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	03/11/2026

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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(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 - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on record and interview, the facility failed to follow physician's orders related to hold parameters and obtaining vital signs for cardiac medications for 7 of 21 residents reviewed for quality of care. (Residents 44, 62, 30, 10, 3, 8, and 104) Findings include:1.The clinical record for resident 44 was reviewed on 03/10/2026 at 10:30 A.M. A Quarterly Minimum Data Set (MDS) assessment, dated 01/01/2026, indicated the resident was cognitively intact. The resident's diagnosis included, but was not limited to, hypertension. An open-ended physician's order, with a start date of 12/22/2025, indicated the resident was to be given midodrine 10 milligrams (mg) twice a day for orthostatic hypertension. The staff were to hold, not give, the medication, if the resident's systolic blood pressure (top number) was greater than 130. The January, February, and March 2026 Electronic Medication Administration Record (EMAR) indicated the resident had received the medication on the following days and times when the resident's systolic blood pressure was greater than 130: -On 01/03/2026 from 6:30 P.M. to 10:30 P.M., when the resident's systolic blood pressure was 139, -On 01/21/2026 from 6:30 P.M. to 10:30 P.M., when the resident's systolic blood pressure was 133, -On 02/09/2026 from 6:30 P.M. to 10:30 P.M., when the resident's systolic blood pressure was 144, -On 02/19/2026 from 6:30 A.M. to 10:30 A.M., when the resident's systolic blood pressure was 133, -On 02/21/2026 from 6:30 A.M. to 10:30 A.M., when the resident's systolic blood pressure was 160, -On 02/25/2026 from 6:30 P.M. to 10:30 P.M., when the resident's systolic blood pressure was 144, and -On 03/04/2026 from 6:30 P.M. to 10:30 P.M., when the resident's systolic blood pressure was 145. 2. The clinical record for Resident 62 was reviewed on 03/06/2026 at 11:56 A.M. A Quarterly MDS assessment, dated 01/02/2026, indicated the resident was severely cognitively impaired. The resident's diagnosis included, but was not limited to, hypertension. An open-ended physician's order, with a start date of 11/21/2025, indicated the resident was to be given metoprolol succinate 25 mg, once a day, for hypertension. The staff were to hold the medication if the resident's pulse was less than 60 beats per minute, or the resident's systolic blood pressure was less than 100. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The January and February 2026 EMARs lacked documented resident blood pressure values at the time the medication was administered. The March 2026 EMAR lacked documented resident blood pressure values at the time the medication was administered from 03/01/20226 through 03/06/2026. Starting on 03/07/2026, the resident's blood pressure values were documented on the EMAR at the time the medication was administered. 3. The clinical record for Resident 30 was reviewed on 03/10/2026 at 9:48 A.M. An admission MDS assessment, dated 02/27/2026, indicted the resident was cognitively intact. The resident's diagnoses included, but were not limited to, heart failure, hypertension and diabetes. A physician's order, dated 02/21/2026 through 03/07/2026, indicated the resident was to be given hydralazine 25 mg, twice a day for chronic kidney disease. The staff were to hold the medication if the resident's systolic blood pressure was less than 170. The February and March 2026 EMAR indicated the resident had received the medication on the following dates and times when the resident's systolic blood pressure was less than 170: -On 02/22/2026 from 6:30 A.M. to 10:30 A.M., when the resident's systolic blood pressure was 122 and at 6:30 P.M. to 10:30 P.M, when the resident's systolic blood pressure was 121, -On 02/23/2026 from 6:30 P.M. to 10:30 P.M., when the resident's systolic blood pressure was 104 and 110, -On 02/24/2026 from 6:30 P.M. to 10:30 P.M., when the resident's systolic blood pressure was 121, -On 02/25/2026 from 6:30 A.M. to 10:30 A.M., when the resident's systolic blood pressure was 146 and at 6:30 P.M. to 