STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155022	A. Building B. Wing	12/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willows of Shelbyville	2309 S Miller St Shelbyville, IN 46176

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview, and record review, the facility failed to ensure residents' fall interventions were in place for 3 of 4 residents reviewed for care plan implementation. (Residents 7, 19, and 44)Findings include:1. The clinical record for Resident 7 was reviewed on 12/19/25 at 11:14 a.m. The resident's diagnoses included, but were not limited to: osteoporosis, Alzheimer's disease, anxiety, chronic obstructive pulmonary disease, and chronic pain. The Interdisciplinary Team (IDT) note, dated 11/13/25, indicated the resident had an unwitnessed fall on 11/12/25 in the common area. She was found on the floor beside a recliner. The resident complained of pain to her left hip. An x-ray was completed and returned positive for left hip fracture.The IDT note, dated 12/16/25, indicated the resident had an unwitnessed fall on 12/15/25. The resident was found laying on the floor next to her bed.The at risk for falls care plan, revised 11/28/25, indicated an intervention was to ensure appropriate footwear was worn, initiated 6/12/25.An observation of Resident 7 was made on 12/22/25 at 12:31 p.m. with Certified Nursing Assistant (CNA) 4. Resident 7 was sitting in her wheelchair at a table in the dining room. She was wearing a pair of black socks and no shoes. The socks were not non-skid socks. An interview was conducted with CNA 4 during the above observation on 12/22/25 at 12:31 p.m. The CNA 4 lifted Resident 7's foot and indicated the socks were not non-skid socks. Resident 7 should be wearing tennis shoes, and usually she did. CNA 4 continued to clean the dining room tables after this interview. An observation of Resident 7 and interview with the Weekend Supervisor was conducted on 12/22/25 at 12:50 p.m. Resident 7 remained sitting in her wheelchair at a table in the dining room. She was still wearing the same black socks with no shoes. The Weekend Supervisor indicated she would find some gripper socks for Resident 7. 2. The clinical record for Resident 44 was reviewed on 12/19/25 at 11:30 a.m. The resident's diagnoses included, but were not limited to: Alzheimer's disease, insomnia, chronic obstructive pulmonary disease, psychotic disorder, bipolar disorder, and anxiety.An interview was conducted with Family Member 5 on 12/19/25 at 11:33 a.m. They indicated Resident 44 had many falls at the facility. The IDT (Interdisciplinary Team) note, dated 11/27/25, indicated she had an unwitnessed fall in her room on 11/26/25.The IDT note, dated 8/8/25, indicated she had a witnessed fall on 8/7/25.The IDT note, dated 6/23/25, indicated she had a witnessed fall on 6/21/25 in the dining room. The IDT note, dated 6/4/25, indicated she had a witnessed fall on 6/3/25 in the common area. The at risk for injury related to falls care plan, revised 10/9/25, indicated to have non-skid strips to the right side of the resident's bed and in front of her chair, initiated 11/20/24.An observation of Resident 44's room was made on 12/22/25 at 12:15 p.m. There were non-skid strips on the floor along the side of her bed, but there were none in front of her recliner. An interview and observation of Resident 44's room was conducted with the Weekend Supervisor on 12/22/25 at 12:45 p.m. The Weekend Supervisor indicated she did rounds a while ago and knew the resident needed the strips in front of her bed, but she was unaware she needed them in front of her recliner. 3. The clinical record for Resident 19 was reviewed on 12/22/2025 at 3:13 PM. The resident's diagnoses included, but were not limited to, dementia and heart failure.A Quarterly Minimum Data Set Assessment, dated 12/4/2025, indicated Resident 19 was not cognitively intact, had one fall with injury since the last assessment, had no physical impairments, and needed substantial to maximal assistance with transferring.A fall care plan, revised 12/16/2025, indicated Resident 19 was at risk for falling for a multitude of reasons, including poor safety awareness. The interventions for Resident 19 included, but was not limited to, the use of a pommel cushion.During an observation, on 12/19/2025 1:21 PM, Resident 13 was leaning to the left side of her high back wheelchair without a pommel cushion in place. During interview and observation, on 12/22/2025 12:30 PM, Resident 13 was assisted back to her room and changed, then placed back into her high back wheelchair. When asked if Resident 13 had her pommel cushion in place, CNA 2 did not know what pommel cushion was. QMA 1 verified pommel was not in place because it like got soiled and needed to be washed.During an interview, on 12/23/2025 at 1:30 PM, DON indicated Hospice was responsible for providing the pommel cushion for Resident 13 but one had not been provided. The facility had been using a saddle cushion, but that was not reflected on the orders or care plan, until she edited it on 12/22/2025.A policy entitled, Use of Assistive Devices, was provided by the Executive Director on 12/22/2025 at 1:55 PM. The policy indicated the facility will provide assistive devices for residents who need them, including mobility devices.The Fall Management policy was provided by the DON (Director of Nursing) on 12/23/25 at 9:40 a.m. It indicated, Fall risk.2. A care plan will be developed at time of admission with specific care plan interventions to address each resident's fall risk factors. 3. The resident specific care

