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	02/18/2025

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

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 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 medication hold parameters for 2 of 22 residents reviewed for Quality of Care. (Residents 71 and 5) Findings include: 1. The clinical record for Resident 71 was reviewed on 02/17/25 at 9:00 A.M. A Quarterly Minimum Data Set (MDS) assessment, dated 11/13/24, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, schizoaffective disorder, heart failure, hypertension, diabetes, and depression. The current open-ended physician's order, with a start date of 09/03/24, indicated the resident was to receive Lisinopril (a blood pressure medication) 10 milligrams (mg), twice a day. The staff were to hold the medication when the systolic blood pressure (SBP) was less than 130 or the heart rate was less than 60. The January and February 2025 Electronic Medication Administration Record (EMAR) indicated the resident had received the medication when the blood pressure was less than 130 or the heart rate was less than 60 on the following dates and times: - On 01/01/25 in the evening, when the resident's blood pressure was 122/67, - On 01/04/25 in the evening, when the resident's blood pressure was 110/71, - On 01/06/25 in the morning, when the resident's blood pressure was 121/70, - On 01/08/25 in the evening, when the resident's blood pressure was 120/73, - On 01/09/25 in the morning, when the resident's blood pressure was 109/81, - On 01/10/25 in the morning, when the resident's blood pressure was 118/67, - On 01/19/25 in the evening, when the resident's blood pressure was 101/69, - On 01/22/25 in the morning when the resident's blood pressure was 118/76, (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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 01/23/25 in the evening when the resident's blood pressure was 124/71, - On 01/24/25 in the morning when the resident's blood pressure was 120/76, - On 01/26/25 in the evening when the resident's blood pressure was 94/72, - On 01/27/25 in the morning when the resident's blood pressure was 108/69, and in the evening when the blood pressure was 113/65, - On 02/01/25 in the evening when the resident's blood pressure was 127/71, - On 02/02/25 in the morning when the resident's blood pressure was 122/67, and in the evening when the blood pressure was 126/65, - On 02/03/25 in the morning when the resident's blood pressure was 126/68, - On 02/05/25 in the evening when the resident's blood pressure was 122/67, - On 02/06/25 in the evening when the resident's blood pressure was 122/75, - On 02/07/25 in the morning when the resident's blood pressure was 128/74, - On 02/08/25 in the evening when the resident's blood pressure was 126/76, - On 02/09/25 in the evening when the resident's blood pressure was 124/73, - On 02/11/25 in the evening when the resident's blood pressure was 126/71, - On 02/12/25 in the evening when the resident's blood pressure was 126/77, - On 02/13/25 in the evening when the resident's blood pressure was 124/76, - On 02/14/25 in the evening when the resident's blood pressure was 123/78, - On 02/15/25 in the evening when the resident's blood pressure was 127/63, and - On 02/17/25 in the morning when the resident's blood pressure was 90/86, and in the evening when the blood pressure was 112/67. The HEART DISEASE Care Plan included, but was not limited to, an intervention to monitor the resident's vital signs as ordered and as needed, and administer medications as ordered. 38239 2. The clinical record for Resident 5 was reviewed on 02/14/25 at 2:00 P.M. A Quarterly MDS assessment, dated 11/22/24 indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, stroke, coronary artery disease, hypertension, and dementia. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident's current MD orders included, but were not limited to the following: An open-ended order, with a start date of 11/07/24, to administer amlodipine (a cardiac medication) 5 mg, twice a day. The medication was to be held if the resident's SBP was less than 120. The January and February 2025 EMARs were reviewed and indicated the medication was administered when the resident's SBP was less than 120 on the following dates and times: - On 01/01/25 the morning the resident's blood pressure was 118/77, - On 01/02/25 the morning the resident's blood pressure was 115/75, - On 01/06/25 the morning the resident's blood pressure was 101/64, - On 01/07/25 the morning the resident's blood pressure was 93/66, - On 01/08/25 the morning the resident's blood pressure was 105/60 and the evening blood pressure was 107/66, - On 01/09/25 the evening the