STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155089	A. BUILDING 00 B. WING	01/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLOWS OF NEW CASTLE	1023 N 20TH ST NEW CASTLE, IN 47362

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00425076. Complaint IN00425076- Federal/state deficiencies related to the allegations are cited at F-689 & F-9999. Survey dates: January 22, 23, 24, 25, 26, & 29, 2024 Facility number: 000035 Provider number: 155089 AIM number: 100266250 Census Bed Type: SNF/NF: 57 Total: 57 Census Payor Type: Medicare: 7 Medicaid: 40 Other: 10 Total: 57 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on January 31, 2024	F 0000	Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because is required by the provisions of Federal and State Law. We respectfully request paper compliance. Willows of New Castle requests this Plan of Correction to be considered the Facilities Allegation of Compliance. Compliance effective date is 2-9-2024.	
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on interview, observation, and record review, the facility failed to complete	F 0554	**F554 Resident Self-Admin Meds-Clinically Appropriate**	02/09/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kelsey Dawn Meal	02/09/2024	02/09/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155089	A. BUILDING 00 B. WING	01/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLOWS OF NEW CASTLE	1023 N 20TH ST NEW CASTLE, IN 47362

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	self-administration assessment for a resident that self-administers nasal spray for 1 of 1 resident reviewed for self-administration. (Resident 37) Findings include: The clinical record for Resident 37 was reviewed on 1/24/2023 at 11:30 a.m. The medical diagnosis included paranoid schizophrenia. A physician order for Resident 37, dated 12/7/2021, indicated for him to utilize a nasal spray that may be kept at the bedside and self-administered. An observation on 1/22/2024 at 11:05 a.m. indicated Resident 37 sitting in his recliner with a bottle of nasal spray on the table next to him. An observation and interview with Resident 37 on 1/22/2024 at 1:30 p.m. indicated that he utilized nasal spray for the last few years for congestion. The staff will order more when he runs low, but he is able to "take care" of giving himself the nasal spray. An interview with the DON on 1/25/2024 at 1:00 p.m., indicated that they did not have a self-administration assessment for Resident 37. A policy entitled, "Medication Administration-Prerpation and General Guidelines", was provided by the Administrator on 1/25/2024 at 2:50 p.m. The policy indicated, " ...For those resident who self-administer, the interdisciplinary team verified the resident's ability to self-administer medication by means of a skill assessment conducted on a [quarterly] basis or when there is a significant change in condition ..." [sic]		**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident #37 was reassessed on 2.7.24 by DNS/designee for self-administration of medication. Self -Administration assessment completed. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents that reside in the facility have the potential to be affected by the alleged deficient practice. A facility wide audit was conducted on all residents with ability to self-administer medication by 2.9.24 by DNS/designee. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** All nursing staff will be educated on the self administration policy and completion of self administration assessment by DNS/designee on 2.8.24 **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155089	A. BUILDING 00 B. WING	01/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLOWS OF NEW CASTLE	1023 N 20TH ST NEW CASTLE, IN 47362

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3.1-11(a)		Self Administration QAPI tool will be evaluated 5 days a week x 4 weeks, 3 days a week x 4 weeks, then weekly by MDS/designee. If 100% threshold did not achieve a plan of action will be initiated and this information will be presented to the QAPI committee during the monthly meeting.	
F 0558 SS=D Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. Based on observation, interview and record review the facility failed to provide fresh water daily for 2 of 5 residents reviewed for hydration (Resident D and Resident 45). Findings include: 1.) During an observation on 1/22/24 at 1:45 p.m., Resident D was sitting in her recliner, there was no water pitcher in the room. Resident D indicated she has a faucet in the bathroom that she could get water out of. During an observation on 1/23/24 at 10:49 a.m., Resident D was sitting in her recliner with no water pitcher in her room. During an observation and interview on 1/23/24 at 1:12 p.m., Resident D and her family was visiting in the resident's room, the resident did not have	F 0558	**F 558 Reasonable Accommodations Needs/Preferences** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The DNS and Registered Dietician reassessed the hydration status and fluid needs for resident D and resident 45 on 2.6.24. All fluids provided were re-evaluated and preferences were readdressed. Appropriate revisions were made to the care plan to reflect hydration interventions. The revised care plans were reviewed with the staff involved in the care of the resident. No negative	02/09/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155089	A. BUILDING 00 B. WING	01/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLOWS OF NEW CASTLE	1023 N 20TH ST NEW CASTLE, IN 47362

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	any water available. Resident D's family searched the resident's room for her water pitcher and was unable to locate it. Resident D's family indicated they were unsure why the resident did not have water available. During an observation on 1/24/24 at 11:22 a.m., Resident D was sitting in her recliner with no water pitcher in her room. During an observation and interview on 1/24/24 at 1:06 p.m., Resident D was sitting in her recliner with no water pitcher in her room. The resident searched her room for her water pitcher and was unable to find one. The resident indicated staff must have forgotten to give her water. During an observation on 1/25/24 at 11:11 a.m., Resident D was sitting in her recliner with no water pitcher in her room. Review of the record of Resident D on 1/29/24 at 12:00 p.m., indicated the resident's diagnoses included, but were not limited to, thrombocythemia, vascular dementia, major depressive disorder, history of transient ischemic attack, cerebral infarction, hyperlipidemia, urinary tract infection, Alzheimer's disease and pelvic fracture. The plan of care for Resident D, dated 2/7/23, indicated the resident had the potential for fluid deficit related to dementia. The interventions included, but were not limited to, encourage fluid intake, Offer fluids between meals and water pitcher at bedside. The dehydration assessment for Resident D, dated 11/2/23, indicated the resident was independent with fluid intake.		outcomes noted. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents that reside in the facility have the potential to be affected by the alleged deficient practice. A facility wide audit completed on 2.2.24 by DNS/designee to ensure all residents care planned to have fluids do have fluids within reach. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** An all-staff in-service was conducted by the DNS/designee on 2.8.24 addressing the significance of encouraging fluid intake, and the provision of sufficient intake between meals to maintain adequate hydration. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** Reasonable Accommodations QAPI tool will be evaluated 5 days a week x 4 weeks, 3 days a week x 4 weeks, then weekly by MDS/designee. If 100% threshold did not achieve a plan of action will be initiated and this information will be presented to the QAPI	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155089	A. BUILDING 00 B. WING	01/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLOWS OF NEW CASTLE	1023 N 20TH ST NEW CASTLE, IN 47362