10:30 P.M., the resident's systolic blood pressure was 139, -On 02/26/2026 from 6:30 A.M. to 10:30 A.M., when the resident's systolic blood pressure was 113 and at 6:30 P.M. to 10:30 P.M., the resident's systolic blood pressure was 112, -On 02/27/2026 from 6:30 A.M. to 10:30 A.M., when the resident's systolic blood pressure was 132 and at 6:30 P.M. to 10:30 P.M., the resident's systolic blood pressure was 125, -On 02/28/2026 from 6:30 P.M. to 10:30 P.M., when the resident's systolic blood pressure was 129, -On 03/01/2026 from 6:30 P.M. to 10:30 P.M., when the resident's systolic blood pressure was 133, -On 03/02/2026 from 6:30 A.M. to 10:30 A.M., when the resident's systolic blood pressure was 130 and at 6:30 P.M. to 10:30 P.M., the resident's systolic blood pressure was 133, -On 03/04/2026 from 6:30 A.M. to 10:30 A.M., when the resident's systolic blood pressure was 119 and at 6:30 P.M. to 10:30 P.M., the resident's systolic blood pressure was 122, -On 03/05/2026 from 6:30 P.M. to 10:30 P.M., when the resident's systolic blood pressure was 102, -On 03/06/2026 from 6:30 A.M. to 10:30 P.M., when the resident's systolic blood pressure was 118 and at 6:30 P.M. to 10:30 P.M., the resident's systolic blood pressure was 121, and (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 03/07/2026 from 6:30 A.M. to 10:30 A.M., when the resident's systolic blood pressure was 101. 4. The clinical record for Resident 10 was reviewed on 03/10/2026 at 11:50 A.M. A Quarterly MDS assessment, dated 01/12/2026, indicated the resident was moderately cognitively impaired. The resident's diagnosis included but was not limited to, diabetes. An open-ended physician's order, with a start date of 12/11/2025, indicated the resident was to receive 6 units of Admelog (a rapid acting insulin) with meals. The staff were to hold the medication for blood sugars that were below 150 or if the resident didn't eat. The January, February, and March, 2026 EMAR indicated the resident had received the medication when the resident's blood sugar was less than 150 on the following dates and times: -On 01/01/2026 at 7:00 A.M., when the resident's blood sugar was 118, -On 01/08/2026 at 4:00 P.M., when the resident's blood sugar was 143, -On 01/18/2026 at 7:00 A.M., when the resident's blood sugar was 143, -On 01/25/2026 at 7:00 A.M., when the resident's blood sugar was 148 and at 11:00 A.M., the resident's blood sugar was 136, -On 02/08/2026 at 7:00 A.M., when the resident's blood sugar was 134 and 11:00 A.M., the resident's blood sugar was 122, -On 02/12/2026 at 7:00 A.M., when the resident's blood sugar was 145, and -On 03/09/2026 at 7:00 A.M., when the resident's blood sugar was 132. 5. Resident 3's clinical record was reviewed on 03/10/2026 at 2:26 P.M. A Quarterly MDS assessment, dated 01/10/2026, indicated the resident's diagnoses included, but were not limited to, heart failure, hypotension, and end stage kidney disease. The resident received dialysis treatments. A current, open-ended physician's order, with a start date of 09/05/2025, indicated the resident was to receive midodrine 10 mg, three times a day for hypotension. Staff were to hold the medication if the resident's systolic blood pressure was greater than 120. The February and March 2026 EMARs indicated the resident received the medication on the following dates and times when the resident's systolic blood pressure was greater than 120: - On 02/04/2026 at 8:00 P.M., when the resident's systolic blood pressure was 122, - On 02/10/2026 at 12:00 P.M., when the resident's systolic blood pressure was 135, - On 02/12/2026 at 12:00 P.M., when the resident's systolic blood pressure was 149, - On 02/15/2026 at 12:00 P.M., when the resident's systolic blood pressure was 126, - On 02/16/2026 at 5:30 A.M., when the resident's systolic blood pressure was 121, (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On 02/25/2026 at 12:00 P.M., when the resident's systolic blood pressure was 141, - On 03/04/2026 at 5:30 A.M., when the resident's systolic blood pressure was 180, - On 03/05/2026 at 5:30 A.M., when the resident's systolic blood pressure was 123 and at 8:00 P.M., when the resident's systolic blood pressure was 126,- On 03/07/2026 at 5:30 A.M., when the resident's systolic blood pressure was 121, and - On 03/08/2026 at 8:00 P.M., when the resident's systolic blood pressure was 129. 