

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  366473	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/20/2025
NAME OF PROVIDER OR SUPPLIER  The Willows at Tiffin		STREET ADDRESS, CITY, STATE, ZIP CODE  410 Fair Lane Tiffin, OH 44883	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49742</b></p> <p>Based on observation, staff interview, medical record review, and review of facility, the facility failed to ensure staff followed physician orders while administering bolus enteral feedings to the residents. This affected one (#32) of one resident reviewed for enteral feedings. The facility identified three residents who receive enteral feedings. The facility census was 57.</p> <p>Findings include:</p> <p>Medical record review for Resident #32 revealed an admitted [DATE] with diagnoses including acute respiratory failure with hypoxia, pneumonia, chronic obstructive pulmonary disease (COPD), moderate protein-calorie malnutrition, and dysphagia. Review of the annual Minimum Data Set (MDS) assessment, dated 12/27/24, revealed Resident #32 was cognitively intact.</p> <p>Review of Resident #32's physician order, dated 05/07/23, revealed an order to check tube placement by air bolus and aspirating stomach contents before medication delivery. The physician order, dated 07/26/24, revealed an order for a residual check every shift, and document amount of residual. Return aspirated contents.</p> <p>Observation on 03/18/25 at 12:47 P.M. revealed Registered Nurse (RN) #358 did not verify tube placement by air bolus and aspirating of stomach contents before medication delivery.</p> <p>Interview on 03/18/25 at 1:13 P.M. with RN #358 verified she did not verify tube placement by air bolus or aspirate stomach contents before medication delivery for Resident #32. RN #358 stated when administering enteral feedings to Resident #32, she visualizes the contents of the tube when attached to the syringe and does not aspirate stomach contents. RN #358 stated she verifies placement with water when she provides the free water flush prior to administering medication and does not verify tube placement by air bolus.</p> <p>Review of the facility policy titled Enteral Tube Medication Administration, with a revision date of November 2018, revealed the facility assures the safe and effective administration of enteral formulas via enteral tubes. With gloves on, check for proper tube placement using air and auscultation only. Never check placement with water. Check gastric content for residual feeding. Return residual volumes to the stomach. Report any residual above 100 milliliters.</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49742</p> <p>Based on observation, resident and staff interview, review of facility policy, and medical record review, the facility failed to ensure medications were not left at the resident's bedside when the resident does not have a self-administration order. This affected one (#17) of one resident reviewed for medication storage. The facility census was 57.</p> <p>Findings Include:</p> <p>Medical record review for Resident #17 revealed an admitted [DATE]. Diagnoses included chronic kidney disease, congestive heart failure (CHF), atrial fibrillation, hypothyroidism, hyperlipidemia, and cervical disc degeneration. Review of the quarterly Minimum Data Set (MDS) assessment, dated 01/09/25, revealed Resident #17 was cognitively intact.</p> <p>Review of Resident #17's self-administration order, dated 03/22/23, revealed Resident #17 was allowed to self-administer Refresh Eyedrops, Pataday Eyedrops, and Flonase Nasal Spray (treats allergies). This self-administration order was silent regarding Resident #17's ability to self-administer any other medications.</p> <p>Review of Resident #17's physician orders revealed the morning medication administration between 6:00 A.M. and 10:00 A.M. on 03/20/25, Resident #17 received the following medications: amiodarone tablet 200 milligrams (mg) administer 100 mg for atrial fibrillation, aspirin 81 mg for atrial fibrillation, lipitor 10 mg for hyperlipidemia, synthroid table 100 micrograms (mcg) for hypothyroidism, and triameterene-hydrochlorothiazid capsule 37.5-25 mg for diuretic.</p> <p>Observation on 03/20/25 at 8:40 A.M. of Resident #17's room revealed on her bedside table, there was a medication cup containing five pills. The pills were observed to be one-half of a round white tablet, a small round yellow tablet, a medium round yellow tablet, a white oval tablet, and a yellow and white capsule. There was no licensed nurse observed in the room or within eyesight of the medications.</p> <p>Interview on 03/20/25 at 8:40 A.M. with Resident #17 stated the nurses often brings her medication and leaves them on her bedside table for her to take independently.</p> <p>Interview on 03/20/25 at 8:44 A.M. with Licensed Practical Nurse (LPN) #475 verified the medication cup containing five pills was left on Resident #17's bedside table.