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	2.) During an observation on 1/23/24 at 11:14 a.m., Resident 45 was sitting in a recliner in the telephone room with a bedside table beside her with no fluids available. Interview with RN 1 indicated the resident never stayed in her room, she preferred to sit in the telephone During an observation on 1/23/24 at 1:32 p.m., Resident 45 was sitting in a recliner in the telephone room with a bedside table beside her with no fluids available. During an observation on 1/24/24 at 11 a.m., Resident 45 was sitting in a recliner in the telephone room with a bedside table beside her with no fluids available. During an observation on 1/25/24 at 11:01 a.m., Resident 45 was sitting in a recliner in the telephone room with a bedside table beside her with no fluids available. Review of the record of Resident 45 on 1/29/24 at 11:40 a.m., indicated the resident's diagnoses included, but were not limited to, dementia, anxiety, hyperlipemia and diverticulosis. The dehydration risk assessment for 45, dated 1/2/24, indicated the resident required limited assist with fluid intake, incontinent of urine, had 1-3 predisposing factors and took 1-3 medications of consideration for dehydration. The plan of care for Resident 45, dated 3/13/23, indicated the resident had potential for fluid deficit related to dementia and use of diuretic medication. The interventions included, but were not limited to, encourage fluid intake and keep fluids within reach.		committee during the monthly meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155089	A. BUILDING 00 B. WING	01/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLOWS OF NEW CASTLE	1023 N 20TH ST NEW CASTLE, IN 47362

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an interview with the Director Of Nursing (DON) on 1/25/24 at 3:45 p.m., indicated it was the responsibility of all nursing staff to ensure Resident D and Resident 45 was provided fluids. The protocol was fluids were passed every shift. The hydration policy provided by the Administrator on 1/26/24 at 10:50 a.m., indicated the facility would offer each resident sufficient fluid, including water and other liquids, consistent with the resident needs and preferences to maintain proper hydration and health. 3.1-3(v)(1)			
F 0561 SS=D Bldg. 00	483.10(f)(1)-(3)(8) Self-Determination §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155089	A. BUILDING 00 B. WING	01/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLOWS OF NEW CASTLE	1023 N 20TH ST NEW CASTLE, IN 47362

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. Based on interview and record review the facility failed to provide a resident with her choice and preference to when she went to bed for 1 of 2 residents reviewed for choices (Resident 56). Finding include: During an interview with Resident 56 on 1/22/24 at 12:52 p.m., indicated she did not feel like her right to choose was honored by the facility. The resident indicated the staff put her to bed at 7:00 p.m., and she preferred to go to bed at 9:00 p.m. or later,. The resident indicated she had talked to the facility about her preference about her bedtime, but they continue to assist her to bed at 7:00 p.m. Review of the Resident 56 on 1/25/24 at 2:00 p.m., indicated the resident's diagnoses included, but were not limited to, dementia, chronic kidney disease, depression, anxiety, osteoarthritis and history of falling. The activity interview and preferences for Resident 56, dated 12/12/23, indicated it was very important to choose her own bedtime. The resident preferred to go to bed after 9:00 p.m., 10:00 p.m., or later. The resident was a late night person. The plan of care for Resident 56, dated 12/13/23, indicated the resident required assistance with	F 0561	**F561 Self-Determination** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident #56 preference was reviewed and updated to care plan/assignment on 2.7.24 by DON/designee. Resident prefers to go to bed after 9pm. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents that reside in the facility have the potential to be affected by the alleged deficient practice. Facility wide audit completed by Activity Director/designee to ensure all preferences are care planned and communicated to assignment sheet by 2.9.24. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** DON/designee completed all staff	02/09/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155089	A. BUILDING 00 B. WING	01/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLOWS OF NEW CASTLE	1023 N 20TH ST NEW CASTLE, IN 47362

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Activities of Daily Living (ADL) related to impaired mobility. The interventions include, but were not limited to, bedtime as preferred. During an interview with Minimum Data Coordinator 1 on 1/25/24 at 2:05 p.m., indicated it was communicated to the CNA's what resident's preferences were on plan of care. The resident rights policy provided by the Administrator on 1/26/24 at 10:50 a.m., indicated each resident had the right to choose his/her own activities, schedules including sleeping and waking times. 3.1-3(u)(1)		Inservice on 2.08.24 to ensure preferences were being followed by plan of care but is not limited to preference time for waking up and going to bed. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** Self Determination QAPI tool will be evaluated 5 days a week x 4 weeks, 3 days a week x 4 weeks, then weekly by MDS/designee. If 100% threshold did not achieve a plan of action will be initiated and this information will be presented to the QAPI committee during the monthly meeting.	
F 0584 SS=D Bldg. 00	483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155089	A. BUILDING 00 B. WING	01/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLOWS OF NEW CASTLE	1023 N 20TH ST NEW CASTLE, IN 47362

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. Based on interview and observations, the facility failed to promote a clean environment for Resident 35 by having dried fecal matter on his toilet and a dried brown substance on his bed linens for 1 of 2 residents reviewed for clean environment. Findings include: The clinical record for Resident 35 was reviewed on 1/25/2024 at 10:55 a.m. The medical diagnosis included Parkinson's disease and chronic respiratory failure. A Quarterly Minimum Data Set Assessment,	F 0584	**F584** **Safe/Clean/Comfortable/Homelike Environment** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** A deep clean was performed for resident #35 room on 1.30.24. No negative outcome. Resident #35 linen was changed on 1.30.24. No negative outcome. **How other residents having the**	02/09/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155089	A. BUILDING 00 B. WING	01/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLOWS OF NEW CASTLE	1023 N 20TH ST NEW CASTLE, IN 47362

