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	04/19/2024

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

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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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45291 Based on interview and record review, the facility failed to timely complete and entry tracking record for 1 of 19 residents reviewed for MDS (Minimum Data Set) timeliness. (Resident 154) Findings include: The clinical record for Resident 154 was reviewed on 4/17/2024 at 11:25 a.m. Resident 154 was admitted on [DATE] with a medical diagnosis of cerebrovascular disease. Review of the clinical record indicated no MDS assessment or entry tracking record was completed for Resident 154. An interview with the MDS Coordinator on 4/17/2024 at 2:00 p.m. indicated that no entry tracking record was completed for Resident 154, and she would complete one immediately. She confirmed this entry tracking record would be late with the latest anticipated date of completion as 4/9/2024. A policy entitled, MDS 3.0 Completion, was provided by the ADON on 4/18/2024 at 1:33 p.m. The policy indicated for entry tracking to be completed and submitted .with every entry into the facility no later than the entry date + 7 calendar days .

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45291 Based on interview and record, the facility failed to accurately encode the smoking status/tobacco use of Resident 30, the date of contraindication of a gradual dose reduction (GDR) for Resident 41's antipsychotic medications, the 6 month or less prognosis for Resident 50, the planned status of a discharge for Resident 51, and the utilization of non-invasive mechanical ventilation for Resident 103. This deficient practice affected 5 of 19 residents reviewed for Minimum Data Set (MDS) accuracy. Findings include: 1. The clinical record for Resident 30 was reviewed on 4/18/2024 at 11:04 a.m. The medical diagnosis included chronic obstructive pulmonary disease. An Annual MDS Assessment, dated 2/1/2024, indicated that Resident 30 did not utilize tobacco products. A smoking care plan, dated 1/7/2020, indicated that Resident 30 is a smoker. An interview with the MDS Coordinator on 4/17/2024 at 2:01 p.m. indicated that Resident 30 was a smoker. Upon review of the assessment, she indicated she would enter a modification of Resident 30's annual to reflect the use of tobacco products. 2. The clinical record for Resident 41 was reviewed on 4/18/2024 at 11:45 a.m. The medical diagnoses included vascular dementia and schizoaffective disorder. A Quarterly MDS Assessment, dated 2/5/2024, indicated that Resident 41 was contraindicated for a GDR of his antipsychotic medication on 6/30/2023. A pharmacy recommendation, dated 12/26/2023, for Resident 41 was signed by the provider on 12/27/2023. The recommendation indicated a GDR was contraindicated due to risk benefits of underlying psychiatric and medical conditions. An interview with the MDS Coordination on 4/18/2024 at 1:20 p.m. indicated that she would modify the Quarterly MDS assessment to reflect the GDR contraindication date of 12/27/2023 for Resident 41. She indicated that it is the expectation that MDS assessments are coded accurately according to the most recent Long-Term Care Facility Resident Assessment Instrument 3.0 User ' s Manual from the Centers for Medicare and Medicaid Services. 3. The clinical record for Resident 50 was reviewed on 4/18/2024 at 11:55 a.m. The medical diagnosis included stroke. A Significant Change MDS Assessment, dated 12/8/2023 indicated that Resident 50 utilized hospice services, but did not have a condition or chronic disease that may result in a life expectancy of less than 6 months. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A hospice certification for Resident 50, verbally certified on 12/1/2023, indicated .The Medical Director/Hospice physician listed above certified that the patient's prognosis is six months or less if the disease runs its normal course . An interview with the MDS Coordinator on 4/19/2024 at 12:05 p.m. indicated that this was an encoding error for Resident 50, and she would be entering a modifications for the aforementioned assessment. 4. The clinical record for Resident 51 was reviewed on 4/18/2024 at 11:58 a.m. The medical diagnosis included displaced comminuted fracture of the patella. A Discharge Return Not Anticipated MDS, dated [DATE], indicated that the discharge for Resident 51 was unplanned. A care plan assessment, dated 2/5/2024, indicated that Resident 51 would discharge home on 2/7/2024. A nursing progress note, dated 2/7/2024, indicated Resident 51 discharged home with his sister. A document for Resident 51 entitled, Discharge Summary for Anticipated Discharges, was dated 2/6/2024. An interview with the MDS Coordinator on 4/19/2024 at 11:55 a.m. indicated that this was an encoding error for Resident 51, and she would be entering a modification of his Discharge Return Not Anticipated MDS to reflect the planned status of his discharge. 15909 5. On 4/15/24 at 12:36 p.m., Resident 103 was observed in her room, sitting on her bed. A BiPap machine (bilevel positive airway pressure machine, used for sleep apnea) was observed on her bed side stand and she indicated she uses it mostly at night. Resident 103's record was reviewed, on 4/17/24 at 10:54 a.m., and indicated diagnoses that included, but were not limited to, acute on chronic congestive heart failure, heart disease, high blood pressure, type 2 diabetes mellitus with diabetic nephropathy and diabetic retinopathy with macular edema, and obstructive sleep apnea. An Admission Minimum Data Set (MDS) assessment, dated 4/3/24, indicated Resident 103 was cognitively intact, and did not use a non-invasive mechanical ventilator, including a bipap or cpap. Physician's orders included, but were not limited to: Bpap on for naps and night time. Bpap has settings completed. Assist resident with putting Bpap on/off. (Connect to oxygen continuously at 2 Liters.) every shift chart resident refusal to wear and if resident is removing during the night dated 3/25/2024. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/19/24, at 1:15 p.m., the MDS Coordinator indicated the area on the MDS had been disabled by the system and she couldn't put a response in (to show the resident was on a bipap). It was disabled and she said she would create a modification request and it would be re-submitted. A policy for MDS 3.0 Completion was provided by the Assistant Director of Nursing, on 4/18/24, at 1:33 p.m. The policy included, but was not limited to, Residents are assessed, using a comprehensive assessment process, in order to identify care needs and to develop an interdisciplinary care plan .1. According to federal regulations, the facility conducts initially and periodically a comprehensive, accurate and standardized assessment of each resident's functional capacity, using the RAI specified by the State