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation, interview, and record review, the facility failed to provide a resident's nutritional supplement, as ordered, and have their family member complete weekly menus, as care planned. (Resident 9)Findings include:The clinical record for Resident 9 was reviewed on 12/19/25 at 11:45 a.m. The resident's diagnoses included, but were not limited to: dysphagia, dementia, depression, malnutrition, and anxiety. The Skin, Wound, Assessment, Treatment (SWAT) note, dated 11/6/25, indicated the resident was reviewed due to a new 180-day significant weight loss. Her current weight was 87.9 pounds, a 16-pound loss in 180 days. She was admitted to the facility for long-term care and on hospice services. She ate meals in the dining room and required total assistance with feeding. The physician's orders indicated the resident was to be provided with a regular diet, thin consistency, finger foods with meals, as needed, and a magic cup at lunch, starting on 1/29/25. An observation of Resident 9 was made in the dining room during the lunch meal on 12/22/25 at 12:36 p.m. The resident was assisted with eating by Certified Nursing Assistant (CNA) 4. There was no magic cup observed with the resident's meal. The lunch meal ticket was on the table in front of Resident 7. It indicated, INSTRUCTIONS: MAGIC CUP. An interview was conducted with CNA 4 on 12/22/25 at 12:36 p.m. The CNA indicated the kitchen did not send the magic cup with the resident's meal, but she didn't notice. The nutrition care plan, revised on 9/8/25, indicated an intervention was to honor the resident's preferences/intolerances/allergies, and the resident's family member was to complete menus weekly, last revised on 5/28/24. An interview was conducted with Family Member 8 on 12/19/25 at 11:47 a.m. He indicated the facility served items to Resident 9 that she did not like and would not eat. They used to let him fill out a menu to choose what she ate, but they hadn't been doing that lately. An interview was conducted with the Dietary Manager (DM) on 12/22/25 at 2:37 p.m. She indicated she'd been the dietary manager since February, 2025. She sent menus to the memory care unit, where Resident 9 resided, but staff did not regularly complete them. She spoke directly with Family Member 8 two or three months ago, in regard to having him complete the weekly menus for Resident 9. They agreed she would leave a menu packet in Resident 9's room every week for him to complete and return. She usually left the packet for him on Wednesday or Thursday for the following week's meals. She did not give him a menu packet for completion for this week's menu. She'd missed giving him a packet, maybe three times, since they spoke about it. The DM was unaware Resident 9 did not receive her magic cup at lunch today. The dietary aide at the end of the line was responsible for reading the meal ticket and placing any necessary nutritional supplement onto the tray. The Nutritional and Dietary Supplements policy was provided by the DON (Director of Nursing) on 12/23/25 at 9:40 a.m. It indicated, The facility will provide nutritional and dietary supplements to each resident, consistent with the resident's assessed needs.3.1-46(a)(2)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to revise a resident's plan of care to address her behavior of picking/scratching herself and adequately monitor this behavior for 1 of 5 residents reviewed for dementia care. (Resident 53)Findings include:The clinical record for Resident 53 was reviewed on 12/23/25 at 1:00 p.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease, chronic pain, depression, and dementia. An observation of Resident 53 in her wheelchair was made on 12/18/25 at 12:40 p.m. in the common area of the unit she resided. The resident had a quarter sized, reddish area with a partially scabbed center on her right cheek. There were no progress notes or assessments in the clinical record referencing the area on the resident's right cheek. An observation of Resident 53 and interview with Qualified Medication Aide (QMA) 6 were conducted on 12/23/25 at 11:52 a.m. QMA 6 indicated she hadn't noticed any areas on Resident 53's right cheek, so she went to Resident 53's room for an observation. Resident 53 was observed in bed with quarter sized, reddish areas on both cheeks. QMA 6 indicated, She's picking at it right now. She has areas on both cheeks now. QMA 6 indicated Resident 53 picked at her skin when she first admitted to the facility, and she remembered discussing it and being told to be cautious of it. Resident 53's care plans were reviewed with the Memory Care Facilitator (MCF) on 12/23/25 at 12:00 p.m. The resident's behavior care plan did not reference any picking or scratching behaviors. There were no care plans referencing the areas on the resident's cheeks. An interview was conducted with the MCF on 12/23/25 at 12:00 p.m. during the review of Resident 53's care plans. The MCF indicated she was responsible for doing the resident's care planning. The areas on her cheeks and her picking/scratching behavior should be on her skin condition and/or behavior care plan. An interview was conducted with the Director of Nursing (DON) on 12/23/25 at 12:07 p.m. The DON indicated Resident 53 was always messing with things, but if she was picking at her skin, that was a new behavior for her, and they needed to notify the nurse practitioner, care plan it, look at the areas on her cheeks, let the wound nurse know about the areas to see if they needed treatment, and inform their psychiatric provider, because Resident 53's medications were changed around lately. The DON reviewed Resident 