STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365708	A. Building B. Wing	12/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willow Woods Rehabilitation and Nursing	9625 Market Street North Lima, OH 44452

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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. 48565 Based on record review, interview and policy review the facility failed to ensure the resident and resident representative received written notice of room changes for Resident #2, #3, #6, #8, #24, #29, #57 and #65. This affected eight residents (Residents #2, #3, #6, #8, #24, #29, #57, and #65) of eight residents reviewed for room change notifications. The facility census was 71. Findings include: 1. Review of the medical record for Resident #2 revealed a date of admission 09/23/19 with diagnosis of schizophrenia. Resident #2 had a court appointed guardian of person. Review of the census data for Resident #2 revealed a room change on 12/07/24. There was no documentation within the medical record for Resident #2 to verify the legal guardian was notified of the room change. 2. Review of medical record for Resident #3 revealed a date of admission of 10/13/19 with diagnosis of schizophrenia. Resident #3's mother was listed as the resident representative. Review of the census data for Resident #3 revealed a room change on 12/11/24. There was no documentation within the medical record for Resident #3 to verify the mother was notified of the room change. 3. Review of medical record for Resident #6 revealed a date of admission of 04/10/19 with diagnosis of schizophrenia. Resident #6 had a court appointed guardian Review of the census data for Resident #6 revealed a room change on 11/14/24 and 12/4/24. There was no documentation within the medical record for Resident #6 to indicate the legal guardian was notified of the room change. 4. Review of medical record for Resident #8 revealed a date of admission of 12/10/24 with diagnosis of alcohol dependence. Resident #8 was their own responsible party. Review of census data for Resident #8 revealed a room change on 12/15/24. There was no evidence in the medical record regarding written notification to Resident #8 about the room change. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365708	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/31/2024
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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Review of the medical record for Resident #24 revealed a date of admission of 06/21/23 with diagnosis of schizophrenia. Resident #24's brother was their power of attorney (POA). Review of the census data for Resident #24 revealed a room change on 11/17/24. There was no documentation within the medical record for Resident #24 indicating the POA was notified of the room change. On 12/19/24 at 2:43 P.M. an interview with the POA for Resident #24 revealed they were not notified of the room change on 11/17/24. 6. Review of medical record for Resident #29 revealed a date of admission of 11/22/14 with diagnosis of unspecified dementia. Resident #29 had a friend listed as POA. Review of the census data for Resident #29 revealed a room change on 12/04/24. There was no documentation within the medical record for Resident #29 indicating the POA was notified of the room change. 7. Review of medical record for Resident #57 revealed a date of admission of 10/11/24 with diagnoses including hemiplegia, hemiparesis following cerebrovascular disease left dominant side and schizophrenia. Resident #57 was their own responsible party. Review of the census data for Resident #57 revealed a room change on 11/13/24 and 11/14/24. There was no documentation within the medical record for Resident #57 indicating written notification of room change was given to the resident. A review of the November 2024 grievance log revealed on 11/14/24 Resident #57 filed a grievance related to the room change of 11/13/24. 8. Review of medical record for Resident #65 revealed a date of admission of 08/02/21 with diagnosis of Alzheimer's dementia. The daughter of Resident #65 was listed as the responsible party. Review of the census data for Resident #65 revealed a room change on 11/17/24. There was no documentation within the medical record for Resident #65 indicating notification of room change was given to the daughter. On 12/19/24 at 12:16 P.M. an interview with the Administrator and the Regional Director of Clinical Services/ Registered Nurse #272 verified there was no written notification of room change for Residents #2, #3, #6, #8, #24, #29, #57, and #65. The Administrator stated there was no social worker designee in the building since 11/06/24. The Administrator stated she was handling room changes and was unaware written notification needed to be obtained for each of the affected residents. A review of the policy titled Room Change/Roommate Assignment dated May 2017 revealed in subpoint 2, prior to changing a room or roommate assignment all parties involved in the change/assignment (residents and their representatives/sponsors) will be given advance notice. In subpoint 4 the policy stated, unless medically necessary or for the safety and well-being of the resident(s), a resident will be provided with an advance notice of the room change. Such notice will include the reason(s) why the move is recommended. In subpoint 8 the policy stated, documentation of a room change is recorded in the resident's medical record. (continued on next page)

