

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155089	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/06/2026
NAME OF PROVIDER OR SUPPLIER  Willows of New Castle		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on interview and record review the facility failed to ensure a resident who received the wrong medication had a assessment completed, ongoing monitoring and vitals signs completed for 1 of 2 residents reviewed for quality of care (Resident B). Finding include:During an interview with Licensed Practical Nurse (LPN) 1 on 3/03/2026 at 1:05 p.m., the LPN indicated she witnessed RN 4 who no longer works at the facility administered Resident B one of Resident E's morning medication. This occurred months ago and LPN 1 was unsure of the date. The medication error was reported to the Director Of Nursing (DON) who no longer works at the facility. During an interview with the Nurse Practitioner (NP) on 3/4/26 at 2:37p.m., the NP indicated on 10/17/25 at 9:31 a.m., LPN 1 reported to her that Resident B had received Resident E morning medication of rivastigmine 3 milligrams (mg). The medication was used to treat dementia. The medication was not harmful to Resident B and the NP told LPN 1 to monitor the resident's vital signs and to observe for anxiety and tremors every shift for 24 hours. During an interview with the Regional Nurse Consultant 3 on 3/5/26 at 10:55 a.m., the Regional Nurse Consultant indicated on 10/17/26, there was no assessment, no progress note and no vital signs documented in the Electronic Health Record (EHR) for Resident B after she received Resident E's morning medication. The floor nurse was responsibility to ensure this was completed for Resident B. Review of the clinical record of Resident B on 3/4/26 at 1:25 p.m., indicated the resident's diagnoses included, but were not limited to, diabetes, chronic kidney disease, osteoporosis, hypertension, congestive heart failure, depression, anxiety disorder, intellectual disability (below average cognitive function) and cerebral infarction (stroke caused by a blocked or narrow arteries). The annual Minimum Data Set (MDS) assessment for Resident B, dated 1/1/26, indicated the resident was moderately impaired for daily decision making. The Medication error policy provided by the Administrator on 3/6/26 at 10:10 a.m., indicated a medication error means the observed or identified preparation or administration of medications or biologicals which was not in accordance with the prescribers order. If a medication error occurs, the following procedure would be initiated: the nurse assesses and examines the resident's condition, monitor and document the resident's condition, including response to medical treatment or nursing interventions, document actions taken in the medical record. The citation relates to Intake 2665000. 410 IAC(Indiana Administrative Code) 3.1-37(a)</p>		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  155089	Facility ID:  155089  If continuation sheet Page 1 of 7

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>Based on observation, interview and record review, the facility failed to implement a splint for a resident with bilateral hand contractures as ordered by the physician for 1 of 1 resident reviewed for Range Of Motion (Resident 51). Finding include: During an observation on 3/02/2026 2:35 p.m., Resident 51 had bilateral hand contractures (a chronic hand condition where connective tissue in the palms of both hands thicken ) with no splints in place. During an observation on 3/04/2026 at 1:54 p.m., Resident 51 had bilateral hand contractures with no splints in place. During an observation on 3/05/2026 at 11:33 p.m., Resident 51 had bilateral hand contractures, the resident had a splint on his left hand and did not have a splint on his right hand. The splint was observed to be on the resident's bedside table. During an observation on 3/05/2026 at 12:46 p.m., Resident 51 was sitting in the dining room, the resident had a splint on his left hand and did not have one on his right hand. Review of the clinical record of Resident 51 on 3/5/26 at 12:55 p.m., indicated the resident's diagnoses included, but were not limited to, traumatic brain injury (a disruption in normal brain function caused by an external force) and dementia (mental decline). The plan of care for Resident 51, dated 8/22/24, indicated the resident had an alteration in functional performance as evidenced by: Needed assistance from at least one staff member to complete self-care tasks. The intervention included, but was not limited to, bilateral palm protectors per order. The Occupational Therapy assessment for Resident 51, dated 1/21/26, indicated the resident had impaired range of motion of the right and left upper extremities due to contractures. The quarterly Minimum Data Set (MDS) assessment for Resident 51, dated 2/6/26, indicated the resident was severely impaired for daily decision making. The resident had impairment in range of motion of both of the upper extremities. The physician's order for Resident 51, dated March 2026, indicated the resident was to have bilateral palm protector or hand orthoses as tolerated at day time and off at night time and bathing (original 10/20/25). The Medication Administration Record (MAR) for Resident 51, dated March 2026, lacked documentation by the resident of any refusals to wear bilateral palm protector or hand orthoses. During an interview with the Regional Nurse Consultant (RNC) on 3/5/26 at 2:25 p.m., the RNC indicated floor nurses were responsible to ensure Resident 51 had his bilateral splints in place. The assistive device and splint policy provided by the Administrator on 3/6/26 at 10:10 a.m., indicated the purpose of the policy was to provide a reliable process for the proper and consistent use of assistive devices for those residents requiring equipment to maintain or improve function, dignity and quality of life. The devices included, but were not limited to, orthotic equipment/splints. The nurse would be responsible for the resident and monitor for the consistent use of the device. 410 IAC (Indiana Administrative Code) 3.1-42(a)(2)</p>		