resident's blood pressure was 111/69, - On 01/11/25 the morning the resident's blood pressure was 110/60, - On 01/12/25 the morning the resident's blood pressure was 104/73 and the evening blood pressure was 111/71, - On 01/22/25 the morning the resident's blood pressure was 109/77, - On 01/26/25 the morning the resident's blood pressure was 112/67, - On 02/04/25 the morning the resident's blood pressure was 98/64 and the evening blood pressure was 112/76, - On 02/05/25 the morning the resident's blood pressure was 94/60, - On 02/06/25 the morning the resident's blood pressure was 105/70, - On 02/08/25 the morning the resident's blood pressure was 104/80, and - On 02/11/25 the morning the resident's blood pressure was 102/60 and the evening blood pressure was 110/78. During an interview on 02/18/25 at 10:17 A.M., RN 3 indicated if a resident had a cardiac medication withhold parameters, she would check the resident's blood pressure and heart rate before administering the medication. If the resident's blood pressure or heart rate was out of range, she would hold the medication. She would document in the EMAR that the medication was held. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The current facility policy titled PHYSICIAN ORDERS, dated 10/2014, was provided by the Assistant Director of Nursing (ADON) on 02/18/25 at 1:15 P.M. The policy indicated, .Physician's orders are administered . Ensure any follow through is completed . The current facility policy titled MEDICATION ADMINISTRATION, dated 04/2017, was provided by the ADON on 02/18/25 at 1:15 P.M. The policy indicated, .Always take pulse and B/P as indicated in ordered prior to giving certain cardiac or antihypertensive drugs .Notify the physician if the vital signs are not within the acceptable range . 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. 38239 Based on observation, interview, and record review, the facility failed to prevent and ensure a resident's wound was identified prior to the resident developing a Stage III pressure ulcer for 1 of 3 residents reviewed for pressure ulcers. (Resident 64) Findings include: The resident's clinical record was reviewed on 02/18/25 at 1:29 P.M. A Quarterly Minimum Data Set assessment, dated 07/16/24, indicated the resident was moderately cognitively impaired. The resident's diagnoses included, but were not limited to, stroke, hemiplegia affecting the right dominate side, malnutrition, dementia, peripheral vascular disease, and neuromuscular dysfunction of the bladder. The resident was always incontinent of bowel and had an indwelling urinary catheter. The resident was dependent on staff for toileting, hygiene, and mobility, including rolling left to right. The resident was at risk for pressure ulcers but had no pressures at the time of the assessment. The resident utilized pressure reducing devices for the bed and chair. The clinical record lacked documentation the resident had been absent from the facility for any services for an extended period of time during the month of August. A shower sheet, dated 08/24/24, indicated the resident had a red open area above her buttocks. During an interview on 02/18/25 at 10:30 A.M., the Director of Nursing (DON) indicated when the resident's wound was identified on 08/24/24 he would have assessed it and obtained a physician's order for treatment. He didn't document an assessment of the wound. If he documented a wound's severity or wound stage in the computer, and then the wound specialist came in and staged the wound as less severe, they wouldn't be able to change the wound staging. The wound specialist that came into the facility documented the initial wound assessment on 08/29/24. The resident's physician orders included an order, with a start date of 08/25/24, for a daily treatment to the sacral (base of the spine) wound. The wound was to be cleansed with normal saline. A skin protectant was to be applied to the skin around the wound. An antimicrobial wound gel and calcium alginate was to be applied to the wound bed. The wound was to be covered with a gauze dressing. The Wound Specialist documentation, dated 08/29/24, indicated the wound was a Stage III (full thickness skin loss that may extend into the subcutaneous tissue) pressure ulcer that measured 1.2 centimeters (cm) x (by) 1 cm, with a depth of 0.1 cm. There was a moderate amount of serous (watery, clear, or slightly yellow/tan/pink fluid) exudate. The wound was 70% granulation (new, pink/red moist) tissue and 30% slough (non-viable, dead) tissue. During an observation, on 02/17/25 at 10:09 A.M., Resident 64's sacral wound was observed with RN 3 and the Director of Nursing (DON). The wound was about 3 cm in diameter, with a depth of 1 cm. There was an area of undermining (a separation of the wound edge from the surrounding healthy tissue) along one side of the wound approximately 2 cm long. The wound bed was reddish/pink. There was no drainage or sign of infection. