STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155089	A. Building B. Wing	03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willows of New Castle	1023 N 20th St 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 (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 50436 Based on interview and record review, the facility failed to ensure residents, including a confidential resident, were treated with dignity during care for 2 of 3 residents reviewed for dignity. (Resident 9 and Confidential Resident) Findings include: 1. During an interview with Resident 9 on 3/10/25 at 1:26 p.m., they indicated it had taken an hour for anyone to come into her room when she turned her call light on to go to the restroom. Resident 9 indicated she had to wait so long for help, that she ended up having incontinent episodes of urine and feces in bed. Resident 9 indicated it made them feel bad and it upset them because it was unnecessary and could have been avoided. Resident 9 indicated this occurrence happens at least once a week. The clinical record for Resident 9 was reviewed on 3/11/25 at 12:09 p.m. Diagnoses included, but were not limited to, generalized anxiety disorder, muscle weakness, and chronic pain syndrome. The Quarterly Minimum Data Set (MDS) assessment, dated 2/5/25, indicated Resident 9 was cognitively intact. The quarterly MDS also indicated Resident 9 was frequently incontinent of bowel and bladder, required a wheelchair for ambulation, and needed substantial/maximal assistance with personal hygiene and required moderate assistance with toilet transferring. A care plan for Impaired/Risk for impaired skin integrity was provided by the Administrator on 3/13/25 at 8:30 a.m. It indicated that incontinent care would be performed every two hours and as needed and to turn and reposition every two hours and as needed. A care plan for Bowel/Bladder Incontinence, initiated 10/23/24, indicated to check resident approximately every two hours. Wash, rinse and dry perineum. Change clothing as needed after incontinence episodes. During an interview with the Administrator on 3/13/25 at 9:36 a.m., she indicated she was never aware of this occurring and will start Resident 9 on a toileting program and check in with her more often for care needs. 45291 (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2a. A confidential resident record was reviewed during the survey period. The medical diagnoses included dementia and chronic pain. The last Minimum Data Set (MDS) assessment indicated the confidential resident was cognitively intact. A depression care plan, revised on 1/23/24, indicated the confidential resident was at risk for feeling bad about themselves, and received mental health services. The interventions included listening to the resident and validating their feelings. During a confidential resident interview, the resident indicated they were not treated with respect during care. Staff are often rough and holler at them, have accused them of trying to have someone fired, and did not listen to them when they told them how to provide their care. This resulted in the confidential resident feeling disrespected and bad about themselves. 2b. The medical record for Resident 155 was reviewed on 3/12/25 at 11:45 a.m. The medical diagnoses included depression and Chron's disease. An admission assessment, completed on 2/24/25, indicated Resident 155 was alert and oriented to person, place, time, and situation. During an interview on 3/10/25 at 1:45 p.m., Resident 155 indicated she becomes very upset with the way staff talk and treat the confidential resident. She stated, they [staff] are very unkind to [the confidential resident] at times and should not be in this line of work if they [staff] are going to treat people like that. She indicated that if they were to speak to her in that manner, she would be very upset, and it would make her cry. She had on numerous occasions heard the confidential resident state the staff were hurting her, but they didn't stop care or even acknowledge it. During an interview on 3/14/25 at 12:00 p.m., the Administrator indicated it was the expectation of the facility to treat all residents with respect. 