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	dated for 12/28/2023, indicated that Resident 35 was cognitively intact. An observation and interview with Resident 35 on 1/22/2024 at 1:19 p.m. indicated that his bathroom had dried fecal matter on the toilet bowl and debris on the floor. He stated that they don't clean his bathroom often or always change his linens. An observations on 1/23/2024 at 1:08 p.m. of Resident 35's room indicated he continues to have dried fecal matter on his toilet bowl and dried brown substance on his linens. An interview with the Administrator on 1/25/2024 at 1:15 PM indicated that it is the housekeeping and nursing staff's responsibility to ensure rooms are kept cleaned. A policy entitled, "Safe and Homelike Environment", was provided by the Administrator on 1/25/2024 at 2:50 p.m. The policy indicated, " ...the facility will provide a safe, clean, comfortable and homelike environment ..." 3.1-19(f)		**potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** Resident's that reside in the facility have the potential to be affected by the alleged deficient practice. Housekeeping supervisor/ designee completed facility wide audit to ensure linens clean, floors are swept and mopped and bathrooms are free of feces on toilet seat on 2.2.24. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** All nursing and housekeeping staff will be educated on appropriate clean homelike environment on 2.8.24 by Administrator/Designee. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** Safe Clean home-like environment QAPI tool will be evaluated 5 days a week x 4 weeks, 3 days a week x 4 weeks, then weekly by housekeeping supervisor/designee. If 100% threshold did not achieve a plan of action will be initiated and this information will be presented to the QAPI committee during the monthly meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155089	A. BUILDING 00 B. WING	01/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLOWS OF NEW CASTLE	1023 N 20TH ST NEW CASTLE, IN 47362

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on interview and observation, the facility failed to submit a Discharge or Death Entry Minimum Data Set (MDS) assessment for Resident 48 and failed to accurately code specialized services for Resident 32 for 2 of 2 residents reviewed for MDS assessment accuracy. Findings include: 1. The clinical record for Resident 48 was reviewed on 1/25/2024 at 12:57 p.m. The last MDS assessment for Resident 48 was an admission MDS on 8/28/2023. A nursing progress note, dated 8/30/2023, indicated Resident 48 had passed away. No discharge/death MDS completed. 2. The clinical record for Resident 32 was reviewed on 1/23/2024 at 1:47 p.m. A MDS assessment, dated 11/2/2023, indicated Resident 32 was receiving specialized services of chemotherapy, oxygen therapy, suctioning, tracheostomy care, invasive and non-invasive ventilation, IV medications, dialysis, transfusion, hospice, and isolation. These services were not reflected in the medical record. An interview with the MDS nurse on 1/25/2024 at 2:00 p.m. indicated that the death/discharge assessment for Resident 48 was missed and the specialized services for Resident 32 were coded	F 0641	**F641 Accuracy of Assessments** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident #48 death/discharge assessment completed on 1.25.24 by MDS coordinator. Resident #32 MDS assessment was modified on 1.25.24 by MDS coordinator. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents that reside in the facility have the potential to be affected by the alleged deficient practice. MDS coordinator/designee completed chart audit for all discharges/deaths in the last 30 days to ensure discharge/death MDS completed by 2.9.24. MDS coordinator/designee completed chart audit for MDS assessments completed in the last 30 days to ensure accuracy of assessment on --- by 2.9.24. .---------- **What measures will be put into place and what systemic changes will be made to**	02/09/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155089	A. BUILDING 00 B. WING	01/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLOWS OF NEW CASTLE	1023 N 20TH ST NEW CASTLE, IN 47362

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	incorrectly. She would enter a modification for Resident 32's assessment and enter the death/discharge assessment for Resident 48. A policy entitled "MDS 3.0 Completion", was provided by the Administrator on 1/25/2024 at 2:50 p.m. The policy indicated that MDS assessments should be standardized and accurate, and that "Death Tracking" should be completed within seven calendar days of the of the discharge (death) date.		**ensure that the deficient practice does not recur;** MDS coordinator educated on completing discharge/death assessments and ensuring accuracy of assessments are completed by 2.9.24 by MDS consultant/designee. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** MDS accuracy QAPI tool will be completed weekly X 4 weeks, bi-monthly X 2 and monthly X 4 months by MDS coordinator/designee. If 100% threshold is not achieved an action plan will be developed. This information will be presented to the QAPI committee during the monthly meeting.	
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155089	A. BUILDING 00 B. WING	01/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLOWS OF NEW CASTLE	1023 N 20TH ST NEW CASTLE, IN 47362

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on observation, interview and record review, the facility failed to develop a care plan for 1 of 2 residents reviewed for skin tears. (Resident	F 0656	**F656 Develop/Implement Comprehensive Care Plan** **What corrective action(s) will be accomplished for those**	02/09/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155089	A. BUILDING 00 B. WING	01/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLOWS OF NEW CASTLE	1023 N 20TH ST NEW CASTLE, IN 47362

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	111) Findings include: On 1/23/24 at 2:05 p.m., Resident 111 was observed sitting in a chair by the nurse's station on the South Unit. The area was above her right wrist, oval in shape and scabbed with a black color. Resident 111's record was reviewed on 1/25/24 at 1:32 p.m. and indicated diagnoses that included, but were not limited to, weakness, heart disease, and high blood pressure. An Admission Minimum Data Set assessment, dated 1/9/24, indicated Resident 111 was severely impaired in cognitive skills for daily decision making, and had a skin tear. Progress notes, dated 1/3/24 at 11:30 a.m., indicated: "resident in MDR (main dining room) playing noodle ball with peers, called to MDR and resident has 2 skin tears to her right forearm. 1cm (centimeter) x 1cm x 0.1cm and 0.5cm x 0.5cm x 0.1cm. Treatment applied to arm." On 1/29/24 at 1:36 p.m., the Administrator indicated they did not have a care plan for the skin tear. A policy for Comprehensive Care Plans was provided by the Administrator on 1/25/24 at 2: 50 p.m. The policy included, but was not limited to: "It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are		**residents found to have been affected by the deficient practice;** Care plan of Resident #111 was reviewed and updated as indicated on 1.27.24. No negative outcomes **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents that reside in the facility have the potential to be affected by the alleged deficient practice. A facility wide audit was completed by 2.9.24-- to ensure that skin impairments are reviewed and updated on care plan. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** MDS coordinator was educated on updating skin care plan after identifying skin impairment by 2.9.24 by MDS consultant/designee. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** Care Plan QAPI tool will be evaluated 5 days a week x 4 weeks, 3 days a week x 4 weeks, then weekly by MDS/designee. If	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155089	A. BUILDING 00 B. WING	01/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLOWS OF NEW CASTLE	1023 N 20TH ST NEW CASTLE, IN 47362