53's clinical record and indicated she did not see any documentation referencing the areas on her cheeks. The MCF was responsible for care planning for that unit. An interview was conducted with the DON on 12/23/25 at 12:33 p. m. She indicated that the Assistant Director of Nursing (ADON) and Infection Preventionist (IP) saw Resident 53 take her hands and scratch her face one day last week. The ADON saw the area on her cheek today when she did wound rounds, but she didn't feel it needed a treatment. Scratching her face was a behavior for Resident 53 and it needed care planned. When a resident had a behavior, it should have been documented in point of care by the Certified Nursing Assistants (CNAs) or in a progress note by the nurses. She felt some of the residents on the unit were hard to manage, and if Resident 53's picking/scratching behavior was normal for her, staff didn't always document it, because they were so used to it. The December, 2025 progress notes and the December, 2025 Behavior Monitoring and Interventions Report from point of care did not indicate any scratching or picking or self-injury behaviors for Resident 53. The Mood and Behavior Management policy was provided by the DON on 12/23/25 at 1:27 p.m. It indicated Purpose: To provide interventions for residents exhibiting problematic or distressing moods and/or behaviors. Policy: It is the policy of [name of facility] to provide interventions for all residents with behavioral and/or mood indicators that may be problematic or distressing. Residents are provided a supportive environment that is aimed at prevention, relief, and/or accommodation of their behavior and/or mood in addition to interventions that are specific to the resident's individualized needs. Procedure: A care plan should be initiated for any mood and behavioral symptom that affects, or has the potential to affect, the resident or others.New or worsening behaviors are reviewed by the IDT (Interdisciplinary Team.)The IDT team reviews and discusses the behavior event, evaluates the interventions, presents any new interventions that may be applicable, and attempts to determine an underlying cause such as environmental factors, pain and related diagnoses.3. 1-37(a)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on interview, observation, and record review, the facility failed to ensure indwelling urological devices were maintained in accordance with infection control measures for 3 of 3 residents reviewed for indwelling urological devices. (Resident 96, Resident 11, and Resident 6)Findings include:1. The clinical record for Resident 96 was reviewed on 12/19/2025 at 2:15 p.m. The resident's diagnoses included, but were not limited to, bladder cancer and urinary retention.An admission Nursing Assessment, dated 12/17/2025, indicated Resident 96 had a urostomy and was alert and oriented to person only.A care plan, dated 12/17/2025, indicated Resident 96 had a urostomy with the goal of no infections related to urostomy. The interventions indicated for staff to monitor the resident for signs and symptoms of infection, as well as to use enhanced barrier precautions.A physician's order, dated 12/17/2025, indicated for Resident 96 to have urostomy care daily.During an observation, on 12/18/2025 at 12:59 PM, Resident 96's drainage bag and tubing for urostomy were on the floor.During an observation, on 12/22/2025 at 12:35 PM, Resident 96's drainage bag and tubing for urostomy were making contact the floor.2. The clinical record for Resident 11 was reviewed on 12/23/2025 at 11:05 AM. The resident's diagnoses included, but were not limited to, Alzheimer's and urinary retention.An admission Minimum Data Set Assessment, dated 11/23/2025, indicated Resident 11 was cognitively impaired, used a wheelchair for mobility, had an indwelling urinary catheter, and was dependent on staff for transferring, toileting, and dressing activities of daily living.A care plan, dated 11/18/2025 and revised 11/29/2025, indicated Resident 11 utilized a suprapubic urinary catheter for the diagnosis of obstructive uropathy. The goal was indicated to have no complication with interventions of enhanced barrier precautions and catheter care every shift.During an observation, on 12/18/2025 at 1:38 PM, Resident 11 in wheelchair with his urinary catheter bag contacting the flooring. During an observation, on 12/22/2025 12:25 PM, Resident 11 in wheelchair with his urinary catheter bag contacting the flooring. 3. The clinical record for Resident 6 was reviewed on 12/23/2025 at 11:22 AM. The resident's diagnoses included, but were not limited to, femur fracture and urinary retention.A Significant Change MDS Assessment, dated 10/28/2025, indicated Resident 6 was cognitively impaired, utilized an indwelling urinary catheter, and was dependent on staff for transfers, hygiene, and grooming needs.A care plan, dated 9/11/2025 and revised on 11/04/2025, indicated Resident 6 utilized an indwelling urinary catheter for obstructive uropathy. Goals indicated the resident was to be free of complications related to the indwelling urinary catheter. The interventions indicated the staff were to use enhanced barrier precautions and provide catheter care every shift. During an observation, on 12/22/2025 at 12:16 PM, Resident 6 was in the dining room. The resident's urinary catheter bag was directly contacting the flooring. During an interview, on 12/23/2025 at 1:45 PM, the Infection Prevention Nurse indicated it was the expectation for staff to keep the residents catheter drainage bag and tubing free of contact with the floor to promote infection control measures. 3.1-18(b)(2)