3.1-3(t)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 50436 Based on interview and record review, the facility failed to provide a bath and/or shower upon request and as care planned for 1 of 1 resident reviewed for bathing. (Resident 6) Findings include: The clinical record for Resident 6 was reviewed on 3/11/25 at 12:27 p.m. Diagnoses included, but were not limited to, stress incontinence and osteoarthritis of the left hand. During an interview with Resident 6 on 3/10/25 at 12:32 p.m., she indicated a couple months ago when she had COVID-19, she went several days without a bed bath or shower. Resident 6 indicated she asked staff for a shower, but they told her she could not have one because she had COVID-19 and would have to bathe her in her room. Resident 6 indicated she would have to go into her bathroom and wash up on her own. She indicated no bed baths were offered or given. She also indicated she takes her showers on Tuesdays and Fridays. During an interview with Licensed Practical Nurse (LPN) 2 on 3/12/25 at 11:47 a.m., they indicated when anyone was in isolation, they could take a shower, they are just taken last for the day due to sanitizing afterwards. An Admission Minimum Data Set (MDS) assessment, dated 8/22/24, indicated Resident 6 was cognitively intact, had no behaviors of rejection of care, and it was very important for her to be able to choose from a tub bath, shower, bed bath, or sponge-bath. An Interdisciplinary Team (IDT) follow up note, dated 1/11/25, indicated Resident 6 tested positive for COVID-19. A physician's order, dated 1/11/25, indicated Resident 6 was to be placed in droplet/contact isolation precautions for ten days. Shower sheets were provided by the Administrator, on 3/12/25 at 9:45 a.m., and indicated Resident 6 had a shower, on 1/10/25, and a bed bath given due to isolation documented on 1/14/25. A shower sheet, dated 1/16/25, showed no documentation of a shower or bath being given. The Electronic Health Record (EHR) bathing documentation was provided by the Administrator, on 3/13/25 at 10:25 a.m., and indicated Resident 6 did not receive a shower or bath, on 1/17/25, on her scheduled showering day. The next shower documented for Resident 6 was on 1/21/25. This indicated Resident 6 went seven days without a bath and/or shower being given as documented in her plan of care. During an interview with Resident 6 on 3/12/25 at 11:50 a.m., she indicated she was miserable and crying after she had gone several days without a bath or shower when she was sick. An Activities of Daily Living care plan was provided by the Administrator on 3/12/25 at 9:45 a.m. It indicated Resident 6 would receive tub bath or showers as she preferred, and staff would provide supervision/touching assist of one helper with dressing and grooming. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Resident Showers policy was provided by the Administrator on 3/12/25 at 9:45 a.m. It indicated, .1. Residents will be provided showers as per request .2. Partial baths may be given between regular shower schedules .4. Assist the resident to the shower room 3.1-38(a)(3)(A) 3.1-38(a)(3)(B)

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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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. 50436 Based on interview and record review, the facility failed to provide routine dental care to residents when an inside source was not available for 1 of 3 residents reviewed for dental services. (Resident 2) Findings include: During an interview on 3/10/25 at 1:16 p.m., Resident 2 indicated she would like to see a dentist. Resident 2 indicated she had not seen the dentist in a long time. The clinical record for Resident 2 was reviewed on 3/11/25 at 12:05 p.m. Diagnoses included, but were not limited to, diabetes mellitus and cerebral infarction. The Annual Minimum Data Set (MDS) assessment, dated 1/8/25, indicated Resident 2 was cognitively intact for daily decision making. A Complimentary Dental Assessment consent was provided by the Administrator on 3/12/25 at 9:45 a.m. Resident 2 signed to give consent for dental services on 5/27/21. Resident 2's last dental exam provided by the Administrator, on 3/12/25 at 9:45 a.m., indicated Resident 2 had a dental exam on 9/9/22. During an interview with the Administrator on 3/12/25 at 9:55 a.m., she indicated the facility recently switched dental services to a new company because the facility was having issues with the previous company not providing services. The Administrator indicated the dental company had not seen their residents on a regular basis or conducted annual screenings for everyone enrolled. During an interview with the Social Service Director (SSD) on 3/14/25 at 11:28 a.m., they indicated the dental company, whom they worked with, stopped doing annual dental exams after COVID-19. The SSD indicated the facility did not offer to take residents to an outside provider for an annual screening. They only took residents out of the facility if they had any dental problems. A Dental Services policy was provided by the Administrator on 3/12/25 at 10:30 a.m. It indicated, .It is the policy of this facility to assist residents in obtaining routine (to the extent covered under the State plan) . [Routine dental services] means an annual inspection of the oral cavity 3.1-24(a)(1)