: received 2 times. -[DATE]: received 2 times. -[DATE]: received 2 times. -[DATE]: received 2 times. -[DATE]: received 2 times. -[DATE]: received 3 times. -[DATE]: received 2 times. -[DATE]: received 2 times. -[DATE]: received 3 times. -[DATE]: received once. -[DATE]: received 2 times. -[DATE]: received 2 times. -[DATE]: received 3 times. -[DATE]: received 2 times. -[DATE]: received 2 times. -[DATE]: received 2 times. -[DATE]: received once. -[DATE]: received once. -[DATE]: received once. 3.a. The clinical record of Resident D was reviewed on [DATE] at 10:54 a.m. His diagnoses included, but were not limited to, rhabdomyolysis (muscle breakdown), pulmonary fibrosis, urinary tract infection (UTI), heart failure, history of a fall, a wedge compression fracture of the second lumbar vertebra. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155228	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willows of Richmond	2070 Chester Blvd Richmond, IN 47374

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident D's meal intakes indicated the facility utilized an electronic health record (EHR) to document the meal intakes for Resident D. In an interview with the MDS Coordinator on [DATE] at 2:30 p.m., she indicated the current EHR does not specify what meal is being documented, it only demonstrates what time the staff member inputs the meal intake information. She indicated she has to kind of guess which meal is being documented, such as breakfast, lunch or dinner, by the time the information is placed into the EHR system. The documentation for [DATE], through [DATE], indicated the following dates and meals were unclearly documented, as represented by unclear time frames or lack of documentation of which meal was being documented in the EHR: -[DATE]: Meals documented at 12:03 p.m., and 1:56 p.m., by CNA 4, indicated, Resident Not Available. Two meals documented by CNA 3 as an intake of ,d+[DATE]% twice at 8:05 p.m., and 8:19 p.m. -[DATE]: Dinner meal documented by CNA 5, at 8:48 p.m., as intake of ,d+[DATE]%, and a second intake at 8:49 p.m., by CNA 5, indicated, Resident Refused. -[DATE]: All meal intakes documented by CNA 6, at 12:14 a.m., twice, and twice at 11:34 p.m. by CNA 6, indicated, Not Applicable. -[DATE]: Only two entries at 8:39 p.m., by CNA 3, indicated meal intakes of ,d+[DATE]%. -[DATE]: Meal intakes documented by the MDS Coordinator at 9:00 a.m. and 1:00 p.m., but no further meal documentation for the day. -[DATE]: No meal documentation for this date. -[DATE]: Meal documentation for an early breakfast, due an appointment, at 5:52 a.m., was completed by CNA 7. The only other documentation was at 10:22 a.m., which indicated, Resident Not Available, by CNA 8. -[DATE]: Meal documentations were in place for breakfast consumption at 9:00 a.m., and lunch at 1:00 p.m., but no other documentation was present for the dinner meal. -[DATE]: The dinner meal intake was documented twice by CNA 3, at 7:30 p.m. and 7:41 p.m. -[DATE]: The dinner meal intake was documented by CNA 3, twice at 6:38 p.m. -[DATE]: The dinner meal intake was documented by CNA 3, twice at 9:58 p.m. -[DATE]: The dinner meal intake was documented by CNA 3, twice at 7:10 p.m. -[DATE]: The dinner meal intake was documented by CNA 3, at 8:23 p.m. and 8:24 p.m. -[DATE]: The dinner meal intake was documented by CNA 6, twice at 11:16 p.m. -[DATE]: Meal intakes were documented on this date by CNA 3 twice at 6:51 p.m., of ,d+[DATE]% and by CNA 6 twice at 12:07 a.m., and twice at 11:28 p.m. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155228	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willows of Richmond	2070 Chester Blvd Richmond, IN 47374

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-[DATE]: Meal intakes were documented twice by CNA 8 at 1:53 p.m., with no other meal intake information for this date. -[DATE]: Meal intake information was documented by CNA 8, with 2 other entries by CNA 6 at 11:22 p.m. which indicated, Not Applicable. -[DATE]: The dinner meal intake was documented by CNA 3, twice at 6:20 p.m. -[DATE]: Meal intakes were documented by CNA 9 at 8:59 a.m. and 1:10 p.m. No further meal information was documented. [DATE]: No meal documentation for this date. In an interview with the Regional Nurse Consultant on [DATE] at 4:34 p.m., she indicated if a resident refuses a meal or declines a meal, meal documentation in the EHR should reflect this as a refusal. She indicated each resident is offered three meals daily. 3.b. The EHR indicated four (4) choices of yes, no, Resident Not Available, or Resident Refused, for oral care provision by facility staff, related to, Task [oral care] Completed. In an interview with the Regional Nurse Consultant on [DATE] at 4:36 p.m., she indicated the frequency in which oral care should be offered is three (3) times a day or on each shift. Resident D's oral care provision, as documented in the EHR, for [DATE], through [DATE], was as follows: -[DATE]: received once. -[DATE]: received once. -[DATE]: received once with one resident refusal. -[DATE]: received once with one resident refusal. -[DATE]: received once with one resident refusal. -[DATE]: received 2 times. -[DATE]: received 2 times. -[DATE]: received once. -[DATE]: received once. -[DATE]: received 2 times. -[DATE]: receive 2 times. -[DATE]: received once. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155228	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willows of Richmond	2070 Chester Blvd Richmond, IN 47374

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-[DATE]: nothing documented. -[DATE]: nothing documented. -[DATE]: received 2 times. -[DATE]: received 2 times. -[DATE]: received 2 times. -[DATE]: received 2 times. -[DATE]: received 2 times. -[DATE]: received 2 times. -[DATE]: received 2 times. -[DATE]: received 2 times. -[DATE]: received 2 times. -[DATE]: received 2 times. -[DATE]: received once. -[DATE]: received 2 times. -[DATE]: received once. -[DATE]: received 2 times. -[DATE]: received 2 times. -[DATE]: received 2 times. -[DATE]: received 2 times -[DATE]: no documentation present for oral care. On [DATE] at 4:10 p.m., the Administrator provided a copy of an undated policy entitled, Serving A Meal. This policy indicated, It is the policy of this facility to serve meals that meet the nutritional needs of residents . when the resident has finished and record the percentage of food consumed as 25%, 50%, 75% or 100% in Point Click Care [electronic health record program]. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155228	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willows of Richmond	2070 Chester Blvd Richmond, IN 47374

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 4:10 p.m., the Administrator provided a copy of an undated policy entitled, Oral Care. This policy indicated, It is the practice of this facility to provide oral care to residents in order to prevent and control plaque-associated oral diseases .documentation of oral care will be completed in Point Click Care [electronic health record program]. This Federal tag relates to Complaints IN00435418 and IN00435596. 3XXX,d+[DATE](a)(1) 3XXX,d+[DATE](a)(2)