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	01/03/2025

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28309 Based on interview and record review, the facility failed to ensure 1 of 3 residents reviewed for accuracy of medication receipt, received their medications as ordered by the physician. (Resident F) Findings include: On 1-2-25 at 4:30 p.m., the facility notified the Indiana Department of Health's (IDOH) Long Term Care Division of a medication error related to Resident F. This notification indicated Resident F was admitted to the facility on [DATE] with a 7-day order for her to receive Xanax (an anti-anxiety agent) 2 milligrams (mg) twice daily, to end on 12-7-24. Resident F returned to the hospital on 12-6-24 and returned to the facility on [DATE] with an order to continue the Xanax at the same dosage of 2 mg twice daily. Medication not restarted upon return date due to prior stop date. A review of Resident F's hospital discharge instructions, dated 11-30-24, indicated she was to continue taking alprazolam [Xanax] 1 mg: two tablets twice daily for 14 doses. It indicated she had received the most recent dose at the hospital on 11-30-24 at 8:58 a.m. Her hospital discharge instructions, dated 12-8-24, indicated she was to continue taking alprazolam [Xanax] 1 mg: two tablets twice daily. This order did not have a stop date indicated. It indicated she had received the most recent dose at the hospital on 12-8-24 at 8:49 a.m. A review of the medication administration record (MAR) for December 2024, indicated she received alprazolam 1 mg: 2 tablets [total of 2 mg] twice daily on 12-1-24, 12-2-24, 12-3-24, 12-4-24, 12-5-24 and the morning dose of this on 12-6-24. The corresponding, Controlled Substance Accountability Sheet, for Resident F's ordered alprazolam [Xanax] 1 mg, two tablets twice daily, indicated she received the 2 mg dosage twice daily on 12-1-24, 12-2-24, 12-3-24, 12-4-24 and 12-5-24, plus the morning dose of this medication on 12-6-24. She was hospitalized [DATE] and 12-7-24, returning to the facility on [DATE]. The accountability sheet indicated Resident F received 2 mg on 12-8-24 at 8:00 p.m., and on 12-9-24 at 8:00 a.m. , despite this order not being properly transcribed upon return from the hospital. The medication administration record (MAR) for the corresponding dates did not reflect these doses were administered. In an interview with the Administrator and Director of Nursing on 1-3-25 at 4:30 p.m., they indicated they were not aware of the entries. There were no entries in the progress notes, MAR or controlled substance accountability forms to indicate Resident F received any additional doses of alprazolam [Xanax] from 12-9-24 and until she was sent to the hospital on 12-22-24. Resident F's progress notes indicated she was sent out to the hospital again on 12-22-24 at 3:35 p.m., related to a possible seizure and a change in mental status. (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: 155228	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/03/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the Administrator on 1-3-25 at 3:50 p.m., she indicated the facility became aware of an issue with this resident on 1-2-25 when a call was received from a staff member following up to see how Resident F was doing at the hospital. It was learned a medication error in which the resident had not been receiving the correct dosage of Xanax. We started our investigation yesterday, right after we found out about it and sent a reportable to the state. The Administrator indicated Resident F was originally admitted with an order for Xanax 1 mg two tablets twice a day for 7 days. The resident went out to the hospital on day 6. When she returned to facility on 12-8-24, we had 2 nurses verify the orders and both nurses did not catch the resident was to resume the Xanax order of 1 mg two tablets twice daily. Even the [Hospital] Nurse Liaison, who always catches things like that, missed it as well. In review of a visit note from Resident F's neurologist, dated 12-24-24, it indicated she had a long history of [AGE] years or more of seizure activity, along with a history of [AGE] years or more of Xanax usage. It indicated previous attempts at reduction of the Xanax dosage had been unsuccessful. It addressed the recent abrupt withdrawal likely is contributing to the seizures were [sic] seen now .Family was concerned that withdrawal symptoms from the alprazolam [Xanax] started last week even before the seizures .At this point I believe that the seizures are multifactorial. On 1-3-25 at 4:37 p.m., a copy of a policy entitled, Medication Orders, was provided by the Corporate Staff. This policy indicated, This facility shall use uniform guidelines for the ordering of medication. Medications should only be administered upon the signed order of a person lawfully authorized to prescribed .Written Transfer Orders (sent with a resident by a hospital or other health care facility) Implement a transfer order without further validation, if it is signed and dated by the resident's current attending physician, unless the order is unclear or incomplete, or the date signed is different from the date of admission. If the order is unsigned, or signed by another physician, or the date is other than the date of admission, the receiving nurse should verify the order with the current attending physician before medications are administered. The nurse should document verification on the admission order record, by entering the time, date, and signature. Example: 'Order verified by the phone with Dr. [NAME]/M. [NAME], R.N.' This citation relates to Complaint IN00450460. 3.1-48(c)(2)