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	This deficiency represents noncompliance investigated under Complaint Number OH00160577.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47570 Based on observation, record review, review of a facility Self-Reported Incident (SRI) and investigation, review of a police report, facility policy review and interview, the facility failed to protect Resident #2's right to be free from physical abuse by Resident #44. Actual harm occurred on 11/28/24 when Resident #2, who was alert and oriented, was punched in the face by Resident #44, who had known aggressive behaviors towards others, during an unprovoked incident while Resident #2 was laying in his bed, sustaining a hematoma to the right eye area and bruising to his right upper arm. Resident #2 was taken to the hospital emergency department for evaluation, diagnosed with a facial hematoma and returned to the facility. In addition, the incident was identified to be a stressor to Resident #2 and Resident #2 indicated he was shook up as a result of the unprovoked incident. This affected one resident (#2) of three residents reviewed for abuse. The facility census was 71. Findings include: Review of the medical record for Resident #2 revealed an admitted [DATE] with diagnoses including schizophrenia, mild protein calorie malnutrition, muscle wasting, muscle weakness, dysphagia, osteoarthritis, age related cataract, major depression, conduct disorder, and cognitive communication deficit. Review of the comprehensive care plan, with a start date of 09/25/24, revealed Resident #2 had an activities of daily living (ADL) self-care deficit related to diagnosis of schizophrenia. Interventions included a wheelchair as needed for mobility, assist with showers as needed, assist with daily grooming, daily hygiene as needed. Supervision was needed for toileting limited assist, use of one person assist for transfers, and independent for bed mobility. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #2's cognition was intact. Resident #2 had no hallucinations or delusions, or verbal or physical behaviors directed towards others. Resident #2 did not refuse care. Resident #2 was independent to walk ten feet. Review of a progress note dated 11/28/24 at 4:22 P.M. written by the Director of Nursing (DON) revealed Licensed Practical Nurse (LPN) #227 was in the hallway when she and a Certified Nursing Assistant (CNA) heard shouting down the hall at 6:30 A.M. LPN #227 entered Resident #2's room while the CNA entered the other resident (Resident #44) room. LPN#227 observed a knot above Resident #2's right eye and bruising to the right upper arm. Resident #2 stated he slugged me. Resident #2 stated Resident #44 hit him. Resident #2 stated he did not know why Resident #44 came in his room for no reason while he was lying in bed. A skin assessment was done on Resident #2 revealing a hematoma above the right eye and bruising to the upper right arm. Both residents denied pain. The local police department was contacted. Both residents were sent to the emergency department (ED), and Physician #279 was notified. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of the medical record for Resident #44 revealed an admitted from a local hospital of 10/25/24. Medical diagnoses included unspecified psychosis not due to a substance or known physiological condition, unspecified dementia mild without behavioral disturbance, cognitive communication deficit, cannabis use, nicotine dependence, depression and homelessness. Review of hospital documentation dated 10/22/24 to 10/25/24 revealed Resident #44 had been in the hospital after signing himself out of another facility and adult protective services became involved to assist with assigning him a legal guardian due to his poor decision making, dementia and history of homelessness. During this hospital stay Resident #44 was noted to have encephalopathy (a medical condition characterized by a general disturbance in brain function) with signs of physical and verbal aggression. He threatened to punch a nurse, pushed staff and slammed a door to obstruct the view of him from staff. Resident #44 could not be reasoned with during the incidents of aggression and had to be de-escalated with a male presence and hospital police. Resident #44 was assessed as stable for transfer to a secured facility on 10/25/24. Review of the nursing admission assessment dated [DATE] revealed he was admitted to the facility from an acute care hospital related to Parkinson's disease and dementia and was alert and oriented to person and time. No behaviors were noted. Review of the initial physician assessment dated [DATE] for Resident #44 revealed he was hospitalized on [DATE] with encephalopathy and altered mental status related to neurocognitive disorder and Parkinson disease. He did not know why he was at the facility and was having no behaviors at the time of the visit. Review of the care plan for Resident #44, date initiated 10/29/24, revealed he was a smoker and enjoyed activities that did not involve group participation. There was no behavior care plan developed for Resident #44 having a history of cognitive impairment with aggressive behaviors prior to admission. Review of a progress note dated 11/01/24 revealed Resident #44 became belligerent with the social service worker stating he did not want to be at the facility and slammed his door and refused to speak to her. His legal guardian was notified who gave instructions to keep him at the facility. Review of the MDS 3.0 assessment dated [DATE] revealed Resident #44 had severely impaired cognition, and no behaviors present. He was independent for eating and upper body dressing and required supervision and set up assistance for lower body dressing, bathing, toileting and oral hygiene. Review of a progress note dated 11/06/24 revealed Resident #44 was throwing his lunch tray at the wall with food still on it. He was screaming and cursing at the staff and slamming the door repeatedly. The physician was notified and gave orders to send him to the emergency room for psychiatric evaluation. Resident #44 was transferred out of the facility with diagnoses of psychosis and agitation. Review of a progress note dated 11/13/24 revealed he was readmitted to the facility and appeared agitated with the nurse when preforming the re-admission assessment. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of a progress note dated 11/18/24 revealed Resident #44 became aggressive with a nurse because he was not permitted to stay on another unit after the smoke break. He was threatening to break a door and he hit a staff member. The physician gave an order to send him to the emergency room and police and emergency services picked up the resident for transport. Further review of the care plan for Resident #44 revealed a revision on 11/19/24 to include behavior problems of attempting to break a door, refusing to return to his own unit after a smoke break, aggression, making threats to leave and had physically assaulted staff. The goal was to have Resident #44 with no evidence of behavior problems. Interventions included administer medication as ordered, monitor and document side effects and effectiveness, discuss resident's behavior and explain and reinforce why the behavior was inappropriate or unacceptable, and intervene as necessary to protect the rights and safety of others. Approach and speak in a calm manner, divert attention, remove from situation and take to alternative location as needed. Monitor behaviors episodes and attempt to determine underlying cause. Consider location, time of day, persons involved and situations, document behaviors and potential causes. Review of a progress note dated 11/20/24 revealed the resident was readmitted to the facility in stable condition. No behaviors were noted at the time. Review of the Medication Administration Records (MAR) and Treatment Administration Records (TAR) from 10/25/24 through 11/28/24 revealed Resident #44's behaviors were tracked each shift from 10/26/24 until 10/28/24 when the behavior tracking was discontinued. There was no further behavior tracking after 10/28/24 through the date of this survey. Review of a progress note dated 11/28/24 at 6:30 A.M. written by the Director of Nursing (DON) revealed LPN # 227 was in the hallway when she and a CNA heard shouting from down the hallway. Resident #44 was noted to be angry and hostile but did not explain why. When Resident #44 was questioned and stated, I'm not telling you, I told him I was going to hit him (referring to Resident #2). Resident #44 denied pain and a skin assessment revealed no areas of notation. The police department was contacted and both Resident #2 and #44 were sent to the emergency department (ED). Upon return from the ED both residents were to remain separated, have every fifteen-minute checks for seventy-two hours and Resident #44 was a one-on-one when out of room. Adult Protective Services (APS) was contacted to request consent for psychiatric management of Resident #44 and awaiting response. Review of a facility Self-Reported Incident (SRI) investigation, dated 11/28/24, revealed the nurse and CNA heard raised voices from Resident #2's room. Staff responded and observed Resident #2 in bed and heard the shared bathroom door close. Resident #44 was not present in the room. The nurse noted a hematoma on Resident #2's right forehead. Staff did not witness the altercation. Resident #44 denied the altercation upon interview. Resident #2 was transported to the hospital for evaluation and Resident #44 was transported to the hospital for evaluation. The local police responded and indicated no further investigation warranted. It was noted Resident #2 had a room change to reside on a different unit. Resident #2 had neurological checks implemented with no negative findings. Both Resident #2 and Resident #44 were transported to the hospital and returned with no new orders. Both were referred for counseling follow up, medication review was done on Resident #44, care plans reviewed and updated for involved parties. The facility unsubstantiated that abuse occurred based on Resident #44 having severely impaired cognition. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of a witness statement dated 11/28/24 at 6:30 A.M. written by CNA #211 revealed she heard Resident #44 yelling from down the hall. CNA #211 entered the room and heard Resident #44 close the bathroom door. Resident #44 was angry and hostile when CNA #211 entered his room. Resident #44 would not state why he was angry and hostile. Upon entering Resident #2's room he was laying in bed and a lump on the right side of the forehead/temple was observed. Resident #2 stated Resident #44 socked him and came in his room for no reason. Review of a witness statement dated 11/28/24 at 6:30 A.M. written by LPN #227 revealed she heard yelling and went into Resident #2's room and observed Resident #2 laying in bed with a knot the size of a gum ball on the side of his right eye. Bruising was observed to right upper arm. Resident #2 stated he slugged me, I don't know, I was just lying there. Review of a witness statement dated 11/28/24 at 6:30 A.M written by LPN #227 revealed she heard yelling and went into Resident #2's room and observed a knot on the side of his right eye. Resident #2 stated Resident #44 hit him. LPN #227 went to check on Resident #44, and Resident #44 stated he was not going to tell LPN #227 what happened and stated, I told him I was going to hit him. Review of a witness statement dated 11/28/24 at 6:30 A.M. written by CNA # 273 revealed she heard residents yelling, and upon entering Resident #44's room she witnessed Resident #44 coming from the other room through the bathroom door. Resident #44 stated to CNA #273 he was not going to tell her anything. CNA #273 then entered Resident #2's room and observed a big knot on the head. Resident #2 stated he slugged me, meaning Resident #44. CNA #273 got the nurse. Review of the local police department (PD) report dated 11/28/24 at 6:20 A.M., revealed the local PD were called to the facility to investigate an assault involving Resident #2 and Resident #44. Upon arrival, nursing staff showed the PD to Resident #2's room and Resident #2 had noticeable swelling on the right side of his face near his eye. Resident #2 pointed to the direction of Resident #44's room when asked who assaulted him. Resident #2 stated Resident #44 hit him, and he did not know why he was struck. Additional bruising was found on the inside of Resident #2's hand that nursing staff stated was not there prior to the assault. Resident #44 was uncooperative and would not speak to staff or the PD about the incident. Local emergency medical services (EMS) were requested to transport Resident #2 to the hospital for evaluation due to swelling on his face and possible concussion. Photos were taken of the injuries. Review of the hospital emergency department (ED) documentation for Resident #2 dated 11/28/24 at 7:49 A. M. revealed Resident #2 presented to the ED for an evaluation of an assault by another resident at the facility and a head injury (hematoma right eyebrow). A Computed Tomography (CT) scan dated 11/28/24 revealed no acute intracranial abnormality, and no intracranial hemorrhage. A CT scan of the spine dated 11/28/24 revealed no acute compression fracture or subluxation of the cervical spine. The final impression was facial hematoma. Resident #2 was discharged back to the nursing home. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of the hospital ED documentation dated 11/28/24 at 8:01 A.M. revealed Resident #44 presented to the ED due to concerns for altercation. Resident #44 had a history of dementia with psychotic episodes and had an altercation with another resident. Resident #44 stated the other resident was messing with me but no physical harm was done to Resident #44. The attending provider attestation revealed Resident #44 presented to the ED for evaluation of psychiatric evaluation because he had a psychotic episode at a facility and tried to fight another resident. Resident #44 was uncooperative per emergency medicine services. The chief complaint was need for psychiatric evaluation. Resident #44 denied homicidal thoughts. The adult psychiatric social worker spoke with Resident #44 in the ED and Resident #44 was calm but confused. Resident #44 stated another resident was messing with him and they got into it. Resident #44 agreed to return to the facility. It was noted the community Compass program was pending legal guardianship for Resident #44. Resident #44 had a protective order from the court to remain in a secured facility. Resident #44 did state he was aware he became angry and frustrated sometimes and stated things did not make sense to him and he did not know how to not be angry about that. Resident #44 was stable to return to the nursing home. Review of