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 15909 Based on interview and record review, the facility failed to ensure care plans were developed for a resident using a bipap machine and insulin (Resident 103), for seizures and anti-seizure medication (Resident 41), and for pain (Resident 5). This affected 3 of 21 residents reviewed for care plans. Findings include: 1. Resident 103's record was reviewed, on 4/17/24 at 10:54 a.m., and indicated diagnoses that included, but were not limited to, acute on chronic congestive heart failure, heart disease, high blood pressure, type 2 diabetes mellitus with diabetic nephropathy and diabetic retinopathy with macular edema, and obstructive sleep apnea. Physician's orders included, but were not limited to: Bpap on for naps and night time. Bpap has settings completed. Assist resident with putting Bpap on/off. (Connect to oxygen continuously at 2 Liters.) every shift chart resident refusal to wear and if resident is removing during the night dated 3/25/2024. Basaglar KwikPen Subcutaneous Solution Pen-injector 100 units per milliliter, inject 54 units subcutaneously in the morning for type 2 diabetes mellitus with diabetic neuropathy, start date 3/26/24. Admelog SoloStar Subcutaneous Solution Pen-injector 100 units per milliliter, inject 28 units subcutaneously three times a day with meals, and plus a sliding scale, for type 2 diabetes mellitus with diabetic nephropathy, start date 3/26/2024. There were no care plans in the clinical record for the use of the bipap machine, nor for the use of insulin for diabetes mellitus. On 4/19/24, at 1:15 p.m., the MDS Coordinator indicated there was no care plan for diabetes and she would add it, and would also add a care plan for the bipap machine. 45291 2. The clinical record for Resident 41 was reviewed on 4/18/2024 at 11:45 a.m. The medical diagnoses included vascular dementia and schizoaffective disorder. A physician order for Resident 41, dated 6/9/2023, indicated to administer an anticonvulsant medication, Keppra, at 1000 milligrams (mg) by mouth daily for seizures. Review of the care plans for Resident 41 indicated no careplan was recorded for his anticonvulsant medication or seizure disorder. An interview with Administrator on 4/18/2024 at 2:35 p.m. indicated they did not have a care plan in place for Resident 41's seizure disorder or use of Keppra. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	25054 3.) During an observation on 4/15/24 at 11:40 a.m., Resident 5 was observed periodically is yelling out. Resident does have a lidocaine patch on her right front shoulder area. When queried what was wrong the resident did not verbally respond. During an observation and interview with Resident 5 on 4/17/24 10:16 a.m., the resident was crying my back is killing me, the call light was activated. CNA 1 came in and changed the resident's repositioned in bed. The CNA 1 indicated she would report the resident's pain to the nurse. The CNA indicated the staff had to frequently reposition the resident for pain relief. The progress note for Resident 5, dated 4/17/24 at 12:58 p.m., indicated the resident had complained of back pain rating the pain as a 7 out of 10. The resident indicated she wanted tylenol. Tylenol was administered around 10:30 a.m., The resident was resting peacefully in bed at this time. Review of the record of Resident 5 on 4/18/24 at 1:10 p.m., indicated the resident's diagnoses included, but were not limited to, chronic pancreatitis, coronary heart disease, arthritis, chronic kidney disease and dementia. During an interview with the Minimum Data Set (MDS) Coordinator on 4/19/24 at 10:47 a.m., indicated the facility did not have a plan of care in place for Resident 5's pain. A plan of care for the resident's pain was implemented today. The care plan policy provided by the Assistant Director Of Nursing (ADON) on 4/18/24 at 1:33 p.m., indicated the facility would develop and implement a comprehensive person centered care plan for each resident. 3.1-45(a) 3.1-45(b)(1)