</p> <p>Interview on 03/20/25 at 9:54 A.M. with Registered Nurse (RN) #613, RN #617, and the Director of Nursing (DON) verified the self-administration order, dated 03/22/23, only allows Resident #17 to self-administer Refresh Eyedrops, Pataday Eyedrops, and Flonase Nasal Spray. RN #613, RN #617, and the DON verified Resident #17 does not have an order to self-administer any oral medications.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility policy titled Medication Administration General Guidelines, with a revision date of November 2018, revealed medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>49742</p> <p>Based on observation, staff interview, and review of facility policy, the facility failed to ensure the kitchen area was maintained in a clean and sanitary manner and refrigerator temperatures were monitored daily in the kitchen. This had the potential to affect all residents who eat food from the kitchen. The facility identified one resident (#157) who does not eat food from the kitchen. The facility census was 57.</p> <p>Findings include:</p> <p>1. Observations on 03/17/25 from 8:02 A.M. to 8:20 A.M. of the kitchen revealed a buildup of food particles in the microwave closest to the hallway door. Observation of the walk-in refrigerator revealed an unidentified dried brown colored fluid on the floor underneath a pan which contained three approximately five-pound bags of thawed boneless skinless chicken breasts. Observation of the walk-in freezer revealed dirt and generalized debris throughout the floor. Observation of the microwave by the door leading to the residential care center revealed a buildup of food particles inside of and on the door of the microwave.</p> <p>Interview on 03/17/25 at 8:22 A.M. with the Director of Food Services (DFS) #434 verified the findings in the microwaves, walk-in refrigerator, and walk-in freezer.</p> <p>Review of the facility policy titled Storage Procedures dated January 2025 revealed all shelves and storage racks or platforms are at least six inches above the floor or on dollies to allow cleaning underneath. Areas are free from garbage and waste. Refrigeration equipment is routinely cleaned and defrosted and free from garbage and other waste.</p> <p>2. Review of the facility provided Daily Temperature Logs for January 2025 revealed the daily refrigerator temperature recordings were not completed on 29 days and only recorded the refrigerator temperatures on 01/01/25 and 01/03/25.</p> <p>The Daily Temperature Logs for February 2025 revealed the daily refrigerator temperature recordings were not completed on 26 days and only recorded the refrigerator temperatures on 02/22/25 and 02/23/25.</p> <p>There was no Daily Temperature Log for March 2025 to review.</p> <p>Interview on 03/18/25 at 8:54 A.M. with the Administrator verified the facility did not maintain a Daily Temperature Log for the month of March 2025. The Administrator verified there were only two days of refrigerator temperatures documented in the January 2025 Daily Temperature Logs and only two days recorded in the February 2025 Daily Temperature Logs.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of the facility policy titled Refrigerator, dated January 2025, revealed temperature checks will be documented on the refrigerator monitoring log daily, and it is the responsibility of each department to maintain appropriate temperatures and logs.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45751</b></p> <p>Based on medical record review, observation, staff interview, review of Centers for Disease Control and Prevention (CDC) guidance, and policy review, the facility failed to follow infection control practices during medication pass and failed to don the appropriate personnel protective equipment (PPE) for a resident on Enhanced Barrier Precautions (EBP). This affected one (Resident #40) of 11 residents observed during medication administration and one (Resident #32) of two residents observed for tube feed administration. The facility census was 57.</p> <p>Findings include:</p> <p>1. Medical record review for Resident #40 revealed an admitted [DATE] with diagnoses including atrial fibrillation, cardiac arrhythmia, hypertension, arthritis, and tachycardia. Review of the significant change in status Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #40 had moderately impaired cognition.</p> <p>Review of current physician orders for 03/18/25 revealed Resident #40 had the following orders: acetaminophen (Tylenol) (treats mild pain) 500 milligrams (mg) two tablets three times daily, brimonidine drops (treats glaucoma and high eye pressure) 0.2 percent (%) eye drop twice daily, dorzolamide-timolol drops (treats glaucoma and high eye pressure) 22.3-6.8 mg/milliliter (ml) twice daily, Eliquis (blood thinner) 2.5 mg twice daily, and furosemide (Lasix) (diuretic) 20 mg daily,</p> <p>Observation on 03/18/25 at 8:40 A.M. of medication administration for Resident #40 revealed Registered Nurse (RN) #358 donned gloves, touched the arm of Resident #40's wheelchair to assist in transferring the resident to her recliner. RN #358 then touched the bed and removed two blankets with the same gloves on to cover up the resident. RN #358 then proceeded to administer the eye drops to the resident with the same potentially contaminated