the facility document Open Water Counseling and Recovery Individual Progress Note dated 12/12/24 at 9:20 A.M. revealed Resident #2 presented with a black eye during the counseling session with the Licensed Social Worker (LSW). The LSW explored when the incident occurred and how. Resident #2 reported a peer hit him last week and said he hated the bruise. The LSW reviewed the incident in the medical record and the incident matched what Resident #2 reported. The LSW needed to reassure Resident #2 the bruise would eventually go away. The bruise on Resident #2's eye was indicated as a stressor for him. Interview and observation on 12/18/24 at 5:05 P.M. with Resident #2 revealed he had a bruise on his face because he was hit in the eye. Resident #2 stated he felt shook up afterwards. Resident #2 motioned a jab-like punching movement with his arm and stated, he went like that. Resident #2 stated the incident happened a few weeks ago. Interview on 12/18/24 at 5:05 P.M. with LPN #227 revealed Resident #44 was known to be aggressive and hit Resident #2. Resident #44 hit Resident #2 because he did not like sharing a bathroom with anyone. Resident #44 was aggressive and had physical behaviors with a staff member before this incident occurred. Interview on 12/26/24 with CNA # 265 revealed Resident #44 was known to be physically and verbally aggressive. Interview on 12/26/24 at 11:13 A.M. with LPN #236 revealed Resident #44 was moody, independent with his care and mobility and was known to be aggressive. Interview on 12/26/24 at 11:18 A.M. with CNA #258 revealed Resident #44 had aggressive behaviors at times. Interview on 12/26/24 at 11:23 A.M. with Resident #44 revealed he shared the bathroom with a man next door. Resident #44 stated Resident #2 would move his clothes in the bathroom so Resident #44 hit Resident #2. Resident #44 stated he hit Resident #2 in the face. Resident #44 stated he was continually annoyed with his neighbor because he would take his clothes down. Resident #44 also stated Resident #2 walked in on him sometimes while using the bathroom and this made Resident #44 feel upset. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Interview on 12/26/24 at 11:32 A.M. with LPN #232 revealed she did not witness the incident with Resident #44 and Resident #2 but reported to work later in the day on 11/28/24. LPN #232 verified she witnessed a bruise on Resident #2's face and stated Resident #44 was known to be aggressive at times. Resident #44 would often yell at Resident #2 for using the bathroom and staff had to explain to Resident #44 that Resident #2 needed time in the bathroom. Interview on 12/26/24 at 11:37 A.M. with CNA #264 revealed Resident #44 was aggressive towards others. Resident #44 had a tendency to become upset easily and with his roommate in the bathroom. Resident #44 did not like sharing a bathroom. Interview on 12/26/24 at 12:00 P.M. with LPN #232 revealed if a resident had behaviors the nursing staff would document behaviors either in the MAR or TAR or behavior monitoring tab in the electronic medical record. The behavior tab could be used for all residents as needed for documentation and no physician orders were needed. LPN #232 verified no behavior documentation was in Resident #44's MAR/TAR or behavior tab after 10/28/24 and indicated there was no physician order to monitor Resident #44's behaviors. Interview on 12/26/24 at 1:00 P.M. with the DON revealed Resident #44 was known to behave aggressively before the incident involving Resident #2. The DON confirmed there had been no behavior tracking for Resident #44 during the month of November leading up to the incident because behaviors were only documented during a change of condition incident if Resident #44 became aggressive to staff or others. The DON also confirmed without the documentation of the behavior tracking there would be no record of what interventions were tried to de-escalate Resident #44. Interview on 12/26/24 at 2:00 P.M. with LPN #227 revealed on 11/28/24 she was passing medications in the hall and heard yelling from Resident #2's room and noise like a painful whine. LPN #227 witnessed Resident #2 laying in bed and Resident #2 stated he hit me Resident #2's eye was swollen. LPN #227 asked Resident #44 what happened, and Resident #44 stated he hit the resident because he was upset with the bathroom. Interview on 12/26/24 at 3:00 P.M. with the Director of Mental Health Counseling (DMHC) #274 revealed Resident #2 was followed for mental health counseling and was seen on 12/12/24 after the incident. It was noted in the progress note Resident #2 presented to the session with a black eye on 12/12/24 and was under the care of mental health for depression and psychosis. DMHC #274 stated Resident #44 refused mental health counseling. Interview on 12/27/24 at 10:17 A.M. with the DON revealed Resident #44 was placed on one-on-one supervision for seven days that started 11/28/24 after the incident. On 12/07/24 Resident #2 was moved to a different room away from Resident #44. The DON stated Resident #44 did not need one-on-one supervision prior to the incident but was known to be aggressive after hitting a nurse earlier in the month of November. The DON verified Resident #44 was placed on the secured dementia unit for behaviors, but there was no evidence behavior tracking was being completed each shift on the MAR, TAR or under the behavior tracking tab in the medical record for November and December 2024. Interview on 12/27/24 at 10:36 A.M. with the DON, the Administrator and the Regional Director of Operations #271 verified a behavior care plan was not initiated until 11/19/24 after Resident #44 was physically aggressive with staff and did not update the care plan after Resident #44 was physically aggressive with Resident #2 on 11/28/24. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Interview on 12/28/24 at 8:00 A.M. with Adult Protective Services Employee (APSE) #280 revealed APS was involved with Resident #44 until a court hearing scheduled for 01/22/24 as a protective gap until a legal guardian could be named. Resident #44 was cognitively impaired, so the facility had authority to make medial decisions for Resident #44's safety while in the facility until guardianship was established. Review of facility policy titled Abuse, Neglect, Exploitation and Misappropriation of Resident Property, dated 10/27/17, revealed abuse was the willful infliction of injury resulting in physical harm or mental anguish. Prevention and identification of abuse included an assessment, care planning, and monitoring of residents with behaviors which might lead to conflict such as residents with history of aggressive behaviors, residents who had behaviors of entering other rooms, and residents with communication disorders. The identification of events such as suspicious bruising of residents may constitute abuse. Upon completion of an investigation the facility would determine if modifications to existing policies and procedures were needed to prevent similar incidents or injuries from occurring in the future. This deficiency represents noncompliance investigated under Complaint Number OH00160577 and OH00160108.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365708	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/31/2024
NAME OF PROVIDER OR SUPPLIER: Willow Woods Rehabilitation and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE: 9625 Market Street North Lima, OH 44452	

