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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365648 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 12/05/2025 |
| NAME OF PROVIDER OR SUPPLIER Willow Knoll Post-Acute and Senior Living | | STREET ADDRESS, CITY, STATE, ZIP CODE 4400 Vannest Avenue Middletown, OH 45042 | |
| 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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. (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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| <p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Based on observation, interview, and facility document and policy review, the facility failed to provide a homelike environment for 3 (Resident #38, #57, and #70) of 8 sampled residents reviewed for environment. The facility census was 53. Findings include: An undated facility policy titled, Homelike Environment, revealed a section titled, Policy Statement, that indicated, Residents are provided with a safe, clean, comfortable, and homelike environment and encouraged to use their personal belongings to the extent possible. The policy revealed a section titled, Policy Interpretation and Implementation, that included, 2. The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include a. clean, sanitary and orderly environment. 1. During a Resident Council meeting on 12/02/2025 at 2:44 PM, Resident #38 stated their closet door would not open. Resident #38 stated it was reported to the Maintenance Director, who said the closet door needed new rollers. During a concurrent observation and interview on 12/03/2025 at 3:18 PM, Resident #38's closet revealed two wooden doors with each door attached to a track system (metal stripping mounted to header) that allow the door to move via rollers (roller mechanism attached to the door) that glide along the track on the top portion of the door and one door on the bottom portion of the door was not attached to the bottom tracking system via rollers and the second door did not slide to open. Resident #38 stated a member of the maintenance staff had shown the resident a demonstration of how to access their belongings, which required them to move the first door by holding the door with both hands and pulling the closet door forward and lifting it towards them. Resident #38 stated that they were informed by staff that they would have to complete those steps in order to access their belongings until the closet door was repaired. Resident #38 further stated that it was difficult to get to the clothes that were behind the second door because that door did not slide open. During an observation and concurrent interview on 12/03/2025 at 3:18 PM, the Maintenance Director observed the closet doors and stated Resident #38 made a request for closet repair approximately a month to a month and a half ago. He stated that he placed new rollers on the closet doors, but the new rollers were the wrong size and did not allow both doors to slide. He stated that the closet doors were from the 1990s, and the rollers available at two local hardware stores were for more modern style doors. The Maintenance Director stated that he had not yet tried other hardware stores and acknowledged the repairs were not completed. During a follow-up interview on 12/05/2025 at 9:05 AM, the Maintenance Director stated Resident #38's closet doors would not open because the wheels were old and worn out. He stated that for the resident to be able to open and close the closet door, the first door must be off the track at the bottom. He further stated that the repair took a month and a half because he did not go to the store for supplies daily. He stated he had too many responsibilities at the facility and used the gas in his personal vehicle, so he limited trips to the store to buy supplies. The Maintenance Director further stated he was unable to provide a receipt for the purchase of the rollers for the closet door and stated the facility had not made any written documentation of Resident #38's request to repair the closet door. During an interview on 12/05/2025 at 9:11 AM, the Director of Nursing (DON) stated that she expected the maintenance department to have a team approach for repairs such that staff and residents reported any concerns found related to the environment and she expected the maintenance department to conduct routine rounds of the facility's environment to identify any concerns or repair needs. The DON stated that Resident #38's closet door should not have taken a month and a half to repair as that amount of time was not reasonable. 2. During an interview on 12/01/2025 at 11:33 AM, Resident #57 stated there was water damage to the ceiling in their room. Resident #57 stated that the water damage was like that since the resident moved into the room in 2018. Resident #57 stated the water damage was not reported because the damage was there when the resident moved in, and since staff allowed the resident to move into a room with water damage to the ceiling the resident did not think there were any plans to fix it or do anything about it. Resident #57 further stated that they would like to have the water damage to the ceiling repaired. During an interview on 12/04/2025 at 10:43 AM, the Maintenance Director stated that for the past four years he repaired leaking pipes from the sprinkler system, which had resulted in water damage to the ceiling, and once the leak was repaired, the maintenance staff replaced the ceiling tiles. During a follow-up interview on 12/05/2025 at 8:37 AM, the Maintenance Director stated his department did not have a practice of completing room rounds to identify areas in need of repair. He stated that the ceiling in that room should have been repaired and looked at, to make sure there was no mold growth. During an interview on 12/05/2025 at 9:11 AM, the Director of Nursing (DON) stated that she expected the maintenance staff to</p> | | |