

Department of Health & Human Services  
Centers for Medicare & Medicaid Services

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>155089                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                            | (X3) DATE SURVEY<br>COMPLETED<br><br>07/22/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Willows of New Castle                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1023 N 20th St<br>New Castle, IN 47362 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                     |                                                 |
| <p>F 0677</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>Based on observation, interview, and record review, the facility failed to assist a dependent resident with nail care for 2 of 8 residents reviewed for ADLs (Activities of Daily Living). (Resident D and Resident J) Findings include:1.) The clinical record for Resident D was reviewed on 7/22/26 at 11:50 a.m. The diagnoses included, but were not limited to, aphasia (inability [or impaired ability] to understand or produce speech), dementia (a decline in mental abilities), and contractures (permanent tightening or shortening of muscles, tendons, skin, or other soft tissues that causes joints to become stiff and restricts normal movement). A Quarterly Minimum Data Set (MDS) assessment, dated 5/9/26, indicated Resident D was moderately cognitively intact, and was dependent on staff for personal hygiene. During observations on 7/21/26 at 9:50 a.m. and 7/22/26 at 10:55 a.m., Resident D was sitting in his wheelchair in his room. Resident D's hands were contracted and had long, jagged nails that curled up into both palms due to contractures. During an interview on 7/22/26 at 10:58 a.m. with Certified Nurse Aide (CNA) 2, they indicated they usually would cut nails on shower days and acknowledged Resident D's long nails. A plan of care, dated 8/22/24, indicated Resident D had alteration in functional performance as evidenced by: need from at least one helper to complete self care tasks. The interventions included, but were not limited to, grooming every day and as needed. 2.) The clinical record for Resident J was reviewed on 7/22/26 at 12:12 p.m. The diagnoses included, but were not limited to, Alzheimer's disease (a progressive, irreversible brain disorder that destroys memory) , anxiety, and Type 2 diabetes mellitus. A Significant Change Minimum Data Set (MDS) assessment, dated 7/13/26, indicated Resident J was severely cognitively impaired, had no behaviors for rejection of care, and was dependent on care for personal hygiene. During observations of Resident J on 7/21/26 at 10:05 a.m. and 7/22/26 at 11:08 a.m., they were sitting in a wheelchair in their room. Resident J's left thumb nail was long, thick, and jagged, while all other nails were also long and uncut. During an interview with Qualified Medical Assistant (QMA) 3 on 7/22/26 at 11:08 a.m., indicated they had noticed Resident J's nails being long last week and had thought about placing Resident J on a podiatry list because he was diabetic, but did not attempt to cut or file Resident J's nails at the time. During an interview with Licensed Practical Nurse (LPN) 4 on 7/22/26 at 11:30 a.m., indicated nail care should be done with every shower. If a resident is diabetic, the nurse should be the one cutting them and filing if needed. The CNAs were supposed to report long nails to the nurse, so they knew they needed to be cut. A plan of care, dated 4/2/25, indicated Resident J had alteration in functional performance. The interventions included, but were not limited to, assist Resident J with up to 2 staff to assist with ADLS including personal hygiene. A Nail Care policy was provided by the Executive Director (ED) on 7/22/26 at 1:18 p.m. It indicated .Policy Explanation and Compliance Guidelines: .4. Routine nail care, to include trimming and filing, will be provided on a regular schedule .6. Principles of nail care: .a. Nails should be kept smooth to avoid skin injury .b. Only licensed nurses shall trim or file fingernails of resident's with diabetes . This Federal citation relates to intake 3092756410 IAC (Indiana Administrative Code) 3.1-38(a)(3)(E)</p> |                                                                                     |                                                 |

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

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER<br>REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0690<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | <p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>Based on interview and record review, the facility failed to provide catheter care as ordered by the physician for 1 of 4 residents reviewed for catheter care. (Resident C) Findings include: The clinical record for Resident C was reviewed on 7/21/26 at 1:36 p.m. The diagnoses included, but were not limited to, intellectual disabilities, urinary tract infections, and obstructive and reflux uropathy (conditions where urine flow is blocked or flows backward into the kidneys). An admission Minimum Data Set (MDS) assessment, dated 5/9/26, indicated Resident C was severely cognitively impaired and had no behaviors for rejection of care. A physician's order, dated 5/18/26, indicated urinary catheter care every shift. A review of June and July 2026 Treatment Administration Record (TAR) indicated Resident C had missed catheter care on the following dates and shifts: 6/2/26, Evening shift 6/4/26, Night shift 6/16/26, Morning shift 6/23/26, Morning shift 6/30/26, Evening and Night shift 7/4/26, Morning and Evening shift 7/5/26, Evening shift, and 7/6/25, Evening shift. A Catheter Care policy was provided by the Executive Director (ED) on 7/22/26 at 2:24 p.m. It indicated .Policy: It is the policy of this facility to ensure resident's with indwelling catheters receive appropriate catheter care .Policy Explanation: .1. Catheter care will be performed every shift . This Federal citation relates to intake 3092756.410 IAC (Indiana Administrative Code) 3.1-41(a)(2)</p> |                                                                                     |                                                 |