6. Resident 8's clinical record was reviewed on 03/10/2026 at 10:47 A.M. A Significant Change MDS assessment, dated 01/01/2026, the resident's diagnosis included, but was not limited to, coronary artery disease and hypertension. A current, open-ended physician's order, with a start date of 09/18/2025, indicated the resident was to receive metoprolol succinate, 25 mg, once a day for hypertension. The medication was to be held if the resident's SBP was less than 120 or their heart rate was less than 60. The February and March 2026 EMARs indicated the resident received the medication on the following dates when the resident's systolic blood pressure was less than 120: - On 02/15/2026, when the resident's systolic blood pressure was 103, - On 02/27/2026, when the resident's systolic blood pressure was 94, and - On 03/06/2026, when the resident's systolic blood pressure was 116. 7. Resident 104's clinical record was reviewed on 03/10/2026 at 2:00 P.M. A Comprehensive MDS assessment, dated 02/11/2026, indicated the resident's diagnoses included, but were not limited to, heart failure, hypertension, and end stage renal disease. The resident received dialysis treatments. A current, open-ended physician's order, with a start date of 01/23/2026, indicated the resident was to receive midodrine 5 mg, once a day on Monday, Wednesday, and Friday at 6:00 A.M. for hypotension. The medication was to be held if the resident's SBP was greater than 130 or if their heart rate was greater than 80. The February and March 2026 EMARs indicated the resident received the medication on the following dates and times when the resident's systolic blood pressure was greater than 130: - On 02/04/2026, when the resident's systolic blood pressure was 133. - On 02/09/2026, when the resident's systolic blood pressure was not assessed, - On 02/16/2026, when the resident's systolic blood pressure was 132, - On 03/02/2026, when the resident's systolic blood pressure was 143, and - On 03/04/2026, when the resident's systolic blood pressure was 132. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview, on 03/11/2026 at 10:56 A.M., RN 2 indicated when a resident had hold parameters for a medication, she would obtain the required vital signs (blood pressure or heart rate) before she administered the medication. If the resident's blood pressure or heart rate was out of range, she would not administer the medication and she would indicate in the EMAR the medication was held due to the resident's condition. The current facility policy, revised on 09/2025 and titled MEDICATION ADMINISTRATION was provided by the Assistant Director of Nursing on 03/11/2026 at 1:30 P.M. The policy indicated, '.To safely administer medications as per physicians' orders. Always take pulse and B/P as indicated if ordered prior to giving certain cardiac or antihypertensive drugs. Notify the physician if the vital signs are not within the acceptable range. 410 IAC (Indiana Administrative Code) 16.2-3.1-48(a)(6)

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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. Based on observation and interview, the facility failed to maintain resident records in a private manner related to computer screens being left open with resident information visible for 3 random observations. (Residents 32 and 33)Findings include:During an observation, on 03/09/2026 at 10:18 A.M., the computer screen on the 100 Hall Medication Cart 1 was observed to have Resident 32's personal and medical information visible and was left unattended. - On 03/09/2026 at 10:18 A.M., a staff member walked by the medication cart,- On 03/09/2026 at 10:19 A.M., a resident walked by the medication cart, - On 03/09/2026 at 10:19 A.M., a Certified Nurse Aide (CNA) walked by the medication cart,- On 03/09/2026 at 10:20 A.M., RN 3 returned to the medication cart. During an observation, on 03/09/2026 at 11:58 A.M., the computer screen on the 100 Hall Medication Cart 2 was observed to have resident information visible and was left unattended. - On 03/09/2026 at 11:59 A.M., the Administrator and the Assistant Director of Nursing (ADON) walked by the medication cart,- On 03/09/2026 at 12:00 