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to adequately monitor and treat a resident's wandering behavior for 1 of 3 residents reviewed for dementia care and services. (Resident C) Findings include: The clinical record for Resident C was reviewed on 3/5/26 at 11:11 a.m. His diagnoses included, but were not limited to, dementia (mental decline) with agitation and anxiety. The nursing admission note, dated 2/17/26 at 4:10 p.m., by Licensed Practical Nurse (LPN) 7 indicated the resident was confused and combative. Within the first five minutes of arrival, he was up, refusing to wait on a physical therapy evaluation. He refused to follow staff direction. He moved over to his roommate's area of the room and started to move items around. He then had contact with the roommate. Verbal redirection by staff failed and Resident C became physical, he lashed out and stroke staff. The nursing note, dated 2/17/26 at 10:06 p.m., by LPN 7 indicated the resident was temporarily moved to another room, because he and his roommate were screaming at each other. He was administered a one-time order which was effective for approximately two hours. Then he was found in another resident's room holding her hand, saying he loved her. He was combative with staff during the redirection at that time. An interview was conducted with LPN 7 on 3/5/26 at 2:27 p.m. The LPN indicated he was the nurse on duty when Resident C was admitted to the facility on [DATE]. Resident C touched his roommate's belongings and touched him on his leg. The two of them argued back and forth. The LPN's solution was to separate them and move Resident C to a different room and let management figure out how to handle things the next day. Resident C would not stay in his room, he kept wandering into other resident's rooms and was physically combative with staff, including the LPN. Resident C's discharge medications were unavailable for administration when he arrived at the facility, so LPN 7 had to get emergency medication for him that night, but it had little to no effect. His scheduled Risperidone was not available for administration. His medications were not available until Resident C's second day there. Several female residents were voicing they wanted him kept away from them. The behavior note, dated 2/18/26 at 3:03 a.m., indicate Resident C was confused and ambulated in the hallways. He refused to stay in his bed in his room with repeated attempts. The Interdisciplinary Team note, dated 2/18/26, indicated a review of Resident C's noted behaviors after arrival was completed. The resident was noted to be wandering with no purpose, difficult to redirect, rummaged through his roommate's belongings, and caused irritation to his roommate. Upon investigation and interviews with staff, the contact made with his roommate was a hand on his roommate's leg as this was Resident C's way of communication. It was not done in a manner of aggression. The family reported that Resident C had a difficult time adjusting at first to new environments. In the past, as needed medications were effective. A new order for intramuscular Haldol and Ativan were obtained. A wander guard was placed for the resident's safety. The Haldol was effective for two hours after administration. Resident C continued with intermittent redirectable behaviors. Resident C was found in another resident's room during the night, sitting next to the other resident's bed, holding hand, having civil conversation. No aggression or inappropriate behaviors were noted. A referral was made for psychiatric services to evaluate and treat Resident C. The behavior note, dated 2/18/26 at 9:34 p.m., indicated Resident C continued to enter other residents' rooms, striking staff as they attempted to redirect him. He spit on the nurse and laid on the floor at the nurse's station. The behavior note, dated 2/19/26 at 9:56 p.m., indicated Resident C continued to be agitated without the ability to be redirected, was exit seeking and striking staff. He walked into other resident's rooms. From 9:00 p.m. to 10:00 p.m. the nurse provided one on one supervision to prevent the behaviors. The behavior note, dated 2/22/26 at 2:09 p.m., indicated Resident C</p> <p>(continued on next page)</p>		

