STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155535	A. Building B. Wing	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willow Crossing Health & Rehabilitation Center	3550 Central Ave Columbus, IN 47203

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33613 Based on observation and interview, the facility failed to to protect resident information related to unlocked computer screens for 4 of 6 random observations for personal privacy. Findings include: During an observation on 04/14/24 at 10:02 A.M., a 200 Hall medication cart had a computer screen opened to resident names and list of medications. The opened computer screen was in the resident hallway on top of the medication cart. There was no staff with in 20 to 30 feet of the medication cart. The DON (Director of Nursing) closed the computer screen as he was walking down the hall passed the cart at 10:03 A.M. During an continuous observation on 04/14/24 at 12:15 P.M. to 12:17 P.M., the front 200 Hall medication cart had a computer tablet on top of the cart. The screen was opened to the resident names and pictures. QMA (Qualified Medication Aide) 9 was in room [ROOM NUMBER] talking with a resident, at 12:17 P.M. she came out of room [ROOM NUMBER] and picked the tablet up off of the medication cart. On 04/15/24 at 10:49 A.M., the front 200 Hall medication cart computer screen was up to show resident names and medication lists, at 10:51 A.M., with no staff in view. The DON was walking past the medication cart and pushed the tablet closed. On 04/18/24 at 8:30 A.M., the computer tablet on top of the medication cart at beginning of the 200 Hall was opened to resident names and medication lists. There was no staff present in the hallway or near the medication cart. During an interview on 04/18/24 at 10:32 A.M., the DON indicated the computer screens should be closed when staff were not present. Resident information should not be visible when staff are not at their medication cart. The current Employee Handbook, dated April 2022, was provided by the Regional Director on 04/19/24 at 12:25 P.M. The Handbook indicated .Health Insurance Portability and Accountability Act (HIPAA) .HIPAA's Privacy Rule requires that all identifiable health information be protected from unauthorized access, use, or disclosure . 3.1-3(o)

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 33613 Based on interview and record review, the facility failed to ensure a resident was free from mental and physical abuse for 1 of 23 residents reviewed for abuse. (Resident 203) Findings include: A facility reported incident, dated 12/30/23, indicated CNA (Certified Nurse Aide) 20 had became agitated and had spoken to Resident 203 inappropriately during care. The resident's clinical record was reviewed on 04/19/24 at 12:37 P.M. A Quarterly Minimum Data Set assessment, dated 10/18/23, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, hypertension, diabetes, Alzheimer's disease, stroke, anxiety, and stage 4 chronic kidney disease. During an interview on 04/19/24 at 10:46 A.M., CNA 21 indicated on 12/30/23 she was providing care to the roommate of Resident 203 when she heard CNA 20 become agitated with Resident 203. She stepped around the curtain and assisted CNA 20 with the residents care. CNA 20 told Resident 203 if you hit me again I'll hit you back, CNA 20 then took a wet wipe and smacked at the resident's face, and pushed her head down to the pillow when she attempted to sit up. CNA 21 asked CNA 20 to leave the room while she finished care to the resident. CNA 21 told the QMA (Qualified Medication Aide) on the hall what she had witnessed. The QMA phoned the ADON (Assistant Director of Nursing). During an interview on 04/19/24 at 11:19 A.M., the Administrator indicated on 12/30/23, she received a phone call from the ADON explaining what had been reported to her. CNA 20 had been asked to clock out and leave the building pending the facility's investigation of abuse. Written statements were taken from CNA 21 and two CNA students who also witnessed the abuse. The ADON assessed each resident for verbal and physical abuse. The Social Service Director came to the facility and interviewed resident who could be interviewed. Resident 203 was unable to be interviewed and had no recollection of the incident because of her low cognition. The abuse was substantiated and CNA 20 was terminated from employment with the facility. Abuse education was provided to each employee. The incident was reported to the state department of health. The current facility policy, titled Abuse Prohibition, Reporting, and Investigation, with a most recent revision date of January 2015, was provided by the Administrator on 04/14/24. The policy indicated, .The facility shall prohibit and prevent abuse, neglect, misappropriation of resident property, and exploitation . The Past noncompliance began on 12/30/23 and the deficient practice was corrected prior to the start of the survey. On 01/01/24, the facility implemented a systemic plan that included the following actions: The facility completed education on the Abuse for all staff members. 