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	identified in the resident's comprehensive assessment...3. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest physical, mental, and psychosocial well-being...Resident specific interventions that reflect the resident's needs and preferences...." 3.1-35(a) 3.1-35(b)(1)		100% threshold did not achieve a plan of action will be initiated and this information will be presented to the QAPI committee during the monthly meeting.	
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155089	A. BUILDING 00 B. WING	01/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLOWS OF NEW CASTLE	1023 N 20TH ST NEW CASTLE, IN 47362

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on interview, observation, and record review, the facility failed to update a fall care plan for Resident 15 after his refusal to utilize careplanned fall interventions for 1 of 3 reviewed for fall care plans. Findings include: The clinical record for Resident 15 was reviewed on 1/24/2024 at 2:05 p.m. The medical diagnosis included dementia. A fall care plan, dated 3/24/2023, indicated interventions for Resident 15 of adding a sign to his walker for shows on 4/16/2023, call don't fall sign on the walker on 4/12/2023, and to utilize a walker instead of rollator on 4/12/2023. An observation of Resident 15's room on 1/22/2024 at 11:45 a.m. indicated he had a rollator in his room without signage, did not have a standard walker, and a call don't fall sign was on the closed bathroom door. An interview and observation on 1/25/2024 at 12:03 p.m. indicated that he did not have a standard walker in his room, did not have signage on his rollator, and had a call don't fall sign on the back of his bathroom door. Resident 15 indicated they tried to get him to use a walker and he "turned it in to the nurse months ago" and later elaborated it was in the end of summer last year. He indicated when he did that, they took the sign for call don't fall off of his walker and hung it on his door. He stated he did not want to use a walker or have signs on his rollator.	F 0657	**F657 Care Plan Timing/Revision** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident #15 fall care plan was reviewed and updated on 02.07.24 by DON/designee. Walker and fall sign on walker removed per resident preference. Added shoes at bedside, call don't fall sign to bathroom door. Resident utilizes rollator. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** Resident's that reside in the facility have the potential to be affected by the alleged deficient practice. A facility wide audit will be completed by 2.9.24-- to ensure that all fall interventions are updated and in place on fall care plan. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** MDS coordinator was educated on updating fall care plan next business day and will include	02/09/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155089	A. BUILDING 00 B. WING	01/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLOWS OF NEW CASTLE	1023 N 20TH ST NEW CASTLE, IN 47362

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	An interview with the Administrator on 1/25/2024 at 1:00 pm. Indicated that it is the responsibility of the interdisciplinary team to update care plans as needed. A policy entitled, "Comprehensive Care Plan", was provided by the Administrator on 1/25/2024 at 2:50 p.m. The policy indicated, " ...The comprehensive care plan will be reviewed and revised by the interdisciplinary team ..." 3.1-35(b)(1)		refusals with new intervention by MDS consultant/designee by 2.9.24. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** Care Plan Timing/Revision QAPI tool will be evaluated 5 days a week x 4 weeks, 3 days a week x 4 weeks, then weekly by MDS/designee. If 100% threshold did not achieve a plan of action will be initiated and this information will be presented to the QAPI committee during the monthly meeting.	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on interview, observation, and record review, the facility failed to complete weekly nursing assessments per physician order for 3 of 3 residents reviewed for potential impaired skin integrity. (Resident 18, Resident 32, and Resident 38)	F 0684	**F684 Quality of Care** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident #18 Weekly Nursing	02/09/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155089	A. BUILDING 00 B. WING	01/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLOWS OF NEW CASTLE	1023 N 20TH ST NEW CASTLE, IN 47362

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Findings include: 1. The clinical record for Resident 18 was reviewed on 1/26/2024 at 1:02 p.m. The medical diagnosis included peripheral vascular disease. A Quarterly Minimum Data Set (MDS) Assessment, dated 12/14/2023, indicated that Resident 18 was at risk for developing pressure areas, had one stage three pressure area, and received pressure ulcer care, surgical wound care, and applications to ointments/medications to the feet. A physician order for Resident 18, dated 12/12/2023, indicated to complete "Weekly Nursing Assessment V2" every Tuesday. A review of the medical record indicated that Resident 18 had Weekly Nursing Assessments completed on: 1/23/2024, 1/2/2024, 12/26/2023. Assessments were not able to be located for 12/19/2023, 1/9/2024, or 1/16/2024. 2. The clinical record for Resident 32 was reviewed on 1/23/2024 at 1:47 p.m. A MDS assessment, dated 11/2/2023, indicated Resident 32 was at risk for developing pressure areas. A physician order for Resident 32, dated 10/13/2023, indicated to complete "Weekly Nursing Assessment V2" every Friday. Weekly nursing assessments completed on 1/19/2024, 1/12/2024, 1/6/2024, 12/29/2023. The weekly nursing assessment was not completed on 1/26/2024.		Assessment was completed on 2.6.24 by DNS/designee. Skin impairment identified on Weekly Nursing Assessment Resident #32 Weekly Nursing Assessment was completed on 2.2.24 by DNS/designee. Skin impairment identified on Weekly Nursing Assessment Resident #38 Weekly Nursing Assessment was completed on 2.1.24 by DNS/designee. Skin impairment identified on Weekly Nursing Assessment **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents have the potential to be affected by the alleged deficient practice. A facility wide audit for weekly nursing assessment for last 30 days will be completed by 2.9.24 by the DNS/Designee. All areas were properly identified and documented. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** All nursing staff was educated on following physician order of completing weekly nursing assessments on 2.8.24 by DNS/designee. **How the corrective action(s) will be monitored to ensure the**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155089	A. BUILDING 00 B. WING	01/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLOWS OF NEW CASTLE	1023 N 20TH ST NEW CASTLE, IN 47362