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>wandered the facility all shift. He entered other residents' rooms multiple times and upset the residents. He sat on a resident's bed and refused to move. Multiple nursing staff attempted to redirect him. He had taken off his pants and socks and was attempting to lay down. The owner of the room was sitting in his recliner, was angry, and told the resident it was not his room and he needed to leave. Resident C eventually got up and staff were able to redirect him out of the room. An interview was conducted with Certified Nursing Assistant (CNA) 8 on 3/5/26 at 12:30 p.m. She indicated she'd worked at the facility for two years and normally worked evening shift on the hallway Resident C resided. She was eventually assigned to provide one on one supervision to him. When Resident C first arrived, he got into a verbal altercation with Resident 7. Resident C was provided one-on-one for a few days, maybe five after arriving. He wandered into other residents' rooms. She received information in shift report that he climbed in bed with Resident 13. It was chaotic when he wasn't provided one-on-one supervision (one staff member to one resident continuous supervision). Some days he was more on edge than others. An interview was conducted with CNA 9 on 3/5/26 at 12:12 p.m. She indicated she'd worked at the facility for two years. She was familiar with Resident C. He would scream out, was combative if you got too close. He would get outrageous, cussing, wouldn't cooperate. She saw him go into other residents' rooms, randomly. The other residents would put on their call lights for staff to come get him out of their room. She had to assist him out of other residents' rooms, where he was maybe messing with their television remote, going through their closet, messing with clothes, and picking up stuff. She explained to him it wasn't his room, kept coaching him, and eventually he would leave. An interview was conducted with Resident 60 on 3/6/26 at 11:35 a.m. She indicated Resident C came into her room and shut the door, which made her feel uncomfortable. He took her wheelchair foot pedals off of the bed and asked her where to put them. She told him he needed to leave. Eventually he put her foot pedals into the trash can and left her room. Another time he came into her room, he laid on the bed. She told him he needed to leave and it was not his room. A staff member came to the door and redirected him out of her room. He went into other residents' rooms too. An interview was conducted with Resident 25 on 3/5/25 at 2:57 p.m. She indicated Resident C came into her room one night. He closed the door and came to the empty bed and started to turn back the covers. He was sitting on the empty bed and started putting dirty signs up on his hands and told her to 'shut up, just shut up.' She told him he needed to go back to his own room. He eventually left her room and shut the door. It didn't make her feel very good. She was a little scared. She never had anyone speak to her like that before. An interview was conducted with Resident 3 on 3/6/26 at 11:25 a.m. She indicated she and her roommate shared a restroom with Resident C. He came into their room through the restroom one time. An interview was conducted with the Social Services Director (SSD) on 3/5/26 at 12:41 p.m. She indicated when a resident had dementia, it was really looked at, as to whether they were a good fit for the facility admission. They were under the impression Resident C was not able to walk and needed assistance for mobility. They were blown away that he was able to walk everywhere as soon as he was admitted. He started having behaviors right away and was more confused when off of the original hospital medications. She saw him go into other residents' rooms. He was not placed on one-on-one supervision until 2/23/26, and she was unsure as to why. He did not get his medications the first night he was at the facility, because the pharmacy did not deliver them. An interview was conducted with the Administrator on 3/6/26 at 10:41 a.m. She indicated Resident C wandered into other residents' rooms and was aggressive with staff. He wandered everywhere until he was placed on one-on-one supervision. Prior to one-on-one supervision, they tried redirection, all the things, but their facility was not the appropriate setting for him. Other residents were upset about his behaviors, as</p> <p>(continued on next page)</p>		

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>they were not used to other residents coming into their rooms. The Dementia Care policy was provided by the Administrator on 3/5/26 at 3:02 p.m. It indicated, It is the policy of this facility to provide the appropriate treatment and services to every resident who displays signs of, or is diagnosed with dementia, to meet his or her highest practicable physical, mental, and psychosocial well-being. Policy Explanation and Compliance Guidelines: 1. The facility will assess, develop, and implement care plans through an interdisciplinary team (IDT) approach that includes the resident, their family, and/or resident representative, to the extent possible. 2. The care plan goals will be achievable and the facility will provide resources necessary for the resident to be successful in meeting their goals. 3. The care plan interventions will be related to each resident's individual symptomology and rate of dementia (or related disease) progression with the end result being noted improvement or maintained of the expected stable rate of decline associated with dementia and dementia-like illnesses. 4. Care and services will be person-centered and reflect each resident's individual goals while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety. 5. Individualized, non-pharmacological approaches to care will be utilized, to include meaningful activities aimed at enhancing the resident's well-being. 6. If needed, the environment will be modified to accommodate individual resident care needs. 7. The care plan goals and interventions will be monitored on an ongoing basis for effectiveness, and will be reviewed/revised as necessary. 