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47570 Based on record review, staff interview and policy review, the facility failed to ensure a comprehensive care plan was developed to address the behavioral needs of Resident #44. This affected one resident (Resident #44) of three residents reviewed for care plans. The facility census was 71. Findings include: Review of the medical record for Resident #44 revealed an admitted [DATE] with diagnoses including encephalopathy, unspecified psychosis not due to a substance or known physiological condition, unspecified dementia mild without behavioral disturbance, cognitive communication deficit, Parkinson's diseases, cannabis use, nicotine dependence, depression, and homelessness. Review of hospital documentation dated 10/22/24 to 10/25/24 revealed Resident #44 had been in the hospital after signing himself out of another facility and adult protective services became involved to assist with assigning him a legal guardian due to his poor decision making, dementia and history of homelessness. During this hospital stay Resident #44 was noted to have encephalopathy (a medical condition characterized by a general disturbance in brain function) with signs of physical and verbal aggression. He threatened to punch a nurse, pushed staff and slammed a door to obstruct the view of him from staff. Resident #44 could not be reasoned with during the incidents of aggression and had to be de-escalated with a male presence and hospital police. Resident #44 was assessed as stable for transfer to a secured facility on 10/25/24. Review of the care plan for Resident #44, date initiated 10/29/24, revealed he was a smoker and enjoyed activities that did not involve group participation. There was no behavior care plan developed for Resident #44 having a history of cognitive impairment with aggressive behaviors prior to admission. Review of a progress note dated 11/01/24 revealed Resident #44 became belligerent with the social service worker stating he did not want to be at the facility and slammed his door and refused to speak to her. His legal guardian was notified who gave instructions to keep him at the facility. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #44 had severely impaired cognition, and no behaviors present. He was independent for eating and upper body dressing and required supervision and set up assistance for lower body dressing, bathing, toileting and oral hygiene. Review of a progress note dated 11/06/24 revealed Resident #44 was throwing his lunch tray at the wall with food still on it. He was screaming and cursing at the staff and slamming the door repeatedly. The physician was notified and gave orders to send him to the emergency room for psychiatric evaluation. Resident #44 was transferred out of the facility with diagnoses of psychosis and agitation. Review of a progress note dated 11/13/24 revealed he was readmitted to the facility and appeared agitated with the nurse when performing the re-admission assessment. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a progress note dated 11/18/24 revealed Resident #44 became aggressive with a nurse because he was not permitted to stay on another unit after the smoke break. He was threatening to break a door and he hit a staff member. The physician gave an order to send him to the emergency room and police and emergency services picked up the resident for transport. Review of a progress note dated 11/20/24 revealed the resident was readmitted to the facility in stable condition. No behaviors were noted at the time. Review of a progress note dated 11/28/24 at 6:30 A.M. written by the Director of Nursing (DON) revealed Licensed Practical Nurse (LPN) # 227 was in the hallway when she and a Certified Nursing Assistant (CNA) heard shouting from down the hallway. Resident #44 was noted to be angry and hostile but did not explain why. When Resident #44 was questioned and stated, I'm not telling you, I told him I was going to hit him (referring to Resident #2). Resident #44 denied pain and a skin assessment revealed no areas of notation. The police department was contacted and both Resident #2 and #44 were sent to the emergency department (ED). Upon return from the ED both residents were to remain separated, have every fifteen-minute checks for seventy-two hours and Resident #44 was a one-on-one when out of room. Adult Protective Services (APS) was contacted to request consent for psychiatric management of Resident #44 and awaiting response. Further review of the care plan for Resident #44 revealed the care plan was not updated to reflect behavioral problems of Resident #44 until 11/19/24 which included behavior problems of attempting to break a door, refusing to return to his own unit after a smoke break, aggression, making threats to leave and had physically assaulted staff. The goal was to have Resident #44 with no evidence of behavior problems. Interventions included administer medication as ordered, monitor and document side effects and effectiveness, discuss resident's behavior and explain and reinforce why the behavior was inappropriate or unacceptable, and intervene as necessary to protect the rights and safety of others. Approach and speak in a calm manner, divert attention, remove from situation and take to alternative location as needed. Monitor behaviors episodes and attempt to determine underlying cause. Consider location, time of day, persons involved and situations, document behaviors and potential causes. There were no further updates to the care plan to reflect the incident on 11/28/24 involving Resident #44 hitting Resident #2. Interview on 12/26/24 at 1:00 P.M. with the Director or Nursing (DON) revealed the facility was aware Resident #44 had behaviors prior to admission to the facility. Resident #44 was placed on the dementia unit for behaviors. Interview on 12/27/24 at 10:36 A.M. with the DON , the Administrator and the Regional Director of Operations #271 verified a behavior care plan was not initiated until 11/19/24 after Resident #44 was physically aggressive with staff and the facility did not updated or revise the care plan after Resident #44 was physically aggressive with Resident #2 on 11/28/24. Review of facility policy titled, Care Plans Comprehensive Person Centered, revised December 2016, revealed the care plan interventions were derived from a through analysis of the information gathered as part of the comprehensive assessment and would be person centered that included measurable objectives and timetables to meet the resident's physical, psychological and functional needs. This deficiency represents noncompliance investigated under Complaint Number OH00160577.

