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	04/29/2025

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 0600 Level of Harm - Minimal harm or potential for 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** 49774 THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on medical record review, review of the facility's Self-reported incident (SRI), review of facility investigation, observations, staff and resident interviews, and review of the facility's Abuse, Neglect, Exploitation, and Misappropriation of Resident policy, the facility failed to ensure a resident was free from staff to resident physical abuse. This affected one (#17) of four residents reviewed for abuse. The facility census was 67. Findings include: Record review revealed Resident #17 was admitted to the facility on [DATE] with diagnoses of schizoaffective disorder bipolar type, borderline personality disorder, and mild intellectual disabilities. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #17 was cognitively intact, and required supervision with showers, dressing, and personal hygiene. Resident #17 did not require any mobility devices. Review of the care plan dated 03/13/25 revealed Resident #17 was prone to behaviors that included verbally abusing staff and others and threatening self-harm. Resident #17 also had the potential for mood problems related to the identified mental health diagnoses of which interventions included anticonvulsant medication therapy, behavioral health services, and monitoring of signs and symptoms of mania, increased irritability, and frequent mood changes. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365708	A. Building B. Wing	04/29/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Police Report (Incident Number 25BV04872) revealed a report time of 04/07/25 at 9:07 P.M. The original narrative indicated the police department responded to an assault at nursing home. The supplemental narrative revealed the officer was dispatched for a fight/assault between a resident and and employee. The officer spoke to Licensed Practical Nurse (LPN) #153 who advised she was the supervisor for the night shift and the resident was identified as Resident #17. Resident #17 was hysterically crying in the hallway. When asked what happened, Resident #17 stated she was trying to get from one area to the other but there was another resident in her way who was in a wheelchair. Resident #17 began to move the other resident out of her way when Certified Nurse Aide (CNA) #177 shouted at her and told her not to touch her residents ever again. Resident #17 then explained that she told CNA #177 to move her own damn patient out of the way, both parties than began shouting at one another. Resident #17 then stated CNA #177 walked over to her and got in her face and belly bumped her causing them to fight. The next thing Resident #17 knew, she was pushed to the ground causing her to hit her head. CNA #177 and the officer spoke outside of the facility (CNA #177 had been suspended prior to the officer's arrival and was not permitted in the facility). CNA #177 said she was coming out of another resident's room and observed Resident #17 pushing another resident. CNA #177 told Resident #17 to stop pushing the resident. CNA #177 explained Resident #17 called her an expletive and told her to catch her outside. CNA #177 then told Resident #17 do something if you want, I'm not scared. CNA #177 then explained she began moving the other resident down the hall when Resident #17 ran up to her and belly bumped her causing them to fight. CNA #177 grabbed Resident #17 by the arms causing her to fall to the floor. CNA #177 then showed the officer scratch marks on her arms and elbow that occurred during the altercation. The officer spoke with LPN #153 and asked if she witnessed the incident which she did and LPN #153 filled out a witness statement. LPN #153 told the offices that everything Resident #17 explained to the officer was accurate and CNA ran up to Resident #17 and started the altercation by belly bumping Resident #17. The report further indicated after discussion with other officers, it was apparent that CNA #177 was the aggressor in the situation. CNA #177 was told she was being placed under arrest for assault. CNA #177 was transported to the police department. Resident #17 was transferred to the local hospital for evaluation. Review of progress noted dated 04/07/25 timed 9:42 P.M. revealed Resident #17 had a change in condition due to a fall and was transported to the hospital for evaluation. Review of the presenting problem in the hospital assessment dated [DATE] revealed Resident #17 presented with complaints of headache and had been assaulted by one of the staff members in her facility and was subsequently punched on the head. A computed tomography (CT) scan of her head and spine was performed and did not show evidence of abnormal findings. Resident #17 did not suffer any loss of consciousness, there was no presence of any external lacerations or bleeding. Resident #17 was discharged back to the facility per the legal guardian's request. Review of the facility SRI dated 04/07/25 revealed Resident #17 reported the altercation began when she attempted to move another resident out of her way when CNA #177 told Resident #17 not to do that, then began to yell at Resident #17 and approached her quickly. CNA #177 then punched Resident #17 in the head at which time Resident #17 fought back. During the melee, Resident #17 suffered a fall and hit her head. (continued on next page)