8. Appropriate referrals will be made if current interventions are ineffective or resident shows a decline in psychosocial, mood, or behavioral status (i.e. physician, mental health provider, licensed counselor, pharmacist, social worker). 9. All staff will be trained on dementia and dementia care practices upon hire, annually, and as needed to ensure they have the appropriate competencies and skill sets to ensure residents' safety and help resident's attain or maintain the highest practicable physical, mental, and psychosocial well-being. This citation relates to Intakes 2787990 and 2794869. 410 IAC (Indiana Administrative Code) 3.1-37(a)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to ensure a resident's ordered medication was available for administration upon admission to the facility for 1 of 3 residents reviewed for pharmacy services. (Resident C) Findings include: The clinical record for Resident C was reviewed on 3/5/26 at 11:11 a.m. His diagnoses included, but were not limited to, dementia (mental decline) with agitation and anxiety. The hospital discharge orders, dated 2/17/26, indicated staff were to administer Resident C's Risperidone one time a day, three 0.5 mg tablets. The resident's next dose was due on 2/17/26 at 4:00 p.m. The resident was to receive Trazadone at bedtime, one 50 mg tablet. The resident's next dose was due on 2/17/26 at bedtime. The nursing admission note, dated 2/17/26 at 4:10 p.m., by Licensed Practical Nurse (LPN) 7, indicated the resident was confused and combative. Within the first five minutes of arrival, he was up, refusing to wait for a physical therapy evaluation. He refused to follow staff direction. He moved over to his roommate's area of the room and started to move items around. He then made contact with the roommate. Verbal redirection by staff failed and Resident C became physical, lashing out and striking staff. The February 2026 medication administration record (MAR) indicated Resident C's three 0.5 mg tablets of Risperidone were not administered at 4:00 p.m. on 2/17/26. The administration of the Resident C's Risperidone since admission was first administered on 2/18/26 at 4:00 p.m. The February 2026 MAR indicated Resident C's 50 mg tablet of Trazadone was not administered at bedtime on 2/17/26. The administration of Resident C's Trazadone since admission was first administered on 2/18/26 at bedtime. The nursing note, dated 2/17/26 at 10:06 p.m., by LPN 7, indicated Resident C was temporarily moved to another room, because he and his roommate were screaming at each other. Resident C was found in another resident's room. He was combative with redirection by staff. An interview was conducted with LPN 7 on 3/5/26 at 2:27 p.m. The LPN indicated he was the nurse on duty when Resident C was admitted to the facility on [DATE]. Resident C's discharge medications were unavailable for administration when he arrived at the facility, including his scheduled Risperidone. The resident's medications were not available until his second day there. An emergency behavior medication was administered with little to no effect. The resident was having behaviors and difficult to redirect after arrival. The Pharmacy Services policy was provided by the Administrator on 3/6/26 at 12:20 p.m. It indicated, The facility will provide pharmaceutical services to include procedures that assure the accurate acquiring, receiving, dispensing, and administering of all routine and emergency drugs and biologicals to meet the needs of each resident, are consistent with state and federal requirements, and reflect current standards of practice. This citation relates to Intakes 2787990 and 2794869. 410 IAC (Indiana Administrative Code) 3.1-25(a)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, interview, and record review, the facility failed to ensure the stove hood was maintained in a clean sanitary manner. This deficiency had the potential to affected 58 of 58 residents who dine in the facility. Findings include:A tour of the kitchen was conducted with the Dietary Manager (DM) on 3/2/26 at 12:30 p.m. During the tour, the stove hood was observed. There was a griddle/stove underneath the left side of the hood. The hood had a significant amount of built-up, greasy debris on the back panels and sprinklers. The back panels appeared furry substance completely covering the panels and sprinklers. There was stringy debris of dark substance hanging from one of the sprinklers above the griddle/stove where food was prepared. The sticker on the front of the stove hood indicated it was last serviced on 11/26/25, and the next service was to be in May of 2026. An interview was conducted with the DM during the above observation on 3/2/26 at 12:30 p.m. She indicated they regularly used the griddle/stove underneath the hood, and she noticed the amount of built-up debris on the stove hood, but she was told not to clean it, because it would void the warranty. After reviewing the next scheduled service visit on the sticker, she indicated perhaps it needed scheduled to be cleaned more often than every six months. The work order for the stove hood cleaning, dated 11/26/25, was provided by the DM on 3/2/26 at 12:47 p.m. It indicated cleaning of the kitchen exhaust system every 180 days for two years. The Sanitation policy was provided by the Administrator on 3/6/26 at 2:06 p.m. It indicated, All food service areas shall be kept clean, sanitary, free from litter, rubbish . 410 IAC (Indiana Administrative Code) 3.1-21(i)(3)</p>		