P.M., a CNA walked by the medication cart. - On 03/09/2026 at 12:01 P.M., RN 2 returned to the medication cart. During an interview at that time, she indicated the resident information shouldn't be left visible and she was sorry. During an observation, on 03/09/2026 at 1:13 P.M., the computer screen on one of the 100 Hall Medication Cart 2 was observed to have Resident 33's personal and medical information visible and was left unattended. - On 03/09/2026 at 1:13 P.M., a CNA walked by the medication cart. - On 03/09/2026 at 1:14 P.M., a visitor walked by the medication cart. - On 03/09/2026 at 1:15 P.M., RN 2 returned to the medication cart. During an interview, on 03/10/2026 at 11:30 A.M., Licensed Practical Nurse (LPN) 5 indicated the computer screen should not be left with resident information visible. There was a walk away button on the computer to hide resident information without closing the computer lid. The Current HIPPA (Health Insurance Portability and Accountability Act) policy was provided by the ADON on 03/09/2026 at 2:19 P.M. The policy indicated .All staff members are responsible for safeguarding the privacy of resident health information.410 IAC (Indiana Administrative Code) 16.2-3.1-3(o)

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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. Based on interview, record review, and observation, the facility failed to ensure appropriate procedure was followed during providing care for a suprapubic urinary catheter replacement for 1 of 2 residents reviewed for urinary catheters. (Resident 78) Findings include:The clinical record for Resident 78 was reviewed on 03/09/2026 at 9:46 A.M. A Quarterly Minimum Data Set (MDS) assessment, dated 01/30/2026, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, neurogenic bladder (dysfunction of the urinary bladder caused by nervous system damage), and obstructive uropathy (structural or functional blockage of urine flow anywhere along the urinary tract). The resident had an indwelling urinary catheter. The Electronic Medication Administration Record (EMAR) for February and March 2026, indicated the resident had received the antibiotic Ciprofloxacin 250 milligrams twice a day from 02/25/2026 through 03/03/2026 for a urinary tract infection. The procedure for changing the resident's indwelling suprapubic urinary catheter was observed on 03/09/2026 at 2:18 P.M., with RN 3. The nurse entered the resident's room, washed her hands, adjusted the resident's bed, placed supplies on an over-bed table, draped the resident with a clean towel, and donned clean gloves. The nurse took her gathered supplies and placed them on the over-bed table. She then peeled the resident's brief back and attached an empty syringe to the port to deflate the retention balloon. The nurse pulled out 30 cubic centimeters (cc) of clear fluid, squirted it in the trash, tried pulling more fluid, squirted it in the trash, and removed her gloves. The nurse then opened the sterile kit box and dropped the paper wrapped sterile gloves on the over-bed table. She opened the paper wrapper, donned the sterile gloves, took the paper drape out of the package and placed it over the insertion site of the suprapubic catheter. She removed a syringe from the box and placed it on the paper the gloves had been wrapped in, using the paper for a sterile field. She opened the betadine swabs and placed them on the paper. She squirted lubricant from the kit out on the paper, removed the new catheter tubing from the plastic bag/wrapper, just the end, and placed the open end in the lube on the paper. She picked up the betadine swabs and cleaned around the insertion site of the catheter on the resident's abdomen, pulled out the old catheter tubing, and placed it on the towel on the bed. She continued to clean around the insertion site. There was some black residue in the crease of the resident's abdomen where the insertion site was located. The nurse squirted some normal saline from a syringe onto a gauze pad and cleaned around the insertion site to remove the black residue. Then the nurse inserted the new catheter tubing into the insertion site, pulling the plastic off the tubing as she fed the tubing into the resident's abdomen, using both gloved hands. There was no