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 02/18/25 at 1:45 P.M., Qualified Medication Aide (QMA) 4 indicated the resident required extensive assistance from two staff members for care. Staff would provide catheter care and incontinence care multiple times each day. The current facility policy, titled SKIN MANAGEMENT PROGRAM, dated 10/2013, was provided by the DON on 02/18/24 at 2:40 P.M. The policy indicated, .Residents who receive assistance with bathing and/or pericare will be observed daily by nursing staff and any observance of red areas, open areas .will be reported to the licensed nurse for further assessment . The current facility policy, titled PRESSURE ULCERS, dated 10/2014, was provided by the DON on 02/18/24 at 2:45 P.M. The policy indicated, .assure that residents with pressure ulcers will receive necessary care and treatment to promote healing, prevent new ulcers from developing and prevent infection . 3.1-49(a)(2)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 38769 Based on record review and interview, the facility failed to document meal consumption values for 2 of 4 residents reviewed for nutrition. (Residents 55 and 62) Findings include: 1. A Quarterly Minimum Data Set (MDS) assessment, dated 01/29/25, indicated Resident 55 was cognitively intact. The resident's diagnoses included, but were not limited to, hypertension, urinary tract infection, seizure disorder, anxiety, depression, and bipolar. The resident had experienced weight loss. A Weight Loss Care Plan, with a start date of 01/18/25, included, but was not limited to, the following intervention: Monitor meal consumption and encourage resident to consume 100% (percent) of meals. The January and February 2025 Meal Consumption Record for the resident lacked documented meal intake values for the following dates: - 01/18/25 at dinner, - 01/26/25 at lunch, - 02/03/25 at breakfast, - 02/10/25 at dinner, and - 02/17/25 at breakfast. 2. A Quarterly MDS assessment, dated 11/27/24, indicated Resident 62 was severely cognitively impaired. The resident's diagnoses included, but were not limited to, dementia, hypertension, Alzheimer's disease, seizure disorder, malnutrition, anxiety, and depression. A Potential for Weight Loss Care Plan, with a start date of 10/01/24, included, but was not limited to, the following intervention: Monitor intake of each meal. The December 2024, January and February 2025 Meal Consumption Record for the resident lacked documented meal intake values for the following dates: - 12/01/24 at lunch, - 12/07/24 at breakfast, lunch, and dinner, - 12/11/24 at lunch, - 12/12/24 at breakfast and lunch, (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 12/13/24 at breakfast, - 12/14/24 at dinner, - 12/22/24 at breakfast and lunch, - 12/28/24 at breakfast and lunch, - 01/18/25 at lunch, - 01/19/25 at lunch, - 01/25/25 at lunch, - 02/01/25 at lunch, - 02/05/25 at lunch, and - 02/12/25 at breakfast and lunch. During an interview, on 02/18/25 at 1:07 P.M., Qualified Medication Aide (QMA) 6 indicated residents' meal consumption values should be documented in the computer system after every meal. The current facility policy titled, Meal Consumption Record, dated 10/2014, was provided by the Assistant Director of Nursing (ADON) on 02/18/25 at 1:55 P.M. The policy indicated, .To provide a means to monitor the resident's daily intake .At the end of each meal, resident trays should be observed and percentage of food consumed recorded on Meal Consumption Record . 3.1-46(a)(1)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 33613 Based on observation and interview, the facility failed to store medications appropriately for 2 of 3 medication carts reviewed. (Back 200 Medication Cart and Front 100 Medication Cart) Findings include: 1. The Back 200 Medication Cart was observed, on 02/18/25 at 2:33 P.M, with Qualified Medication Aide (QMA) 9. The medication cart contained the following loose pills laying loose in the bottom of the drawers: - two small round white tablets, - one small oval white tablet, and - one small oval blue tablet. The medication cart had several bits of debris/paper that were scattered heavily throughout the cart. During an , on 02/18/25 at 2:35 P.M., QMA 9 indicated she didn't clean the medication cart; she just passed the medications. 