3.1-27(a)(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. 33613 Based on record review and interview, the facility failed to follow physician's orders related to hold parameters for a blood pressure medication for 1 of 23 residents reviewed for quality of care. (Resident 48) Findings include: The clinical record for Resident 48 was reviewed on 04/16/24 at 1:35 P.M. A Quarterly Minimum Data Set assessment, dated 01/20/24, indicated the resident was moderately cognitively impaired. The diagnoses included, but were not limited to, dementia, heart failure, hypertension, stroke, diabetes, anxiety, and depression. A current physician's order, with a start date of 03/29/24, indicated the resident was to get losatan 100 mg (milligrams), one time a day, for hypertension. The staff were to hold the medication if the resident's systolic blood pressure (the top number) was less than 110 or the heart rate was less than 60. The clinical record that included the March and April 2024 EMAR/ETAR (Electronic Medication Administration Record/Electronic Treatment Administration Record) lacked indication the resident's blood pressure and heart rate had been obtained prior to the administration of the medication. The resident received his medication daily and no resident blood pressure or heart rate values were document from 3/29/24 to 4/18/24. During an interview on 04/17/24 at 10:55 A.M., RN 11 indicated if a medication had hold parameters they should be documented on the EMAR. During an interview on 04/18/24 at 2:57 P.M., QMA (Qualified Medication Aide) 12 indicated if a resident had hold parameters for a blood pressure medication, the blood pressure should be documented on the EMAR. During an interview 04/18/24 at 3:01 P.M., the Clinical Consultant indicated if there are parameters for a medication it should be documented on the EMAR. The current facility policy titled, Medication Administration with a revised date of 04/2017, was provided by the Regional Director on 04/19/24 at 2:45 P.M. The policy indicated, .To safely administer medications as per physicians' orders .Always take pulse and B/P (blood pressure) as indicated if ordered prior to giving certain cardiac or antihypertensive drugs . 3.1-37(a)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 33613 Based on record review and interview, the facility failed to prevent and follow physician's orders related to a pressure ulcer for 1 of 4 residents reviewed for pressure ulcers. (Resident 48) The clinical record for Resident 48 was reviewed on 04/16/24 at 1:35 P.M. A Quarterly Minimum Data Set assessment, dated 01/20/24, indicated the resident was moderately cognitively impaired. The diagnoses included, but were not limited to, dementia, heart failure, hypertension, stroke, diabetes, anxiety, and depression. A physician's order with a start date of 03/11/24 and discontinue date of 04/18/24, indicated the resident was to wear Blue Prevalon boots at all times. An Initial Pressure Ulcer Assessment form, dated 03/14/24, indicated a suspected deep tissue injury (a purple or maroon area of discolored intact skin due to damage of underlying tissue) was discovered on the right medial heel. On 04/16/24 at 11:27 A.M., the resident was observed in bed without her blue boots on. On 04/16/24 at 2:54 P.M., the resident was observed in bed without her blue boots on. The blue boots were observed on the top self of her closet. On 04/17/24 at 8:59 A.M., the resident was in her bed without her blue boots on. On 04/17/24 at 02:30 P.M., the DON (Director of Nursing) and LPN (Licensed Practical Nurse) 22 were observed providing wound care to the resident. The resident did not have her blue boots on prior to the start of the wound care. the non skid sock was removed, the purple area on the right medial heel was cleansed, and skin prep applied as ordered. The non skid sock was placed back on the resident's foot. Neither the DON or LPN 22 placed the blue boot on the resident's foot after the wound care. During an interview on 04/18/24 at 9:28 A.M., the facility wound physician indicated the resident should have some kind of off loading either a pillow or boots. During an interview on 04/18/24 at 2:01 P.M., QMA (Qualified Medication Aide) 2 indicated if a resident had an order for off loading of their heels it would be the responsibility of all nursing staff and if the resident refused a behavior sheet should be filled out. The resident's clinical record lacked documentation the resident refused to wear her blue boots. The current facility policy titled, PRESSURE ULCER PREVENTION dated 10/2014, was provided by the Regional Director on 04/19/24 at 2:45 P.M. The policy indicated, .To prevent pressure ulcers and promote healing .reposition resident approximately every two hours .float heels, as appropriate . 