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3. The clinical record for Resident 38 was reviewed on 1/23/2024 at 11:10 a.m. the medical diagnosis included dementia. An Admission MDS Assessment, dated 11/30/2023, indicated Resident 38 was at risk for pressure areas and received applications of ointments/medications other than to feet. An observation and interview on 1/22/2024 at 2:30 p.m. indicated that Resident 38 had a noticeable dried scab to his left forehead and had scabs to his right knee that he reported was from a fall. A physician order for Resident 38, dated 11/23/2023, indicated to complete "Weekly Nursing Assessment V2" every Thursday. Weekly nursing assessments were completed on 12/21/2023, 12/28/2023, and 1/4/2024. No weekly nursing assessment could be located for 1/11/2024, 1/18/2024, or 1/25/2024. An interview with the DON on 1/25/2024 at 1:15 p.m. indicated that the nurse taking care of the resident is responsible for completing the weekly nursing assessment and that herself, or the corporate support, should be auditing for the completion of those assessments. A policy entitled, "Physician Medications/Ancillary Order Policy & Procedure", was provided by the Administration on 1/25/2024 at 2:50 p.m. The policy indicated, " ...Physician orders may include non-medication orders ...[that] may be assess to the MAR/TAR [Medication Administration Record/Treatment Administration Record] for documentation as needed ..." and to " ...Ensure medications/treatments are provided to		**deficient practice will not recur, i.e., what quality assurance program will be put into place;** Quality of Care QAPI tool will be evaluated 5 days a week x 4 weeks, 3 days a week x 4 weeks, then weekly by housekeeping supervisor/designee. If 100% threshold did not achieve a plan of action will be initiated and this information will be presented to the QAPI committee during the monthly meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155089	A. BUILDING 00 B. WING	01/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLOWS OF NEW CASTLE	1023 N 20TH ST NEW CASTLE, IN 47362

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	resident ..." 3.1-17(a) 3.1-50(a)(1)			
F 0689 SS=G Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. A.) Based on observation, interview and record review the facility failed to adequate supervision during care and ensure two staff were providing care for a dependent resident resulting in the resident falling out of bed and sustaining 3 brain bleeds and 5 facial sutures (Resident B). B.) Based on observation, interview and record review the facility failed to have fall interventions of two assistive devices in place and failed to have a call light available for a resident who had sustained a fall with a fracture (Resident D). This affected 2 of 4 residents reviewed for accidents (Resident B and Resident D). Findings include: A.) During an interview with Resident B's Family member 1 on 1/22/24 at 1:21 p.m., indicated on 12/22/23 CNA 2 was attempted to provide incontinent care by herself and the resident rolled out of bed. When CNA 2 rolled the resident on	F 0689	**F689 Free of Accidents/Supervision/Devices** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Director of Nursing/designee reviewed the plan of care for fall interventions with all staff involved in the care of Resident B on 2.7.24. Care plan reviewed and updated to reflect need for assistance with ADLS. Director of Nursing/designee reviewed the plan of care for fall interventions with all staff involved in the care of Resident D on 2.7.24. Care plan reviewed and updated for touch pad call light. **How other residents having the potential to be affected by the same deficient practice will be**	02/09/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155089	A. BUILDING 00 B. WING	01/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLOWS OF NEW CASTLE	1023 N 20TH ST NEW CASTLE, IN 47362

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	her side, the resident grabbed the privacy curtain and fell out of bed. The family member indicated she visits the resident every day but she was not at the facility when this occurred it happened early in the morning, RN 1 called her and notified her of what had happened. The resident was suppose to have 2 staff provide care. The resident sustained 3 brain bleeds and 5 sutures above her eyebrow. The resident was in the Intensive Care Unit (ICU) for one night. Family member 1 indicated the resident had "significantly declined" since the fall, the resident was now on hospice, the resident would get up every day and would go to activities, now the resident slept all day. The resident now takes morphine (pain medicine) in the morning and in the evening. The family member pointed to a sign on the wall that said "care in pairs" and indicated after the fall the facility put the sign up. Resident B was observed to be lying in bed with her eyes closed, the resident had a scab above her right eye brow. During an interview with CNA 2 on 1/24/24 at 11:53 a.m., indicated she was Resident B's CNA on 12/22/23 when she fell out of the bed. CNA 2 indicated the resident was incontinent of urine and was laying on her side. CNA 2 turned around to get clothes out of the resident's closet and when she turned around the resident had grabbed the privacy curtain and her legs were off of the bed. CNA 2 indicated she grabbed the resident's upper body to try to keep her from falling but the resident had a tight grip on the privacy curtain with both hands. The resident went on over the bed and fell onto the floor. During an interview with RN 1 on 1/24/24 at 11:41 a.m., indicated she was Resident B's nurse on 12/22/23 when she fell out of bed. RN 1 indicated CNA 2 came running out and told her she had		**identified and what corrective action(s) will be taken;** All residents have the potential to be affected by the alleged deficiency. An all-staff in-service will be conducted on 2.8.24 by the DON/designee which addressed following fall interventions for all residents. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Director of Nursing/designee completed chart audit for all falls in the last 30 days to ensure appropriate interventions are in place and present on care plan by 2.9.24. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** Free of Accidents QAPI tool will be evaluated 5 days a week x 4 weeks, 3 days a week x 4 weeks, then weekly by MDS/designee. If 100% threshold did not achieve a plan of action will be initiated and this information will be presented to the QAPI committee during the monthly meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155089	A. BUILDING 00 B. WING	01/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLOWS OF NEW CASTLE	1023 N 20TH ST NEW CASTLE, IN 47362