2. The Front 100 Medication Cart was observed, on 02/18/25 at 2:39 P.M., with QMA 8. The medication cart contained the following loose pills laying loose in the bottom of the drawers. - one small round white tablet, - one medium round white tablet, and - one large round white tablet. The medication cart had several bits of debris/paper that were scattered throughout the cart. During an interview, on 02/18/25 at 2:42 P.M., the Assistant Director of Nursing (ADON) indicated there should not be any loose pills in the medication carts. The current Storing Drugs policy, dated 4/2021, was provided by the ADON on 02/18/25 at 3:06 P.M. The policy indicated .Drugs and biologicals will be stored in a safe, secure, and orderly manner . 3.1-25(j)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. 38239 Based on record review and interview, the facility failed to obtain a urinalysis in a timely manner for 1 of 4 residents reviewed for laboratory services. (Resident 36) Findings include: A Quarterly Minimum Data Set assessment, dated 11/06/24, indicated Resident 36 was moderately cognitively impaired. The resident's diagnoses included, but were not limited to, vascular dementia, diabetes, and stroke. A progress note, dated 01/02/25 at 1:47 P.M., indicated the resident had a new physician's order to obtain a urine dip (a rapid urine test performed in the facility). If the urine dip was positive, nursing staff were to obtain a urine sample to send to the lab for urinalysis (UA) and a Culture and Sensitivity (C&S). The resident's family member was notified. The lab report from the urinalysis indicated the urine sample was collected on 01/07/25 and resulted on 01/08/25. The report indicated there were greater than 100,000 CFU/ml (colony forming units per milliliter) of Streptococcus beta hemolytic Group B bacteria. The bacteria were universally susceptible to Penicillins (a type of antibiotic). Susceptibility testing was not routinely performed. A progress note, dated 01/09/25 at 2:18 P.M., indicated the resident was to receive Amoxicillin (an antibiotic) 500 mg (milligrams) by mouth four times a day for a UTI. During an interview, on 02/18/25 at 10:17 A.M., RN 3 indicated if there was an order to obtain a UA, she would put the order in the computer. She would fill out a lab requisition form and fax the form to the lab, so they were aware. She would collect the urine sample and place it in the designated refrigerator. If she was having a hard time obtaining a sample, she would document that in the computer. The lab technicians came every day, and staff could call the courier to pick up a sample as well. UA C&S results were usually available within 48 to 72 hours of the sample arriving at the lab. During an interview, on 02/18/25 at 10:11 A.M., the ADON indicated the lab came in every morning to collect specimens to take to the local hospital. The order for the UA was given on 01/02/25. The sample was not collected until 01/07/25. It did not usually take five days to obtain a urine specimen. The current facility policy, titled SPECIMEN COLLECTION ROUTINE URINE, dated 10/2014, was provided by the ADON on 02/18/25 at 1:15 P.M. The policy indicated, .obtain a fresh urine specimen for lab analysis . Routine urine specimens are collected as per physician's orders . 3.1-49(a)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 38769 Based on observation and interview, the facility failed to follow infection control guidelines during dining service for 1 of 2 dining observations. (Residents 102 and 15) Findings include: During a continuous observation on 02/12/25, from 11:49 A.M. to 11:57 A.M., in the Dementia Unit Dining Room, the following was observed: At 11:49 A.M., Activity Aide (AA) 10 sat an empty lunch tray on a table, opened the trash can lid with her bare left hand, threw some trash into the can, went to the meal cart, and moved around several meal trays within the cart that were to be served to the residents. She retrieved a tray from the cart and served it to Resident 102. After serving the tray she sanitized her hands. At 11:54, she sat an empty tray on a table; opened the trash can lid with her bare left hand; threw some trash into the can; went to the meal cart; and moved several resident meal trays within the cart. She retrieved a meal tray and served it to Resident 15. After serving the tray she sanitized her hands. During an interview, on 02/18/25 at 1:31 P.M., Certified Nurse Aide (CNA) 7 indicated when she was serving meal trays to residents, she would sanitize her hands after every tray served and wash her hands after every third tray served. If she ever touched anything besides the tray while serving, then she would immediately wash or sanitize her hands. The current facility policy titled, Meal Service dated 10/2014 was provided by the Administrator on 02/18/25 at 2:00 P.M. The policy indicated, .To ensure that all meals are delivered to resident as per physician's order . 3.1-21(i)(3)