

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155158	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/25/2026
NAME OF PROVIDER OR SUPPLIER Life Care Center of the Willows		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 Elizabeth Dr Valparaiso, IN 46383	
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 0677</p> <p>Level of Harm - Minimal harm 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 record review and interview, the facility failed to ensure residents who were dependent on staff for activities of daily living (ADL's) received bathing/showers at least twice a week for 1 of 4 residents reviewed for ADL's. (Resident C) Finding includes: Resident C's record was reviewed on 3/25/26 at 1:14 p.m. Diagnoses included, but were not limited to, dementia. A Care Plan, updated 1/7/26, indicated the resident required ADL (Activities of Daily Living) assistance. The interventions included to assist the resident with mobility and ADLs as needed. The facility Point of Care bathing task documentation, dated 2/4/26 through 3/24/26, indicated the resident was to receive showers on Thursdays and Sundays. There was no bathing documented for 3/1/26, 3/12/26, and 3/19/26. The Shower Sheets, dated 2/4/26 through 3/24/26, indicated no shower sheets had been completed on 3/1/26, 3/12/26, and 3/19/26 for Resident C. The Quarterly Minimum Data Set (MDS) assessment, dated 2/27/26, indicated the resident was cognitively impaired and required partial to moderate staff assistance with toileting hygiene, dressing, personal hygiene, and bathing. During an interview on 3/25/26 at 4:18 p.m., the Assistant Director of Nursing (ADON) indicated she was unable to find any completed shower sheets for 3/1/26, 3/12/26, or 3/19/26 for Resident C. The resident had been mistakenly left off of the shower schedule on 3/12/26 and had not received a shower. This citation relates to Intake 2960382.410 IAC (Indiana Administrative Code) 16.2-3.1-38(a)(3)410 IAC (Indiana Administrative Code) 16.2-3.1-38(b)(2)</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
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