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	been providing incontinent care for Resident B and she had fell out of bed onto the floor. The resident had a "huge laceration" on the right eye brow and she attempted to get the bleeding to stop. RN 1 had CNA 2 get the Director Of Nursing and another nurse come help her. CNA 2 did not have another staff member assisting her with the resident's care. During an interview with RN 1 on 1/24/24 at 12:58 p.m., indicated the resident had on socks and hospital gown when she fell. The resident did not have on a brief. The resident had urinated on the floor when she fell. RN 1 indicated it was a struggle to clean the resident and put on the brief because they were trying not to move the resident. RN 1 indicated LPN 4 assisted her. During an interview with LPN 4 on 1/24/24 at 7:58 p.m., indicated she assisted with Resident B on 12/22/23 when she fell out of bed. LPN 4 indicated CNA 2 came to the nursing station and said she had rolled the resident over to clean her up and get her dressed and the resident grabbed the privacy curtain and rolled out of bed. The resident had a laceration above her right eye, the right side of her face was red and there was blood on the floor. LPN 4 held a washcloth on the resident's laceration to prevent blood from going into her eyes and held the resident's hand while RN 1 was vital signs. Resident B did not have on a brief and had urinated on the floor after she fell out of the bed. LPN 4 and RN 1 put a brief on the resident before the ambulance arrived. During an interview with Resident B Family member 2 on 1/25/24 at 11:57 a.m., indicated the resident should have never fallen out of bed on 12/22/23, the resident was suppose to have two staff when providing care. Family member 2			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155089	A. BUILDING 00 B. WING	01/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLOWS OF NEW CASTLE	1023 N 20TH ST NEW CASTLE, IN 47362

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated she talked with the Administrator and the Director Of Nursing and they told her the resident was suppose to have to have 2 staff when providing care and they would ensure that she would have 2 staff from now on. Family member 2 indicated this was an unfortunate situation that should have never happened to begin with. Review of the record of Resident B on 1/24/24 at 1:17 p.m., indicated the resident's diagnoses included, but were not limited to, Alzheimer's disease, diabetes, bipolar, dementia, pain, hypertension and depression. The Annual Minimum Data Set (MDS) assessment for Resident B, dated 11/30/23, indicated the resident was severely cognitive impaired for daily decision making. The resident was dependent with toileting needs and was always incontinent of bowel and bladder. The resident ability to roll from lying on back to left and right side, and returning to lying on back on the bed, the resident was dependent. The resident had a fall with a major injury. The State Optional MDS assessment for Resident B, dated 11/30/23, the resident required extensive assistance of two people for bed mobility and toileting need. The fall plan of care for Resident B, dated 11/30/23, indicated the resident at risk for falls related to dementia, arthritis, cancer, diabetes mellitus, history of falls, impaired mobility, non ambulatory, use of anti anxiety medication. The interventions included, but were not limited to, 2 staff to assist with bathing, turning and repositioning.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155089	A. BUILDING 00 B. WING	01/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLOWS OF NEW CASTLE	1023 N 20TH ST NEW CASTLE, IN 47362

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The fall risk assessment for Resident B, dated 11/30/23, indicated the resident was disoriented x 3, chair bound, required assistance with elimination, and takes 3-4 medications that can contribute to falls, and 1-2 predisposing diseases that could contribute to falls. The progress note for Resident B, dated 12/22/23 at 6:40 a.m., Interdisciplinary Team (IDT) progress note indicated resident noted with fall during staff assistance. Nurse called to room, found resident on right side, laceration noted to right outer eyebrow, forehead , applied cold towel and pressure, notified the physician and orders to send to emergency room for evaluation and called Emergency medical Services, notified the daughter and care plan updated with bed moved to wall if daughter agreeable. The hospital note for Resident B, dated 12/22/3, indicated per report the resident fell out of bed while being cleaned this morning. The CAT SCAN (CT) of the head showed Parenchymal hemorrhage in the right frontal lobe, right parietal lobe and left parietal lobe (largest in the left parietal region) (bleeding in the brain). The resident was not a candidate for surgery and a hospice consult was obtained. The resident had a 2.5 centimeter (cm) laceration on the right eyebrow and 5 sutures was applied. During an observation on 1/26/24 12:27 p.m., CNA 2 and CNA 3 provided the Resident B with incontinent care, rolling the resident from side to side with total assist, the resident did not participate in the bed mobility. B.) During an observation on 1/22/24 at 1:41 p.m., Resident D was sitting in her recliner, the resident's call light was on the floor between the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155089	A. BUILDING 00 B. WING	01/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLOWS OF NEW CASTLE	1023 N 20TH ST NEW CASTLE, IN 47362

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	bed and the wall. The roommates call light was activated. CNA 2 came into the room and retrieved the resident's call light and indicated she would get a clip on the call light so she could clip it to her bed. The resident was observed to have one touch pad call light and not two as care planned. During an interview with Resident D's family on 1/23/24 at 1:14 p.m., indicated the resident fell in October 2023 and fractured her pelvis. During an observation on 1/25/24 at 11:11 a.m., Resident D was sitting in her recliner , the resident did not have a call light available it was located between the wall and bed on the floor. RN 1 came in and clipped the pad call light to the resident's bed. The resident was observed to have one touch pad call light and not two as care planned. Review of the record of Resident D on 1/29/24 at 12:00 p.m., indicated the resident's diagnoses included, but were not limited to, thrombocythemia, vascular dementia, major depressive disorder, history of transient ischemic attack, cerebral infarction, hyperlipidemia, urinary tract infection, Alzheimer's disease and pelvic fracture. The progress note for Resident D, dated 10/11/23 at 11:24 a.m., indicated the resident had a fall and was complaining of right groin pain. An order was received for an x-ray. Received x-ray and resident had a pelvic fracture. Called Orthopedics for an appointment. The Significant Change Minimum Data (MDS) assessment for Resident D, dated 10/28/23, indicated the resident was severely impaired for daily decision making. The resident required substantial/maximal assistance with toileting,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155089	A. BUILDING 00 B. WING	01/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLOWS OF NEW CASTLE	1023 N 20TH ST NEW CASTLE, IN 47362

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	putting on and taking off footwear. The resident had a fall with a major injury. The plan of care for Resident D, dated 1/2/23, indicated the resident was at risk for falls related to dementia, history of falls, history of transient ischemic attack and pelvic fracture. The interventions included, but were not limited to, 2 touch pad call lights on bed/chair and call light in reach, encourage resident to use it. and respond promptly to call light. During an interview with the Director Of Nursing (DON) on 1/25/24 at 3:30 p.m., indicated it was the responsibility of all nursing staff to ensure Resident D's fall interventions were in place and her call light was within reach. The fall management policy provided by the Administrator on 1/26/24 at 10:50 a.m., indicated the purpose was to protect residents and promote safety. The call light policy provided by the Administrator on 1/26/24 at 10:50 a.m., indicated the resident's call light was to be within reach. This Federal tag relates to Complaint IN00425076. 3.1-45(a)(1) 3.1-45(a)(2)			
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155089	A. BUILDING 00 B. WING	01/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLOWS OF NEW CASTLE	1023 N 20TH ST NEW CASTLE, IN 47362