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48565 THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY Based on record review, interview and review of facility policy, the facility failed to provide adequate supervision and/or intervention to prevent Resident #64 from sustaining a burn to his abdomen. This affected one resident (#64) of four residents who were reviewed for accidents. The facility census was 71. Actual harm occurred on 11/03/24 when Resident #64, who had severe cognitive impairment, was found in his room with a cigarette lighter (belonging to Resident #85) and his clothing smoldering subsequently sustaining a second-degree burn (an injury that affects both the outer layer of skin or epidermis and part of the underlying layer called the dermis) to his abdomen requiring treatment in the emergency room . Resident #64 returned to the facility from the emergency roiagnom on [DATE] and required follow-up treatment at a wound clinic for the burn. Findings include: Review of the medical record for Resident #64 revealed a date of admission of 04/18/24 with diagnoses including chronic obstructive pulmonary disease, depression, difficulty walking, hypertension, anxiety, and burn of unspecified body region. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #64 had severely impaired cognition, required (staff) set up or clean up assistance with eating, substantial/maximal (staff) assistance with oral hygiene and dressing and was dependent on staff for toileting, bathing and transfers. Resident #44 had no impairment in range of motion to his upper and lower extremities and did not use a mobility device. There was no skin impairment identified on the MDS assessment. Review of an incident note dated 11/03/24 at 4:45 P.M. authored by the Director of Nursing (DON) revealed a resident hollered for help and fire. A Certified Nursing Assistant (CNA) patted out a smolder on Resident #64's shirt. The nurse removed the shirt, and a blister was noted to the abdomen. Resident #64 was noted to have a blue lighter in his hand. 911 was called and the resident was transported to the hospital. Record review revealed no nursing progress note was entered by the nurse assigned to care for the resident at the time of this incident. Review of facility incident documentation and related investigation revealed an incident report, dated 11/03/24 and authored by the DON, that indicated at 4:45 P.M. a nurse and CNA were alerted by a resident shouting there was a fire. Resident #64 was discovered in his room with a blue lighter in his hand. The resident was not a smoker, and he was unable to give a description of what happened. The resident had a smolder to his shirt and shorts. The CNA patted out the smolder and the nurse removed the shirt to assess his skin. A blister was noted to the abdomen. 911 emergency services were called. Record review revealed no measurements or assessment of the burn/blister contained in the initial incident report or incident note completed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of the emergency call log to the local fire department and 911 emergency revealed a call came in at 4:45 P.M. on 11/03/24 regarding a male (Resident #64) who burnt himself with a lighter. At 5:01 P.M. the fire department entered the facility. The fire was noted to be out. Resident #64 was transferred to the hospital. A review of the document titled: SNF/NF to Hospital Transfer Form dated 11/03/24 revealed Resident #64's skin was not intact related to a burn to mid-abdomen. A review of the document titled: SBAR Communication Form and Progress note for Registered Nurses/Licensed Practical Nurses/Licensed Vocational Nurses dated 11/03/24 revealed Resident #64 had a burn. A review of the emergency room note dated 11/03/24 revealed Resident #64 sustained a seven-centimeter by seven-centimeter burn to the right abdomen likely first degree after attempting to light a cigarette and caught his shirt on fire. Follow up with a burn center was advised. There were no discharge medications. A review of the document titled Witness Statement dated 11/03/24 and completed by the DON revealed she interviewed the sister of Resident #85 and discovered the sister had given Resident #85 a lighter which was brought back to the facility after a leave of absence with her. The DON provided education to the sister including any smoking materials were to be given to the unit nurse upon return to the facility. The sister stated she forgot she gave Resident #85 the lighter. The sister verbalized understanding and said she would be vigilant when she returned the resident to the facility. A review of the document titled Witness Statement dated 11/03/24 and completed by Certified Nurse Assistant (CNA) #273 revealed Resident #64 had a smoking shirt and she ran down the hall to Resident #64 and extinguished it with her hands. CNA #273 also stated in the witness statement a lighter was picked up from the floor. A review of the document titled Witness Statement dated 11/03/24 completed by Licensed Practical Nurse (LPN) #241 revealed she heard a resident yelling fire. LPN #241 witnessed Resident #64's shirt on fire. LPN #241 put water on the resident to treat the area. A burn was noted. Review of physician orders for November 2024 for Resident #64 revealed following the burn incident on 11/04/24 the resident had orders for a weekly body audit, abdominal binder to be used to assist with leaving dressing intact, and assess skin integrity under binder every shift, notify wound care center with any increase in pain, temperature greater than 101 degrees, increase of drainage from the wound, drainage with foul odor, bleeding of the wound, increase of swelling, cleanse wound to abdomen with wound cleanser, apply silver alginate to wound bed and cover with silicone border dressing, and multivitamin daily. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #64 had severe cognitive impairment. (continued on next page)

