

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155363	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/16/2024
NAME OF PROVIDER OR SUPPLIER Willowdale Village		STREET ADDRESS, CITY, STATE, ZIP CODE 404 W Willow Rd Dale, IN 47523	

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)
<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>46416</p> <p>Based on interview and record review, the facility failed to ensure services of a Registered Nurse (RN) were available at least 8 consecutive hours in a 24 hour period, 7 days a week for 2 of 7 days reviewed for nurse staffing. (11/29/24, 11/30/24)</p> <p>Findings include:</p> <p>On 12/11/24 at 9:50 A.M., the daily nursing schedules were provided for the week of 11/27/24 through 12/3/24 and reviewed. The schedules indicated there was an RN that worked from 6:00 P.M. to midnight (6 consecutive hours) on Friday, 11/29/24 and lacked RN coverage on Saturday, 11/30/24.</p> <p>During an interview on 12/16/24 at 12:10 P.M., the Director of Nursing (DON) indicated there was not RN coverage for those dates but there should have been 8 hours of consecutive RN coverage every day.</p> <p>On 12/16/24 at 1:10 P.M., a current RN Coverage Policy was requested. The DON indicated they did not have a policy, but they would follow the regulations.</p> <p>3.1-17(b)(3)</p>

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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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>45933</p> <p>Based on observation, interview, and record review, the facility failed to ensure infection control practices were followed for 1 of 1 residents reviewed for Transmission Based Precautions (TBP). Staff failed to don (put on) personal protective equipment (PPE) prior to entering a contact isolation room. (Resident 16)</p> <p>Findings include:</p> <p>During an observation on 12/11/24 at 8:45 A.M., the following sign was observed on Resident 16's door, STOP CONTACT PRECAUTIONS EVERYONE MUST: Clean their hands (hand sanitizer or hand washing) before entering and when leaving the room. Put on gloves before room entry. Discard gloves before room exit. Put on a gown before room entry. Discard gown before room exit .Use dedicated or disposable equipment .</p> <p>During an interview on 12/11/24 at 8:46 A.M., the Infection Preventionist (IP) indicated Resident 16 had a contact precautions sign on the door due to a diagnosis of extended-spectrum beta-lactamase (ESBL bacteria) in her urine.</p> <p>During an observation on 12/11/24 at 12:13 P.M., Housekeeper 4 entered Resident 16's room and grabbed hangers. Housekeeper 4 failed to don PPE before she entered the room.</p> <p>During an observation on 12/11/24 at 12:14 P.M., CNA (Certified Nurse Aide) 2 failed to don PPE before she brought Resident 16 a meal tray. CNA 2 then exited the room, failed to sanitize hands, grabbed packets off the top of the meal cart, and then re-entered Resident 16's room without donning PPE.</p> <p>During an observation on 12/11/24 at 12:17 P.M., CNA 2 exited Resident 16's room, failed to sanitize hands, pushed the meal cart down the hall, and delivered a meal tray to Resident 14.</p> <p>During an observation on 12/12/24 at 11:51 A.M., LPN (Licensed Practical Nurse) 6 failed to don PPE prior to entering Resident 16's room when she administered medications.</p> <p>During an interview on 12/16/24 at 9:40 A.M., the Housekeeping Supervisor indicated all housekeeping staff should don a gown and gloves before they enter a contact isolation room.</p> <p>During an interview on 12/16/24 at 11:05 A.M., the IP indicated all staff should have had a gown and gloves on before they entered the contact isolation room.</p> <p>On 12/16/24 at 11:29 A.M., the IP provided a current Standard and Transmission-Based Precautions (Isolation) Policy, revised 4/24/24, that indicated, CONTACT PRECAUTIONS: .put on gown and gloves upon entry to room .</p> <p>3.1-18(b)(2)</p> <p>3.1-18(l)</p>		