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155089	A. BUILDING 00 B. WING	01/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLOWS OF NEW CASTLE	1023 N 20TH ST NEW CASTLE, IN 47362

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	§483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.			
	Based on interview, and record review, the facility failed to accurately complete weekly nursing assessments to reflect pressure areas for 2 of 2 residents reviewed for pressure areas (Resident 19 and Resident 32) Findings include: The clinical record for Resident 18 was reviewed on 1/26/2024 at 1:02 p.m. The medical diagnosis included peripheral vascular disease. A Quarterly Minimum Data Set (MDS) Assessment, dated 12/14/2023, indicated that Resident 18 was at risk for developing pressure areas, had one stage three pressure area, and received pressure ulcer care, surgical wound care, and applications to ointments/medications to the	F 0842	**F 842 Resident Records-Identifiable Information** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident #18 was reassessed by DNS/designee and weekly nursing summary updated on 2.6.24. Skin impairment documented. Resident #32 was assessed by DNS/designee and weekly nursing summary updated on 2.2.24. Skin impairment documented. **How other residents having the potential to be affected by the**	02/09/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155089	A. BUILDING 00 B. WING	01/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLOWS OF NEW CASTLE	1023 N 20TH ST NEW CASTLE, IN 47362

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	feet. A physician order for Resident 18, dated 12/12/2023, indicated to complete "Weekly Nursing Assessment V2" every Tuesday. A rounding wound care provider had seen Resident 18 for skin areas, including a pressure area to the right heel, on 1/12/2024, 1/17/2024, and 1/24/2024. During the 1/24/2024, the pressure area was resolved. The medical record indicated that Resident 18 had Weekly Nursing Assessment completed on 1/23/2024. The assessment did not indicate the presence of a pressure area. 2. The clinical record for Resident 32 was reviewed on 1/23/2024 at 1:47 p.m. A MDS assessment, dated 11/2/2023, indicated Resident 32 was at risk for developing pressure areas. A physician order for Resident 32, dated 10/13/2023, indicated to complete "Weekly Nursing Assessment V2" every Friday. A rounding wound care provider had seen Resident 32 for a stage three pressure area to the left buttock on 1/24/2024, 1/17/2024, and 1/12/2024. Weekly nursing assessments were completed on 1/19/2024, 1/12/2024. These assessments did not indicate the presence of a pressure area. An interview with the DON on 1/28/2024 at 11:45 a.m. indicated that charting should be complete and accurate.		**same deficient practice will be identified and what corrective action(s) will be taken;** All residents that reside in the facility have the potential to be affected by the alleged deficient practice. A facility audit of weekly nursing summaries in the last 30 days was completed by DON/designee to ensure accurate assessment of skin impairment by 2.9.24. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** All licensed staff will be educated on accurate documentation of skin impairment on weekly nursing assessments by DNS/designee on 2.8.24. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** Resident records audit will be completed weekly X 4 weeks, bi-monthly X 2 and monthly X 4 months by MDS coordinator/designee. If 100% threshold is not achieved an action plan will be developed. This information will be presented to the QAPI committee during the monthly meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155089	A. BUILDING 00 B. WING	01/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLOWS OF NEW CASTLE	1023 N 20TH ST NEW CASTLE, IN 47362

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A policy entitled, "Charting and Documentation" was provided by the Administrator on 1/26/2024 at 10:50 a.m. The policy indicated, " ...Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate ..." 3.1-50(a)(2)			
F 0909 SS=D Bldg. 00	483.90(d)(3) Resident Bed §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. Based on observation, interview, and record review, the facility failed to ensure one resident's bed rail had safe dimensions. This affected 1 of 1 resident reviewed for accident hazards related to bed rail use. (Resident 21) Findings include: On 1/22/24, at 1:18 p.m., Resident 21 was observed sitting in her recliner watching TV. Attached to the open side of her bed was a one quarter width bed rail, and the lower section of the bed rail had a large opening between the lower bars of the bed rail. On 1/22/24, at 1:32 p.m., the bed rail was measured by the Administrator, and the Director of Nurses was also present. The inside dimensions of the	F 0909	**F909 Resident Bed** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The bed for resident # 21 was assessed for safe siderail and siderail assessment completed on 1.29.24 by DON/designee. Siderail was replaced on 1.29.24 by Maintenance Director. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents that reside in the facility have the potential to be	02/09/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155089	A. BUILDING 00 B. WING	01/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLOWS OF NEW CASTLE	1023 N 20TH ST NEW CASTLE, IN 47362

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	lower part of the bed rail measured eight and one half inches by fifteen inches. The Director of Nurses said Resident 21 didn't walk, so they could remove the bar, and Resident 21 indicated she wanted them to leave it alone. On 1/23/24, at 10:40 a.m., Resident 21 was observed in bed watching TV and the bed rail was in place on the bed. On 1/24/24, at 9:40 a.m., Resident 21 was observed in bed, the bed rail remained on the open side of the bed. The head of the bed was raised about 25 degrees and the resident was awake. Resident 21's record was reviewed on 1/24/24, at 11:35 a.m. The record indicated Resident 21 had diagnoses that included, but were not limited to, small strokes, stroke with weakness on one side, type 2 diabetes mellitus, anxiety, dementia with mood disturbance, glaucoma and macular degeneration (eye diseases that decrease vision), depression, and high blood pressure. A Significant Change Minimum Data Set assessment, dated 12/10/23, indicated Resident 21 was moderately impaired in cognitive skills in daily decision making and required substantial/maximal assistance for bed mobility. A side rail assessment, dated 9/26/23, was provided by the Administrator on 1/25/24 at 10:06 a.m. The assessment indicated Resident 21 utilized side rails, her cognitive skills for decision making were severely impaired, her mental function varied throughout the day, she was unable to turn herself from side to side unassisted while in bed, she did not attempt to get in and out of bed unassisted, she was able to turn side to side while in bed with side rails, she currently used the side		affected by the alleged deficient practice. Facility wide audit completed by 2.9.24 by Maintenance Director for all residents utilizing siderails to ensure safe measurements. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Maintenance Director was educated by ED/designee on manufactures guidelines to safe dimensions of siderails by 2.9.24 **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** Siderail QAPI tool will be evaluated 5 days a week x 4 weeks, 3 days a week x 4 weeks, then weekly by MDS/designee. If 100% threshold did not achieve a plan of action will be initiated and this information will be presented to the QAPI committee during the monthly meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155089	A. BUILDING 00 B. WING	01/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLOWS OF NEW CASTLE	1023 N 20TH ST NEW CASTLE, IN 47362