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F 0689

Level of Harm - Actual harm

Residents Affected - Few

A review of a progress note dated 11/04/24 at 12:03 A.M. revealed Resident #64 returned to the facility from the emergency room with a burn diagnosis. Bacitracin (an antibiotic ointment) had been applied in the emergency room and a dressing was applied. The burn from a nurse-to-nurse report prior to Resident #64's transfer back to the facility was seven centimeters by seven centimeters with minor blistering. The note included the resident's vital signs were within normal limits and Resident #64 had no complaints of pain.

Review of the facility document Wound Weekly Observation Tool V4.0, dated 11/04/24, for Resident #64 revealed he had a first-degree burn acquired 11/03/24. The burn measured 6.0 centimeters (CM) in length by 6.5 cm in width with a depth of 0.1 cm. There was slight clear drainage and no sign of infection. The treatment was cleansing mid-abdomen with normal saline solution, apply Silvadene to wound bed and cover with a dry clean dressing daily and as needed.

Review of the facility care plan for Resident #64, revised on 11/04/24, revealed he had impaired skin integrity related to a first degree burn on the abdomen. Interventions included abdominal binder to be in place to assist with leaving dressing in place due to resident removing dressing, assess skin integrity under binder every shift, cleanse wound to abdomen with wound cleanser, apply silver alginate to wound bed and cover with silicone border dressing, observe wound for signs and symptoms of infection every shift, notify the physician of any changes keep skin clean dry and odor free, multivitamin daily to assist with wound healing, observe skin for signs and symptoms of breakdown and notify the physician, resident displays noncompliance of leaving dressing intact regardless of education, one-on-one and redirection provided, resident following with local burn center for continued/ongoing care of the burn to the abdomen, and skin assessment completed weekly and as needed.

