STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155535	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willow Crossing Health & Rehabilitation Center	3550 Central Ave Columbus, IN 47203

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on observation, interview, and record review, the facility failed to ensure a resident was free of physical and mental abuse by a staff member purposely and forcefully causing a resident to fall from the wheelchair onto the floor. This resulted in the staff member leaving the resident lying on the floor with no assistance, she walked away from the resident going into other resident rooms, while another resident was maneuvering their wheelchair around the resident, and the staff member failed to provide accurate details related to the fall for assessment and follow-up care for 1 of 6 residents reviewed for abuse (Resident B). Using the reasonable person concept, it is likely this would lead to fear, confusion, anxiety, and intimidation for Resident B. Findings include:The clinical record for Resident B was reviewed on 02/17/2026 at 11:22 A.M. A Quarterly Minimum Data Set (MDS) assessment, dated 12/31/2025, indicated the resident was moderately cognitively impaired. The resident's diagnoses included, but were not limited to, depression, anxiety, and unspecified dementia (decline in mental ability). The resident had not exhibited any behaviors during the assessment time frame. The resident utilized a wheelchair and walker for mobility. A Facility Reported Incident, dated 02/10/2026, indicated the Assistant Director of Nursing (ADON) was conducting a root cause analysis of a fall when she reviewed video footage related to a fall for Resident B. Upon review of the video footage, it was noted that Certified Nurse Aide (CNA) 2 was observed forcefully pulling the residents wheelchair backwards causing the resident to fall from the wheelchair. During an interview, on 02/17/2026 at 9:27 A.M., the Regional Nurse Consultant indicated that after a resident had a fall in the facility, they would conduct root cause analysis to determine what caused the fall. While reviewing the hallway recorded video, the morning after it was reported, related to Resident B falling out of his wheelchair in a common area, it was determined a CNA was aggressive with the resident and caused him to fall. There were no other staff members on the unit at the time of the incident. On 02/17/2026 at 10:08 A.M., during an observation of the recorded video footage from 02/09/2026 at 4:20 A.M., with the Regional Nurse Consultant, Resident B was observed sitting in his wheelchair in the hallway on the facility's locked dementia unit. He was in front of the central nurse's station, removed linens from the facility linen cart, and threw the linens on the ground. The resident flipped the linen cart on top of himself, dumping more linens on the floor, and the open linen cart landed on the ground in front of the resident. CNA 2 exited a resident's room directly next to the linen cart where Resident B was sitting. CNA 2 aggressively grabbed the back of Resident B's wheelchair using both handles and proceeded to purposely, forcefully, pull Resident B backwards towards the central nurse's station with two separate jerking, pulling motions. After the second forceful pull Resident B fell out of his wheelchair landing on his buttocks and then fell backwards onto his back to the left of the nurse's desk. The resident's legs were visualized laying in the center of the floor to the left of the nurse's station, with the top half of the resident hidden out of camera view by the nurse's station counter. CNA 2 then stands over Resident B looking down at (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 0600 Level of Harm - Actual harm Residents Affected - Few	him and proceeds to walk back to the linen cart in the hallway. CNA 2 standing approximately two feet away from Resident B's feet then flips the linen cart back onto its wheels and proceeded to put the dropped linens, lying on the floor, back into the linen cart. She then moved the linen cart further down the hallway and proceed back into a resident's room directly in front of the nurse's station that she had exited from prior to the interaction. At 4:22 A.M., CNA 2 wheeled a female Resident out of the resident's room towards the dining walking around Resident B, as the resident was still laying on the floor. At 4:23 A.M., CNA 2 walked back past Resident B as he was laying on the floor on his left side, and leaned against the front of the nurse's station counter on her left elbow looking down at Resident B. She then points back at the linen cart and continues looking down at Resident B. CNA 2 then enters another resident's room directly in front of the nurse's station leaving Resident B lying on his left side next to the central nurse's station. At 4:24 A.M., Resident H attempted to wheel around Resident B lying on the floor. Resident B attempted to scoot his body out of the way so that Resident H could get past him. Resident B then rolled over and after a few attempts the resident sits up on his buttocks on the floor. At 4:27 A.M., Resident B appears to be yelling towards the nurse's station throwing his hands in the air while sitting on the floor. At 4:29 A.M., CNA 2 walked around Resident B and to the linen cart. The CNA then pretended to tip the linen cart over and made the movement of throwing linens on the ground without touching the linens in the cart. The recorded video ended at 4:30 A.M., with Resident B on the floor directly next to the end of to the nurse's station counter with CNA 2 standing in the hallway at the linen cart looking at the resident and another resident sitting in their wheelchair in the hallway beside Resident B. During an interview, on 02/17/2026 at 2:23 P.M., RN 3 indicated she was the nurse working with CNA 2 on the facility's locked dementia unit on 02/09/2026. She was on her lunch break and was off the unit when Resident B had fallen on 02/09/2026. When she walked onto the unit Resident B was sitting on the floor next to the nurse's station with his wheelchair in front of him. CNA 2 told her Resident B had flipped the linen cart on top of himself and then slid himself out onto the floor. Resident B wasn't in any distress and never mentioned anything about the situation at all, so she followed the facility's fall protocol. She did not know the exact time she came back onto the unit, but she had clocked back in when she did. A Facility Clock in Form for RN 3 was provided by the Administrator on 02/17/2026 at 2:40 P.M. The document indicated RN 3 clocked back in from her lunch break on 02/09/2026 at 4:42 A.M. During an interview, on 02/17/2026 at 9:03 A.M., Resident B indicated that he had no memory of falling or sitting on the floor. The current facility policy titled, Abuse Prohibition, Reporting and Investigation with a revision date of 06/2023, was provided by the Administrator on 02/17/2026 at 3:40 P.M. The policy indicated, .This facility shall prohibit abuse . Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish.Mental Abuse - Includes but is not limited to, humiliation, harassment, threats of punishment or deprivation . The past noncompliance deficiency was corrected, on 02/11/26, prior to the start of the survey after the facility implemented a systemic plan that included the following actions: the CNA was removed from the work force, an audit was completed for all residents on the unit, education was provided to all staff related to resident abuse and behaviors, and continued abuse audits and monitoring of residents. This citation relates to Intake 2740223. 3.1-27(a)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident with a major mental illness was appropriately supervised during a physical/mental outburst for 1 of 6 residents reviewed for behavior health services. (Resident B). Findings include:The clinical record for Resident B was reviewed on 02/17/2026 at 11:22 A.M. A Quarterly Minimum Data Set (MDS) assessment, dated 12/31/2025, indicated the resident was moderately cognitively impaired. The resident's diagnoses included, but were not limited to, depression, anxiety, unspecified dementia (mental decline), and a history of visual hallucinations. The resident utilized a wheelchair and walker for mobility. An Incident Report, dated 02/11/2026 at 11:23 P.M., indicated Resident B had grabbed a stationary chair that Resident F was sitting in, and made negative comments towards them. The staff intervened to separate the two residents. Resident B continued to go towards the staff and Resident F in an intimidating manner. A Progress Note, dated 02/11/2026 at 11:30 P.M., indicated Resident F sat next to RN 3 at the nurse's station when a male resident came from behind and stated, I'm going to kill you tonight. I don't need anything to do it; I will strangle you. Staff intervened and moved Resident F away from the other resident. The male resident attempted to grab Resident F's shirt and staff responded, you're not allowed to do that. The male resident replied, Watch me, I can do whatever I want. The male resident then proceeded to grab a colored pencil from behind the desk and moved towards staff and Resident F. Staff and Resident F went into a resident's room and closed the door. The male resident proceeded back to the nurse's station where he threw various items. During an interview, on 02/17/2026 at 3:52 P.M., RN 3 indicated she was working the nightshift on the facility's locked dementia unit on 02/11/2026. She was sitting at the nurse's station with Resident F next to her when Resident B came up behind them and stated, I'm going to kill you tonight. I don't need anything to do it because I'm going to strangle you. He then tried to grab the back of the chair Resident F was sitting in and pull her backwards. Certified Nurse Aide (CNA) 4 came around the desk and helped RN 3 get Resident F out from behind the desk. Resident B then stood up out of his wheelchair and began walking towards all three of them with a colored pencil in his hand. They went into the room directly in front of the nurse's station and RN 3 closed the door. Resident B attempted to get into the room. Resident B then gave up and sat down at the nurse's station. He threw a drink, the phone, and attempted to throw the computer monitor off the desk. It was only her and CNA 4 working on the locked unit at the time of the incident. The police were called and arrived within a few minutes. The resident was calm at the time the police arrived; and the resident was removed from the facility. A Staff Statement from CNA 4, provided by the Regional Nurse Consultant on 02/17/2026 at 9:30 A.M., dated 02/11/2026, indicated when Resident B continued towards the staff and Resident F. RN 3 closed the door of room [ROOM NUMBER] keeping Resident B out of the room. CNA 4 then called the staff in another location (outside of the locked unit) for additional staff for assistance. The two staff members working on the locked unit went into a resident's room and shut the door. The door lacked a window and the resident was left behind the nurses station without a staff member monitoring the residents actions during the outburst. During an interview, on 02/19/2026 at 11:42 A.M., Qualified Medical Assistant (QMA) 5 indicated that during a resident-to-resident altercation she would separate the residents removing them both from harm's way and then ensure safety for both residents. She would never leave a resident during a behavior outburst, and she would attempt to redirect. A current care plan, with the start date of 02/10/2026, indicated Resident B had experienced delusions (fixed false beliefs) that someone was out to get him. The interventions included, but were not limited to: dated 02/10/2026, ensure resident's safety. Attempt (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to ascertain the potential for harm to self or others. The current facility policy titled, Dementia Aggression/Anger dated 05/2016, was provided by the Regional Nurse Consultant on 02/19/2026 at 12:00 P.M. The policy indicated, .Caregivers will strive strategies to understand the aggression that can be caused by many factors including physical discomfort, environmental factors, and poor communication and know how to respond to promote comfort to the resident with dementia . Decrease level of danger.Asses the level of danger - for yourself and the resident with dementia. 3.1-45(a)(2)