3.1-40(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. 38769 Based on observation, interview, and record review, the facility failed to provide appropriate urinary catheter care for a resident with frequent Urinary Tract Infections for 1 of 5 residents reviewed for bladder incontinence care. (Resident 72) Findings include: During an observation on 04/18/24 at 9:46 A.M., CNA (Certified Nurse Aide) 4 washed her hands, closed the door to Resident 72's room with her foot, and donned gloves. The left glove ripped and as she removed the glove, it fell to the floor. She picked it up with her gloved right hand, put it in the trash, and donned a new glove to her left hand. She went to the resident's closet and donned a gown. She moved the resident's bedside table, sat towels down on top of the table, and picked up a bath basin off of the table. She went into the bathroom and turned on the water with her right gloved hand. She returned to the room and moved the bedside table, opened the top drawer of the nightstand, retrieved a container of soap, and sat it on the bedside table. CNA 4 went back to the bathroom and retrieved a graduated cylinder. She went to the side if the bed, emptied the resident's dark urine from the urinary catheter into the graduate cylinder, went to the bathroom, dumped the urine into the toilet, turned on the water with her gloved hand, added water to the graduated cylinder, rinsed it out, dumped the water into the toilet, flushed the toilet with her gloved hand, and put the graduated cylinder into a bag. She went into the room, moved the bedside table, removed the resident's blankets, removed a pillow between the resident's feet, and unfastened the resident's brief. The catheter tubing was going up and out the top of the brief. CNA 4 removed a roll of trash bags from her pocket. She placed washcloths in the water basin, applied soap to the washcloths, and started cleaning the resident's peri area and catheter tubing. She cleansed the catheter tubing from top to bottom, without using a clean area of the washcloth with each motion. CNA 4 changed the resident's brief. The resident's urinary catheter tubing was lying on the residents' bed and contained dark urine with sediment in it. She placed the resident's blankets over the resident, attached the call light to the blanket, emptied the water basin, placed it in the closet, removed her gown, gloves, and washed her hands. The clinical record for Resident 72 was reviewed on 04/17/24 at 11:26 A.M. A Quarterly MDS (Minimum Data Set) assessment, dated 01/15/24, indicated the resident was moderately cognitively impaired. The diagnoses included, but were not limited to, stroke, hypertension, neurogenic bladder, obstructive uropathy, non-Alzheimer's dementia, depression, and anxiety. The resident had the following physician orders for antibiotics: - A physician's order, dated 12/27/23 through 01/02/24, indicated the resident was to take Linezolid 600 mg (milligrams), twice a day, by mouth, for a UTI (urinary track infection), - A physician's order, dated 02/05/24 through 02/11/24, indicated the resident was to receive meropenem, 1 gram every 8 hours, intravenous, for a UTI, (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- A physician's order, dated 03/01/24 through 03/07/24, indicated the resident was to receive meropenem, 1 gram every 8 hours, intravenous, for a UTI, and - A physician's order, dated 03/18/24 through 03/28/24, indicated the resident was to receive meropenem, 1 gram three times a day, intravenous, for a UTI. During an interview on 04/18/24 at 2:31 P.M., QMA (Qualified Medication Aide) 12 indicated the resident had a urinary catheter and had frequent UTIs. The nursing staff performed urinary catheter care every shift. When providing catheter care the staff were to don a gown, gloves and perform the care. If anything was touched before the catheter care began, then the gloves should be changed. The current facility policy titled, Catheter Care, Indwelling, dated 10/2014, was provided by the Regional Director on 04/18/24 at 3:47 P.M. The policy indicated, .Care provided for an indwelling catheter will promote good hygiene and reduce the potential for infection . 