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	rail for positioning or support, and the side rail has been measured and gaps between the rails themselves and the gaps between the side rail and mattress is conducive to the resident safety. The assessment indicated one side rail would be used, one fourth side rail in size. Physician orders for the bed rail were: "Left m-rail to be placed to promote bed mobility. No directions specified for order". A Care plan, initiated 2/28/21, indicated: "Resident requires use of M-rail to assist with positioning and bed mobility. Goal: Resident will demonstrate no decline in ability to use M-rail to assist with repositioning or bed mobility thru next review. Interventions: Assess resident's ability to reposition self in bed and encourage to continue to do so....Requires use of M-rail to assist with repositioning and bed mobility. L side, [Resident name] has an ADL self-care performance deficit r/t decreased mobility, hemiparesis R side, generalized weakness. Extensive assist to total dependence with bed mobility...." On 1/25/24, at 12:20 p.m., the bed rail remained on Resident 21's bed. On 1/29/24, at 10:13 a.m., Resident 21 was observed in bed, awake, and her TV was on. The bed rail remained on her bed. During an interview, on 1/29/24 at 11:18 a.m., the Social Service Director indicated they had taken a piece of the bed rail off, and when they removed that piece, Resident 21 had become upset. Her family wanted her to have a side rail, and she has always had one, so they are going to replace it with a different bed rail.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155089	A. BUILDING 00 B. WING	01/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLOWS OF NEW CASTLE	1023 N 20TH ST NEW CASTLE, IN 47362

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A Policy for "Side or Bed Rails" was provided by the Administrator on 1/25/24 at 10:06 a.m. The policy included, but was not limited to: "Purpose: Side and/or bed rails are used, when ordered by a physician or when requested by the resident and if after the resident's request they are then ordered by the physician, as needed to enable the resident to turn and reposition while in bed. The use of bed rails may be ordered by a physician for a dependent Resident whose medical symptoms would warrant their use. Definitions: "Bed rails" are adjustable metal or rigid plastic bars that attach to the bed. They are available in a variety of types, shapes, and sizes ranging from full to one-half, one-quarter, or one-eight lengths. Also, some bed rails are not designed as part of the bed by the manufacturer and may be installed on or used along the side of a bed..."Entrapment" is an event in which a resident is caught, trapped, or entangled in the space in or about the bed rail...After installation staff will: B. Maintenance will follow the bed manufacturer instructions a FDA Guidance on dimensional limits in entrapment zones for safe bed rail installation as follows...2). Zone 4 = 2 and 3/8 inches (under the rail, at the ends of the rail)...." 3.1-45(1)			
F 9999 Bldg. 00	Based on interview and record review the facility failed to ensure an accurate and detailed description of a resident's fall was with major injury was in their State reportable for 1 of 2 incidents reviewed for falls with major injury (Resident B).	F 9999	**F9999 Final Observation** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Amendment made to incident report by Executive Director on	02/09/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155089	A. BUILDING 00 B. WING	01/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLOWS OF NEW CASTLE	1023 N 20TH ST NEW CASTLE, IN 47362

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Finding include: The incident report for Indiana Department of Health provided by the Administrator on 1/23/24 at 2:15 p.m., indicated Resident B fell on 12/22/3 at approximately 6:20 a.m., The resident's injury was laceration to the right eyebrow. Immediate action taken was assessment, neurological assessment, notification to the physician and family. The resident was sent to the Emergency Room (ER) for evaluation and treatment. The follow up indicated the resident received 5 stitches to the right eyebrow and antibiotics for a Urinary Tract Infection (UTI), the resident was being observed overnight in the hospital due to the resident being on liquids (blood thinner). The resident's care plan reviewed and fall interventions in place. There was no documentation of the resident's 3 brain bleeds or staff involved in the fall. The hospital note for Resident B, dated 12/22/3, indicated per report the resident fell out of bed while being cleaned this morning. The CAT SCAN (CT) of the head showed Parenchymal hemorrhage in the right frontal lobe, right parietal lobe and left parietal lobe (largest in the left parietal region) (bleeding in the brain). The resident was not a candidate for surgery and a hospice consult was obtained. The resident had a 2.5 centimeter (cm) laceration on the right eyebrow and 5 sutures was applied. During an interview with the Administrator on 1/25/24 at 3:30 p.m., indicated Resident B's 3 brain bleeds were not reported to the Indiana Department of Health because there was conflicting information and she was getting guidance from the facility Corporation on the reportable.		2.7.24 to reflect additional injuries. Resident returned and remains in facility. Family and MD updated and aware. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents that reside in the facility have the potential to be affected by the alleged deficient practice. All incidents reported in the last 30 days were reviewed to ensure accurate description of incident reported in follow up by 2.9.24 by ED/designee. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Executive Director was educated on the incident reporting policy on 2.7.24 by the Chief Operating Officer. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** Incident Reporting QAPI tool will be evaluated 5 days a week x 4 weeks, 3 days a week x 4 weeks, then weekly by MDS/designee. If 100% threshold did not achieve a plan of action will be initiated and this information will be presented	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155089	A. BUILDING 00 B. WING	01/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLOWS OF NEW CASTLE	1023 N 20TH ST NEW CASTLE, IN 47362

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The incident reporting policy provided by the Administrator on 1/26/24 at 10:50 a.m., indicated the instruction included, but were not limited to, name and title of staff involved and type of injuries sustained. This Federal tag relates to Complaint IN00425076.		to the QAPI committee during the monthly meeting.	