gloves. RN #358 then removed gloves and washed hands. RN #358 went to medication cart to pull the resident's Tylenol and other eye drop that the resident had stated she would take. Resident #40 stated she would only take the Tylenol and eye drops at this time. RN #358 donned gloves, touched the spoon, apple sauce, computer mouse, medication cart, keys, and over the bed table in the resident's room. RN #358 asked the resident if she would take her Lasix and Eliquis and the resident stated she would. RN #358 then removed her gloves. RN #358 took the crushed Tylenol and the eye drops out of the room to the medication cart to get the Lasix and Eliquis to add to the Tylenol. RN #358 donned gloves at the cart, removed her keys for the cart from her pants pocket with the gloves on. RN #358 then touched the med cart drawers, drug buster, and the pills in the packet to pick out the Lasix and Eliquis and placed those two pills in the medication cup with the same gloves on. RN #358 then removed gloves, donned new gloves and touched the computer mouse, pill crusher packets, pill crusher, medication cart and handles of the medication cart, and added the Lasix and Eliquis to the crushed Tylenol. RN #358 then removed gloves, donned new gloves and touched the computer mouse and locked the screen and walked down to the resident's room. RN #358 then touched the over the bed table, administered the crushed medications, and wiped off the resident's face with a tissue. RN #358 then assessed and touched the resident's lips with the same gloves on. RN #358 then removed gloves, donned new gloves and administered the second eye drop to the resident. RN #358 was not observed washing or sanitizing hands between the glove changes.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 03/18/25 at 9:12 A.M. with RN #358 verified she not wash or sanitize hands after any of the glove changes. RN #358 verified she touched potentially contaminated surfaces with the same gloves prior to touching medications and giving the eye drops to Resident #40.</p> <p>Review of the policy titled Medication Administration-General Guidelines revised 11/2018 revealed handwashing and hand sanitation: the person administering medications adheres to good hand hygiene before beginning medication pass, prior to handling any medication, after coming into direct contact with a resident, before and after administration of ophthalmic, topical, vaginal, rectal, and parenteral preparations, and before and after administration of medications via enteral tubes. Hand hygiene is performed before putting on examination gloves and upon removal for administration of topical, ophthalmic, injectable, enteral, rectal, and vaginal medications.</p> <p>49742</p> <p>2. Medical record review for Resident #32 revealed an admitted [DATE] with diagnoses including acute respiratory failure with hypoxia, pneumonia, moderate protein-calorie malnutrition, and dysphagia. Review of the annual Minimum Data Set (MDS) assessment, dated 12/27/24, revealed Resident #32 was cognitively intact.</p> <p>Review of Resident #32's physician order dated 04/05/24 revealed an order for enhanced barrier precautions (EBP), wearing a gown and gloves at minimum, during high-contact care activities three times a day from 6:00 A.M. to 2:00 P.M., 2:00 P.M. to 10:00 P.M., and 10:00 P.M. to 6:00 A.M.</p> <p>Observation on 03/18/25 at 12:58 P.M. revealed Registered Nurse (RN) #358 prepared Resident #32's medication and bolus enteral feed at the medication cart. After medications were prepared, RN #358 entered Resident #32's bedroom wearing gloves. RN #3358 did not don a gown. RN #358 then administered Resident #32's medication and bolus feed via tube feed wearing gloves only. No other personal protective equipment (PPE) was seen outside or inside of Resident #32's room, nor was there a receptacle to dispose of worn PPE observed in the room.</p> <p>Interview on 03/18/25 at 1:50 P.M. with RN #358 verified she did not don the proper PPE which included a gown and gloves while administering Resident #32's medication and bolus feed via tube feed. RN #358 verified there was no receptacle in Resident #32's room, and there was no PPE available inside or outside of Resident #32's room.</p> <p>Review of the facility policy titled Enhanced Barrier Precautions dated 04/01/24 revealed enhanced barrier precautions will be in place during high-contact care activities for residents with indwelling medical devices including feeding tubes.</p> <p>Review of CDC guidance titled Implementation of PPE Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) found at <a href="https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html">https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html</a> and dated 04/02/24 revealed MDRO transmission is common in skilled nursing facilities, contributing to substantial resident morbidity and mortality and increased healthcare costs. EBP are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. EBP may be indicated for residents with any of the following: wounds or indwelling medical devices, regardless of MDRO colonization status.</p>		