3.1-41(a)(2)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. 34232 Based on interview and record review, the facility failed to implement interventions and complete behavior forms related to dementia care for 1 of 3 residents reviewed. (Resident 69) Findings include: The clinical record for Resident 69 was reviewed on 04/19/24 at 2:18 P.M. A Quarterly MDS (Minimum Data Set) assessment, dated 01/01/24 indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, Alzheimer's disease, dementia, anxiety, depression, and psychotic disorder. The resident had several days of feeling down and depressed, had trouble sleeping, feeling tired, and having a poor appetite. The complete Care Plan was provided by the DON on 04/18/24 at 2:50 P.M., and included, but was not limited to, a Care Plan for Wandering, with a most recent revision date of 01/12/24. The interventions included, but were not limited to, door alarm placed on res. (resident's) room door. The EMAR/ETAR (Electronic Medication Administration Record/Electronic Treatment Administration Record) for March and April 2024 were provided by the DON on 04/19/24 at 9:29 A.M. The records lacked documentation the door frame alarm had been ordered by a physician or checked regularly. The Mood and Behavior Communication Memo, dated 01/09/24, indicated Resident 69 was in the dining room, at dinner time, the resident was physically aggressive towards staff and swinging at their face when attempting to assist the resident to sit down. The Mood and Behavior Communication Memo, dated 01/09/24, indicated Resident 69 was in the dining room/hallway/residents' rooms, on evening shift, the resident was physically aggressive towards staff and swinging his fist at their face when attempting to assist the resident to sit , down. If left unattended, the resident walked to another sleeping resident's room and refused to leave the room. The interventions attempted, toileting, snacks, redirection, one-to-one observation, and time to calm/re-approach, were documented as unsuccessful and the outcome of the interventions indicated the situation had Worsened and the resident continued to stand up and be aggressive towards staff. The Mood and Behavior Communication Memo, dated 01/14/24 at 8:30 P.M., indicated the resident was found in another resident's room, sitting on their bed while the other resident was lying in bed awake. Resident 69 refused to leave the room and it took two staff members to assist Resident 69 to be removed from the bed. The interventions attempted, time to calm/re-approach, redirection, and validation of feelings and words, were documented as unsuccessful and the outcome of the interventions indicated the situation was Unchanged. The Mood and Behavior Communication Memo, dated 01/24/24 at 11:05 A.M., indicated staff heard Resident 33 scream, Help! Get him out! He's hitting me! The staff ran into the room and saw Resident 69 hitting Resident 33 in the chest area while the resident was lying in bed. Resident 69 was removed from the room. The resident was placed on a one-to-one observation until they were sent out of the facility. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Mood and Behavior Communication Memo, dated 03/13/24 at 3:15 P.M., indicated the resident refused to stay in his wheelchair, was redirected back to his chair numerous times during the shift, was walking on the unit without assistance, and combative with staff when redirected to his chair. Interventions attempted, redirection, was documented as unsuccessful and the outcome of the intervention indicated the situation was Unchanged. The Mood and Behavior Communication Memo, dated 03/18/24, indicated on evening shift, the resident continued to walk and self-transfer unassisted. The resident walked into a female resident's room and staff had to redirect him numerous times. The resident was aggressive towards staff and stated, I'm going to beat the s#!* out of you. The resident continued to set off the door frame alarm while in his room. Staff had to reset the alarm each time. Interventions attempted, provide quiet environment, place in chair or bed, and redirection, were documented as unsuccessful and the outcome of the interventions indicated the situation was Unchanged. The Mood and Behavior Communication Memo, dated 03/23/24 at 2:30 P.M., in the Activity Room the resident was talking to a gentleman that came to see him for an evaluation. After sitting next to the man for only a few minutes, the man came out panicked, telling staff to, Take him before he gets aggressive. The resident was upset, and the man kept telling him he would finish without him before he became aggressive. The staff redirected the resident to his room where he relaxed, forgetting about the man. The interventions attempted, toileting and providing one-to-one observation, were documented as successful and the outcome of the interventions indicated the situation had Improved. No Mood and Behavior Communication Memos were provided regarding the incidents between Resident 69 and his roommate, Resident 65. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/16/24 at 11:01 A.M., CNA (Certified Nurse Aide) 14 indicated Resident 69 got aggressive at times and it was usually on second shift. The resident did not like the male CNAs, would get aggressive with them, and start swinging and threatening to beat everybody up. CNA 14 had worked with the resident on third shift and the resident had been sundowning (a state of disorientation and agitation that sometimes occurs in the late afternoon or evening in people with dementia). The resident woke up one day, went across the hall and hit Resident 33. The staff did not see it. They heard Resident 33 yelling, Get out of here! CNA 14 and QMA (Qualified Medication Aide) 2 ran down the hall from the nurse's station where they had been charting. They saw Resident 69 hovering over Resident 33. The residents were hitting each other on the arms. QMA 2 stayed with Resident 33. CNA 14 pulled Resident 69 out of Resident 33's room and kept him at the nurses' station on a one-to-one (one staff to one resident) observation. Resident 69 was on one to one for quite a while. They had a sheet that was a 15-minute check paper, They wrote down what the resident was doing every 15 minutes but stayed with him the whole time. They put an intervention in, a door alarm, that would go off when he was out of his room. During the night shift about two weeks ago Resident 69 hit his room mate Resident 65. He hit him twice. Both times were on third shift. CNA 14 came in for report on day shift at about 6:00 A.M. The staff told her they had moved Resident 65 into a temporary room, 304 or 305, with another resident. Resident 69 was in the room by himself. The report she received was that Resident 69 had hit Resident 65 on one night, then hit him again the next night, two nights in a row. Resident 65 was not injured. The first night Resident 69 hit Resident 65 they had moved Resident 65 to another room, so Resident 69 was by himself on a one-to-one observation. She passed on the information to second shift as to why Resident 65 was in a different room. Resident 69 was still on a one-to-one observation when she left the day Resident 65 was first hit. Resident 69 hit Resident 65 a second time because someone put Resident 65 back in Resident 69's room. She mentioned it to the Unit Manager, and they had her take Resident 65 out of Resident 69's room, but Resident 65 had already been hit a second time on third shift. When staff witnessed a behavior, they were supposed to fill out a behavior sheet. The Unit Manager would determine if a resident needed to be on a one-to-one observation or 15-minute checks. During an interview on 04/16/24 at 2:47 P.M., QMA 2 indicated she was working the day Resident 69 had an encounter with Resident 33, who lived across the hall from his room. He had been aggressive with the lady across the hall twice. Once, she was there when it happened, and another time she had been told about an occurrence in report. When the staff got report it was usually verbal, but night shift would write things on paper sometimes. The night shift papers got put into the shred bin. She had heard that Resident 65 had been moved to a different room because of his roommate being aggressive towards him. She had not seen Resident 69 being aggressive towards his roommate, just towards the lady across the hall, Resident 33. During an interview on 04/16/24 at 3:15 P.M., the DON indicated when a resident had a behavior, the staff member who witnessed the behavior, filled out a behavior sheet, gave it to the manager, then it was passed on to the SSD (Social Services Director). They would discuss it in morning meeting and come up with a plan for the next step. The administrator would sign off on the behavior sheets. During an interview on 04/17/24 at 9:55 A.M., the Therapy Manager indicated Resident 69 was independent in his wheelchair. When he came back from his second stay at a psychiatric facility, he was making a lot more attempts to walk independently in his room, so they tried to get him safer and stronger, and PT (Physical Therapy) had worked with him. Because of his cognition, he was a little hit or miss as to whether he would participate. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/18/24 at 10:40 A.M., the Dementia Care Coordinator/ Unit manager indicated when staff saw a behavior or were the first on the scene of a behavior, the first person who witnessed the behavior filled out the behavior sheet. If the first witness was a CNA, the nurse on duty would go and check on the resident and then review the behavior sheet. The staff communicated behaviors to the oncoming shift verbally. During an interview on 04/18/24 at 2:58 P.M., the DON indicated there was usually a physician's order to put an alarm in place for a resident. Resident 69 had a door frame alarm put in place a couple of weeks ago to alert the staff when the resident left his room. During an interview on 04/18/24 at 3:17 P.M., RN 13 indicated Resident 69 was very confused and it just progressed as he was in the facility. He wandered frequently. In the evenings she would keep him with her, especially after dinner because he wandered the unit. After dinner, the CNAs would be getting the residents ready for bed and doing personal care. He was aggressive with the male caregiver, CNA 18, who frequently worked on the dementia unit. The resident did better with female staff, but not a lot better. He slept a lot. He would be up for 36 hours then sleep for 36 hours. If he was up, he was wandering. He recently discharged to another facility. RN 13 was unsure when the door frame alarm was put into place. The resident knew the alarm was there and would step out of the door to make it go off. Staff had to reset the alarm each time it went off. They kept the door frame alarm on at all times. During an interview on 04/19/24 at 9:19 A.M., the DON indicated they placed the door frame alarm on 03/13/24, after Resident 69 was readmitted to the facility. Normally there was a physician's order for a personal alarm to checked it, test it on and off, and change the batteries on a regular basis. During an interview on 04/19/24 at 2:03 P.M., the Dementia Care Coordinator indicated Resident 69's behaviors usually happened around 2:00 P.M. Sometimes he was up all night long. After the second behavior incident with Resident 33, when Resident 69 hit Resident 33, Resident 69 was sent out to a psychiatric facility. The incident did not happen on her shift. He came back from a stay at a behavioral hospital to his same room. He was on one-to-one observation when he returned. Resident 69 hit Resident 65 on evening/night shift. Resident 69 was on a one-to-one observation until he was sent out again. Someone should have filled out a behavior report when Resident 69 hit Resident 65. They immediately moved Resident 65 to a different room with an empty bed. Resident 69 stayed on a one-on-one observation until they got the door frame alarm in place. The administration staff said they needed to fill out a behavior sheet and that was part of the chart, so they didn't have to put in a nurse's note on behaviors. The current ALARM, POSITION CHANGE policy, with a revised date of 09/17, was provided by the DON on 04/19/24 at 12:16 P.M. The policy indicated, .Position change alarms are alerting devices intended to monitor a resident's movement. The devices emit an audible signal to alert staff when the resident moves in certain ways .Should a position change alarm be deemed [sic] appropriate intervention by the team, a physician's order shall be obtained .Facility personnel will be advised of use per updated plan of care and will routinely check the device for proper placement and function each shift . (continued on next page)

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	155535	A. Building B. Wing	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willow Crossing Health & Rehabilitation Center	3550 Central Ave Columbus, IN 47203

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The current MOOD AND BEHAVIOR PROGRAM policy, with a revised date of 11/2013, was provided by the Clinical Consultant on 04/18/24 at 10:08 A.M. The policy indicated, .The Mood and Behavior Communication Memo will be completed by a staff member upon witnessing a resident mood/behavior .Any mood and/or behavior that can be harmful to any resident in any manner, such as sexual, verbal, mental, or physical abuse, must be immediately reported to the Administrator and/or designee, in an effort to confirm that staff completing the form followed the facility abuse prohibition policy mandating immediate reporting .Should revisions to the care plan be warranted, the same shall be completed and communicated to direct caregivers . 