visible urine return coming out of the tubing. The tubing was open with no catheter bag attached. The RN inflated the 30 cc balloon to anchor the catheter, then attached the urinary catheter drainage tubing and bag, applied a split gauze pad around the catheter tubing at the insertion site, threw the old drainage bag away, pulled up the resident's brief, attached the tubing to the Velcro anchor, hung the drainage bag on the side of the bed, covered the resident up with her blankets, gathered trash from the table and floor, threw the trash away, removed the sterile gloves, and tied the trash bag up. When asked if the resident had urine return, the RN indicated, Well, she had just peed. The resident had a sign on her closet door in her room stating she was in Enhanced Barrier Precautions. The nurse did not don a gown prior to changing the resident's catheter. During an interview immediately following the procedure, RN 3 indicated if a resident was on Enhanced Barrier Precautions there would normally be a cart outside of the resident's room with supplies. When asking the RN if she normally would don a gown before performing invasive procedures, she replied, Not normally with this resident. During an interview, on 03/09/2026 at 3:15 P.M., the Assistant Director of Nursing (ADON) indicated, for residents in EBP, staff were to don appropriate Personal Protective Equipment (PPE) including a gown and gloves. The procedure for changing a suprapubic indwelling urinary catheter was to first get supplies, then gown up, go in, ask permission, and set up the sterile (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	field. She had always put a drape over the table and used a clean towel. She would clean the table, cover it with a clean towel, open the equipment, it's all in one bag that included the drainage bag, the tubing, the insertion kit, and sterile gloves. Clean the resident, remove the old suprapubic catheter, clean the site, remove your gloves and gown, perform hand hygiene, don a clean gown, don the sterile gloves, prepare the site, cleanse the site with the betadine swabs, insert the catheter tubing, ensure there was urine return, then anchor the catheter. Make sure there was urine return before you inflate the catheter anchoring balloon. You should get urine return; if you didn't, there was a problem. The current CATHETER REINSERTION, SUPRAPUBIC policy, dated 10/2014, was provided by the Director of Nursing on 03/11/2026 at 1:06 P.M. The policy indicated, .Wash abdominal area above the pubis with soap and water .Open sterile catheter package .Put on sterile gloves .Lubricate tip of catheter .Insert the catheter slowly until urine begins to flow . 410 IAC (Indiana Administrative Code) 16.2-3.1-41(a)(2)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on record review and interview, the facility failed to have medications available to residents for 2 of 24 residents reviewed for pharmacy services. (Residents 10 and 104)Findings include: 1.The clinical record for Resident 10 was reviewed on 03/10/2026 at 11:50 A.M. A Quarterly MDS assessment, dated 01/12/2026, indicated the resident was moderately cognitively impaired. The resident's diagnosis included, but was not limited to, non-Alzheimer's dementia (mental decline). An open-ended physician's order, with a start date of 09/09/2025, indicated the resident was to be given Aricept (a dementia medication) 10 mg at bedtime. The January, February, and March, 2026 EMAR indicated the resident did not receive the medication on the following dates due to the medication being unavailable: 01/03/2026, 01/04/2026, 01/11/2026, 01/17/2026, 01/18/2026, 01/25/2026, 01/31/2026, 02/05/2026, 02/07/2026, 02/08/2026, 02/14/2026, 02/15/2026, 02/16/2026, 02/19/2026, 02/21/2026, 02/22/2026, 02/28/2026, 03/01/2026, 03/07/2026, and 03/08/2026. 