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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** 15909 Based on interview and record review, the facility failed to assess and document bruising on 1 of 2 residents reviewed for general skin conditions. (Resident 29) Findings include: On 4/15/24, at 1:52 p.m., Resident 29 was observed to have bruising on both forearms; the left forearm had an elongated, half dollar sized bruise, and the right forearm had a half dollar sized bruise. Both bruises were dark purple. The resident indicated she did not know how the bruising had occurred. Resident 29's record was reviewed on 4/18/24 at 12:43 p.m. The record indicated Resident 29 had diagnoses that included, but were not limited to, heart disease, lung disease, transient ischemic attacks (mini strokes), and long term atrial fibrillation. A Quarterly Minimum Data Set (MDS) assessment, dated 3/22/24, indicated Resident 29 was cognitively intact and had no skin issues. Current physician's orders indicated an order for Clopidogrel Bisulfate Tablet, 75 milligrams, one time in the morning by mouth for transient cerebral ischemic attacks, dated 3/9/2022. There was no documentation in the progress notes, or nursing assessment dated [DATE], that indicated Resident 29 had been assessed for the bruising, nor how the bruising had occurred. On 4/19/24, at 10:00 a.m., the Administrator provided a document for a follow up investigation for an injury of unknown etiology, dated 4/18/24, for the bruises on Resident 29's forearms. The investigation included measurements of the bruising on both forearms and the color of the bruising, which was purple and red. There was no known or witnessed occurrence that could have cause the injury and no behaviors have been observed that could indicate potential for self-infliction of injury. The summary of findings indicated: [Resident 29] states she is unsure as to what happened. When she woke today she noticed the bruising. Skin assessment completed on 4/15/24 with no areas noted. MD and daughter made aware of findings. New order to monitor. On 4/19/24 at 1:27 p.m., the Administrator indicated it is her understanding they first saw the bruising yesterday morning, on 4/18/24. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A policy and procedure for Skin Management was provided by the MDS Coordinator, on 4/19/24, at 2:00 p. m. The policy included, but was not limited to, Purpose: To assess each resident to determine the risk of potential skin integrity. Policy: It is the policy of [NAME] Healthcare to assess each resident to determine the risk of potential skin integrity impairment. Residents will have a skin assessment completed upon admission and no less than weekly by the licensed nurse to assess overall skin condition, skin integrity and skin impairment .3. A skin assessment will be completed by a licensed nurse upon admission/readmission and no less than weekly .8. Any skin alterations noted by direct care givers during daily care and or shower days must be reported to the licensed nurse for further assessment, to include but not limited to open areas, redness, skin tears, blisters, and rashes. New bruises should be documented in medical record but do not need to be followed weekly if showing signs of improvement 3.1-37(a)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 25054 Based on observation, interview and record review the facility failed to implement a physician order of a carrot for a resident's left hand contracture for 1 of 1 resident reviewed for limited Range Of Motion (ROM) (Resident 13). Finding include: During an observation on 4/15/24 at 11:51 a.m., Resident 13 was sitting in wheelchair in front of the nursing station. The resident had a left hand contracture with no splint/carrot in place. During an observation on 4/17/24 at 2:00 p.m., Resident 13 was laying in bed, there was no splint/carrot in place for the left hand contracture. During an observation on 4/18/24 12:30 p.m., Resident 13 was in bed no splint/carrot in left hand contracture. During an observation on 4/19/24 10:21 a.m., Resident 13 was in bed no splint/carrot in left hand contracture. During an observation and interview with QMA on 4/19/24 at 10:23 a.m., looked for Resident 13's carrot in her room and was unable to locate it. During an observation and interview on 4/19/24 at 10:27 a.m., QMA 2 found Resident 13's carrot at the nursing station and indicated she would go put it in place. During an interview with the Assistant Director Of Nursing (ADON) on 4/19/24 at 10:31 a.m., indicated the CNA's were responsible to ensure Resident 13's carrot was in place. Review of the record of Resident 13 on 4/19/24 at 10:43 a.m., indicated the resident's diagnoses included, but were not limited to, dementia, major depression, heart failure and hypertension. The plan of care for Resident 13, dated 11/12/2019, indicated the resident wears a left orange hand carrot related to contracture of the left hand. The interventions included, but were not limited to, the resident would wear the left hand carrot 4-6 hours a day. The plan of care for Resident 13, dated 2/2/24, indicated the resident was at risk for skin breakdown and moisture associated skin disorder to her left hand/palm that is contracted related to skin perspiration. The Quarterly Minimum Data Set (MDS) assessment, dated 2/16/24, indicated the resident was severely cognitively impaired for daily decision. The resident had no behaviors of rejecting care. The resident had limited range of motion of upper extremity on both sides. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The April 2024 physician recapitulation for Resident 13, indicated the resident was to wear an orange hand carrot four hours a day or per resident's tolerance. Apply in the morning; and perform hand hygiene prior to applying. The ROM policy provided by the MDS Coordinator on 4/19/24 at 2:00 p.m., indicated the resident would be provided interventions based on the comprehensive assessment to improve and maintain ROM. The appropriate equipment were braces and splints. The nurse was responsible to monitor for consistent implementation of the care plan interventions. Refusals of care or problems would be documented in the medical record. 3.1-42(a)(2)