3.1-37(a)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33613 Based on observation, interview, and record review, the facility failed to store medications appropriately for 2 of 3 medication carts reviewed and for 6 of 15 resident medications reviewed. (Residents 41, 88, 36, 91, 23, and 13) Findings include: 1. During an observation on 04/14/24 at 9:53 A.M., the back 200 Hall medication cart had the following residents' controlled medications preset for the noon medication pass: - Resident 41's Oxycodone 7.5/325 mg (milligrams) and lorazepam 1 mg, - Resident 88's hydrocodone-acetaminophen 7.5-325 mg, - Resident 36's Lyrica 50 mg and hydrocodone-acetaminophen 7.5-325 mg, - Resident 91's tramadol 50 mg, and - Resident 23's hydrocodone-acetaminophen 10-325 mg. During an interview on 04/14/24 at 9:55 A.M., LPN (Licensed Practical Nurse) 8 indicated she usually preset resident medications for the next medication pass by placing them in a medication cup and labeling them with the resident's name. She placed the cup in the top drawer of the medication cart. 2. During an observation on 04/14/24 at 9:58 A.M., the front 200 Hall medication cart had the following controlled medication preset for the 10:00 A.M. medication pass: - Resident 13's tramadol 50 mg. During an interview on 04/14/24 at 9:59 A.M., QMA (Qualified Medication Aide) 9 indicated she usually preset her next medication pass after the previous medication pass. During an interview on 04/18/24 at 10:32 A.M., the DON (Director of Nursing) indicated controlled medications should not be preset. 38769 3. During a continuous observation on 04/14/24 from 12:02 P.M. to 12:04 P.M., an unlocked medication cart on the 200 Hall was parked outside room [ROOM NUMBER]. The door to room [ROOM NUMBER] was closed and there was no staff around. At 12:03 P.M., QMA 9 came out of room [ROOM NUMBER] and prepared medications. At 12:04 P.M. she locked the medication cart and returned to room [ROOM NUMBER] with the prepared medications. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/19/24 at 3:36 P.M., the DON indicated medication carts are to remain locked when unattended. The current STORING DRUGS policy, with a date of 12/2017, was provided by the Clinical Consultant on 04/18/24 at 10:08 A.M. The policy indicated, .Controlled medications must be stored by a double- lock in a separate area from all other medications . 3.1-25(m)

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 38239 Based on observation and interview, the facility failed to ensure food was served in a sanitary manner for 2 of 4 dining observations and 4 of 5 staff observations. (CNA 3, CNA 17, QMA 16, and CNA 5) Findings include: 1. During a dining observation in the Memory Care Unit on 04/14/24 the following occurred: - At 12:20 P.M., CNA (Certified Nurse Aide) 3 delivered Resident 70's meal. She removed the plate and cups from the tray and placed them on the table. She removed a dinner roll from the clear plastic package with her bare hand, placed the package on the table, and placed the roll on top of the package. - At 12:23 P.M., CNA 17 delivered Resident 159's meal. She removed the plate and cups from the tray and placed them on the table. She removed a dinner roll from the plastic package with her bare hand and set the package on the table. She sat the roll on top of the package. - At 12:26 P.M., CNA 3 delivered Resident 90's meal. She removed the plate and cups from the tray and placed them on the table. She removed a dinner roll from the plastic package with her bare hand and set the package on the table. She sat the roll on top of the package. - At 12:29 P.M., CNA 17 took Resident 94's dinner roll out of the package with her bare hand, buttered the roll and then placed the roll on the resident's plate. - At 12:33 P.M., QMA (Qualified Medication Aide) 16 removed Resident 45's dinner roll from the package with her bare hand, placed the package on the table and placed the roll on top of the package. 38769 2. During an observation on 04/14/24 in the Main Dining Room, the following was observed: - At 1:09 P.M., CNA 5 applied gloves and served a tray to Resident 13, she touched the tray and all the resident's bowls of food, she retrieved the bread from a bowl and applied butter to the bread. She removed her gloves after giving the resident all her food. - At 1:13 P.M., CNA 5 applied gloves and served a tray to Resident 27, she touched the tray and the resident's plate. She retrieved the bread and touched it with both hands. During an interview on 04/19/24 at 3:08 P.M., QMA 9 indicated if she were to touch a resident's food then she would don gloves. She wouldn't touch anything else after putting on the gloves. The current facility policy titled, Glove Use & Meal Service, dated 05/2018, was provided by the Administrator on 04/19/24 at 3:41 P.M. The policy indicated, .Employees may not touch ready-to-eat foods with bare hands, gloves must be worn . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3.1-21(i)(3)