2. Resident 104's clinical record was reviewed on 03/10/2026 at 2:00 P.M. A Comprehensive MDS assessment, dated 02/11/2026, indicated the resident's diagnosis included, but was not limited to, end stage renal disease. The resident received dialysis treatments. A current, open-ended physician's order, with a start date of 01/13/2026, indicated the resident was to receive Renvela (phosphate binding medication used to manage high phosphate levels in patients with chronic kidney disease on dialysis) 800 mg with meals due to dependence on renal dialysis. The January and February 2026 EMARs indicated the resident did not receive the medication on the following dates and times due to the medication being unavailable: On 01/13/2026 at 5:00 P.M.; 01/14/2026 at 5:00 P.M.; 01/15/2026 at 8:00 A.M., 12:00 P.M., and 5:00 P.M.; 01/16/2026 at 8:00 A.M., 12:00 P.M., and 5:00 P.M.; 01/17/2026 at 8:00 A.M., and 12:00 P.M.; 01/18/2026 at 8:00 A.M., 12:00 P.M., and 5:00 P.M.; 01/19/2026 at 5:00 P.M.; 01/20/2026 at 8:00 A.M., 12:00 P.M., and 5:00 P.M.; 01/21/2026 at 12:00 P.M., and 5:00 P.M.; 01/22/2026 at 8:00 A.M., 12:00 P.M., and 5:00 P.M.; 01/23/2026 at 8:00 A.M., and 12:00 P.M.; 01/24/2026 at 8:00 A.M., and 5:00 P.M.; 01/26/2026 at 8:00 A.M., and 12:00 P.M.; 01/27/2026 at 5:00 P.M.; 01/28/2026 at 8:00 A.M., 12:00 P.M., and 5:00 P.M.; 02/02/2026 at 8:00 A.M., 12:00 P.M., and 5:00 P.M.; 02/03/2026 at 12:00 P.M., and 5:00 P.M.; 02/04/2026 at 8:00 A.M., 12:00 P.M., and 5:00 P.M.; 02/05/2026 at 8:00 A.M., and 12:00 P.M.; 02/06/2026 at 8:00 A.M., 12:00 P.M., and 5:00 P.M.; 02/07/2026 at 8:00 A.M., and 12:00 P.M.; 02/08/2026 at 8:00 A.M., 12:00 P.M., and 5:00 P.M.; 02/09/2026 at 8:00 A.M., and 12:00 P.M.; 02/10/2026 at 8:00 A.M., 12:00 P.M., and 5:00 P.M.; 02/11/2026 at 8:00 A.M., 12:00 P.M., and 5:00 P.M.; 02/12/2026 at 8:00 A.M., and 12:00 P.M.; 02/14/2026 at 8:00 A.M., 12:00 P.M., and 5:00 P.M.; and 02/15/2026 at 8:00 A.M., 12:00 P.M., and 5:00 P.M. During an interview, on 03/11/2026 at 10:46 A.M., RN 2 indicated the last five doses of a medication were highlighted in blue on the medication cards so nursing staff would know to re-order the medication. Medications were able to be ordered by clicking a button in the resident's Electronic Health Record (EHR) that would notify the pharmacy to send a new supply. If a medication was not available in the medication cart, she would look in the Emergency Drug Kit (EDK) and pull it from there. If the medication wasn't available in the EDK, she would notify the MD or Nurse Practitioner (NP) and see if there was a substitute medication they wanted administered. If not, she would get a (continued on next page)

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	03/11/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Hold order from the provider. If a medication was unavailable, she would contact the pharmacy to re-order the medication. Medications were usually delivered within 48 to 72 hours of being ordered. She would document notes in the resident's EMAR and progress notes regarding unavailable medication. There was an issue between the dialysis center and the pharmacy with obtaining Resident 104's medication. She was unsure if the facility MD or NP were aware that the medication had been unavailable. The current facility policy, revised on 09/2025 and titled MEDICATION ADMINISTRATION was provided by the Assistant Director of Nursing on 03/11/2026 at 1:30 P.M. the policy indicated, '.Should the medication be out of supply, the nurse or QMA must consider the type of medication and whether significant or non-significant for timely administration. If significant, the EDK should be assessed to verify if the medication is available and could be accessed immediately per use of the EDK. If not in the EDK, upon completion of the medication pass, the pharmacy should be contacted and notified of the medication out of supply. If significant, the pharmacy should be notified of the urgent need for delivery. If not significant, the pharmacy may deliver upon next normally scheduled delivery day. Should there be a delay in delivery of a significant medication which could pose risk to the resident's plan of care, the physician must be contacted to ensure he/she is aware of the delay and provide opportunity for an alternative, available treatment to be ordered or to provide further directive due to lack of availability of the medication. 