A review of wound care center notes from the Mercy Health Burn Center dated 11/18/24 through 12/23/24 revealed Resident #64 was being seen for a second degree burn to his abdomen with steady improvement of the wound. An initial wound care note dated 11/18/24 revealed a burn to the abdomen measuring 4.1 centimeters (cm) by 5.4 cm by 0.1 cm. The wound was debrided (a procedure where skin is scraped to promote bleeding which in turn promotes healing). Resident #64 was to return in one week. Subsequent wound care visits revealed:

On 11/27/24 Resident #64 had eschar over the abdominal wall wound with some fat layer exposed. The wound was debrided.

On 12/02/24 it was noted the wound was improving with some fat layer exposed and the wound was mainly skin. The abdominal wound was debrided.

On 12/09/24 it was noted the wound was improving with skin and fat layer noted. The wound was debrided, and Resident #64 was to follow- up in two weeks.

On 12/23/24 it was noted the abdominal wound was improving and was mainly skin. The wound measured 0. 9 cm by 1.1 cm by 0.1 cm. The wound was classified as 96 percent healed. The wound was again debrided, and Resident #64 was to follow-up with the wound care center in two weeks.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 12/18/24 at 8:30 A.M. an interview with the Administrator verified there was an incident (on 11/03/24) with Resident #64 when he got a hold of a lighter belonging to Resident #85 and lit it causing a burn to his clothes and abdomen. The Administrator was unable to determine how Resident #64 obtained the lighter, other than it was discovered during resident audits and resident and family interviews after the incident that Resident #85 had brought a lighter back to the facility after a leave of absence (LOA). On 12/18/24 at 11:25 A.M. an interview with CNA #273 revealed she was at the facility on 11/03/24, the day of the incident with Resident #64. CNA #273 stated Resident #64's shirt was smoldering like a lit cigarette. CNA #273 stated she patted the fire out while a nurse got the fire extinguisher and water. CNA #273 stated 911 was called by the nurse. CNA #273 stated the fire department responded to the incident and took the resident's shirt with them. Resident #64 was then transported to the hospital. On 12/19/24 at 11:57 P.M. an interview with LPN #241 revealed she was present on 11/03/24, the day of the incident. She stated she was unsure of how Resident #64 got the lighter. LPN #241 stated Resident #64 had a burn to the abdomen as a result of the incident. On 12/31/24 at 12:50 P.M. an interview with the Assistant Director of Nursing/LPN #215 revealed the wound for Resident #64 was blistered and classified as a first degree burn from the emergency room . LPN #215 stated she believed once the blister broke and opened it was then classified as a second-degree burn. A review of the facility policy titled Safety and Supervision of Residents dated 12/2007 revealed resident safety and supervision and assistance to prevent accidents were a facility wide priority. The policy also revealed employees were trained and in-serviced on potential accident hazards and how to identify and report accident hazards and try to prevent avoidable accidents. A review of the facility policy titled Smoking Policy and Procedure revised 11/03/24 revealed Residents who smoke are not permitted to keep smoking supplies in their room or on their person. This includes but is not limited to cigarettes, lighters, matches, pipes, e-cigarettes, machines to roll cigarettes and any other smoking paraphernalia that may be combustible. The deficient practice was corrected on 11/04/24 when the facility implemented the following actions: On 11/03/24 an Ad Hoc Quality Assurance Performance Improvement (QAPI) meeting was held with the Administrator, DON, Assistant DON, the Medical Director, Social Services, the Dietary Manager, Business Office Manager, Activity Director, Maintenance, Central Supply/Scheduler and Admissions. The root cause of the incident was identified as a family member allowed Resident #85 to retain smoking materials when they returned from leave of absence. On 11/03/24 Resident #64 was sent to the emergency room . On 11/03/24 room sweeps on all rooms were completed to check for smoking materials. On 11/03/24 room sweeps of five rooms per week for four weeks was started. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 11/03/24 the smoking policy was reviewed and updated to include that any smoking materials obtained on LOA must be returned to staff upon return to the facility. On 11/03/24 smoking assessments for all residents who smoke (#6, #7, #8, #11, #13, #18, #25, #30, #32, #38, #40, #46, #47, #50, #53, #57, #61, #66, #71, and #85) were updated. On 11/03/24 education was completed by Admissions #220 to all residents who smoke. On 11/03/24 all care plans of residents who smoke were reviewed and updated for all residents who smoke. On 11/03/24 a handout was created for Leave of Absence binders and the front desk reminding family and friends that smoking materials must be returned to staff. On 11/03/24 education was provided to Resident #85's family to turn in smoking materials to staff after leave of absence. On 11/03/24 all staff were in-serviced on resident supervision, smoking policy, leave of absence process and ensuring residents who return from leave of absence do not retain smoking materials. On 11/03/24, five resident and or family interview upon return from leave of absence was started and continued for four weeks. There were no further residents experiencing injury from 11/04/24 through the date of this survey 12/31/24. This deficiency represents noncompliance investigated under Complaint Number OH00160577.