410 IAC (Indiana Administrative Code) 16.2-3.1-25(a)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. Based on record review and interview, the facility failed to track infections for 3 of 12 residents reviewed for antibiotic stewardship. (Residents 10, 22, and 78)Findings include:1.The clinical record for Resident 10 was reviewed on 03/10/2026 at 11:50 A.M. A Quarterly Minimum Data Set (MDS) assessment, dated 01/12/2026, indicated the resident was moderately cognitively impaired. The resident's diagnosis included, but was not limited to, urinary tract infection. A physician's order, dated 09/19/2025 through 09/24/2025, indicated the resident was to be given Avycaz (an antibiotic medication) 2.5 grams, every 8 hours for resistance to carbapenem (an antibiotic medication), for a urinary tract infection. The Electronic Medication Administration Record (EMAR) indicated the resident had received the medication. The September 2025 Infection Control Tracking Log lacked indication the resident had received an antibiotic in September 2025. A physician's order, dated 11/14/2025 through 11/21/2025, indicated the resident was to be given Cipro (an antibiotic) 250 milligrams (mg), twice a day for history of urinary tract infections. The November 2025 Infection Control Tracking Log lacked indication the resident had received an antibiotic in November 2025. The Electronic Medication Administration Record (EMAR) indicated the resident had received the medication. During an interview, on 03/11/2026 at 10:37 A.M., the Assistant Director of Nursing indicated she ran an antibiotic report daily to add residents who started on a new antibiotic to the tracking log. If a resident was admitted from the hospital on an antibiotic, then she checked the start and stop dates and tracked them also. She would track and trend infections to see if there needed to be more education or training for resident care. 2. The clinical record for Resident 22 was reviewed on 03/09/2026 9:15 A.M. A Quarterly MDS assessment, dated 01/14/2026, indicated the resident was cognitively intact. The resident's diagnosis included, but was not limited to, chronic respiratory failure. A physician's order, dated 02/19/2026 through 02/26/2026, indicated the resident was to be given Amoxicillin (an antibiotic medication) 500 milligrams (mg), three times each day for acute cough. The EMAR indicated the resident had received the medication. A physician's order, dated 02/26/2026 through 03/06/2026, indicated the resident was to be given Augmentin (an antibiotic medication) 875-125 mg, twice a day each day for acute cough. The EMAR indicated the resident had received the medication. The February 2026 Infection Control Tracking Log lacked indication the resident had received an antibiotic in February 2026. 3.The clinical record for Resident 78 was reviewed on 03/09/2026 at 9:46 A.M. A Quarterly MDS assessment, dated 01/30/2026, indicated the resident was cognitively intact. The resident's diagnosis included, but was not limited to, obstructive uropathy (structural or functional blockage of urine flow anywhere along the urinary tact). The resident had an indwelling urinary catheter. The resident had not been discharged from the facility in over 90 days. (continued on next page)

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	155535	A. Building B. Wing	03/11/2026

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician's order, dated 02/25/2026 through 03/03/2026, indicated the resident was to be given the antibiotic Ciprofloxacin 250 mg, twice a day for a Urinary Tract Infection (UTI). The EMAR for February and March 2026 indicated the resident had received the medication. The February 2026 Infection Control Tracking Log lacked indication the resident had received an antibiotic in February 2026. The current ANTIBIOTIC STEWARDSHIP PROGRAM policy, with a revised date of 06/2018, was provided by the Assistant Director of Nursing on 03/11/2026 at 1:43 P.M. The policy indicated, .The Infection Preventionist will conduct ongoing surveillance for Healthcare-Associated Infections.and other epidemiologically significant infections that have substantial impact on potential resident outcome and that may require transmission-based precautions and other preventative interventions.The purpose of the surveillance of infections is to identify both individual cases and trends of epidemiologically significant organisms and Healthcare-Associated Infections, to guide appropriate interventions, and to prevent future infections. 410 IAC (Indiana Administrative Code) 16.2-3.1-18(b)(1)(A)