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	04/29/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of CNA #177's witness statement dated 04/07/25 revealed Resident #17 was observed pushing Resident #19 into the wall at which time CNA #177 told Resident #17 not to do that. Resident #17 responded by using expletives to communicate that CNA #177 needed to move that resident out of her way. CNA #177 reiterated to Resident #17 not to push Resident #19. Resident #17 then called CNA #177 a derogatory name and threatened her. CNA #177 responded by warning Resident #17 she was not afraid of her. Resident #17 moved into CNA #177's personal space, bumped into her belly, stepped back, then struck her in the face. CNA #177 grabbed Resident #17's arms to prevent being struck again. CNA #100 then grabbed Resident #17 who was still actively fighting. Resident #17 tripped and fell on the floor. Review of CNA #100's witness statement dated 04/07/25 revealed Resident #17 was observed pushing Resident #19 into the wall. CNA #177 then advised Resident #17 not to push Resident #19. Resident #17 began to use profanity and argue with CNA #177 at which time Resident #17 stated she would beat up CNA #177. CNA #177 continued to move Resident #19 towards the nurse's station in a wheelchair when both CNA #177 and Resident #17 became face-to-face. Resident #17 then struck CNA #177 who then grabbed Resident #17's arms. CNA #100 pulled Resident #17 back who then fell . CNA #100 jumped out of the way to prevent herself from falling with Resident #17. Review of LPN #153's witness statement dated 04/07/25 revealed LPN #153 heard CNA #177 yelling at Resident #17 to not push her resident (Resident #19). Resident #17 stated she did it because she needed to use the bathroom. CNA #177 continued to yell and swear at Resident #17 who responded with derogatory insults. LPN #153 advised both Resident #17 and CNA #177 to stop arguing. Resident #17 was standing in the hallway when CNA #177 approached her and the two were face-to-face. LPN #153 did not see who struck the other first but did report Resident #17 fell to the ground and hit her head when CNA #100 broke up the fight. Observations of Resident #17 on 04/28/25 at 9:07 A.M., 11:54 A.M., and 3:03 P.M. revealed the resident remained in her room. Multiple attempts to interview Resident #17 were unsuccessful. Interview on 04/28/25 at 1:34 P.M. with CNA #177 revealed Resident #17 pushed another wheelchair bound resident into a wall. CNA #177 commanded Resident #17 to stop. Resident #17 began calling CNA #177 derogatory names; however, CNA #177 continued to perform her duties and ignored Resident #17 who was yelling down the hallway at CNA #177. When CNA #177 moved towards Resident #17 in the hallway, CNA #177 was bumped by Resident #17 with her belly. CNA #177 grabbed Resident #17's wrist but CNA #177 was still struck in the face. CNA #177 confirmed LPN #153 witnessed the ordeal and said there were no other witnesses. CNA #177 reported she was arrested by the local police the night of 04/07/25 and was charged with assault on a functional disabled person. Interview on 04/28/25 at 1:46 P.M. with CNA #100 revealed Resident #17 pushed Resident #19 into a wall in her wheelchair and CNA #177 advised her not to push her resident (Resident #19) like that. Resident #17 stormed down the hall and began calling CNA #177 derogatory names. Resident #17 and CNA #177 began to argue, and Resident #17 approached CNA #177, bumped her with her belly, and then immediately struck CNA #177. CNA #100 grabbed Resident #17 and pulled her back at which time she (Resident #17) stumbled and fell . CNA #100 confirmed LPN #153 was in the hallway passing medications at the time of the incident. Multiple attempts to interview LPN #153 were unsuccessful; she was not available and did not return phone messages. (continued on next page)

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	04/29/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/28/25 at 2:15 P.M. with the administrator revealed LPN #153 contacted her the night of the incident. The administrator advised LPN #153 Resident #17 needed to be assessed and CNA #177 suspended pending investigation. LPN #153 was also advised to contact local police and to obtain statements from witnesses. The administrator explained Resident #17 was also referred to counseling. After reviewing the conflicting witness statements, the administrator made attempts to contact CNA #177 however the calls were never returned. Review of the Abuse, Neglect, Exploitation, and Misappropriation of Resident Property revised 10/27/17 revealed the facility was intolerant of abuse which was defined as willful injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Instances of abuse irrespective of any mental or physical condition cause harm, pain, or mental anguish. The deficiency was corrected on 04/17/25 when the facility implemented the following corrective actions: Immediately following the incident on 04/07/25, Resident #17 was assessed for injuries by the nurse and transported to the hospital for further assessment. The hospital assessment revealed no injuries. On 04/07/25 CNA #177 was immediately suspended after the incident pending investigation of abuse and was subsequently terminated on 04/17/25. On 04/08/25 a list was compiled by the administrator of the cognitive level of each resident by reviewing the Brief Interview for Mental Status (BIMS) score of each resident. Residents with a BIMS score of 13 and above which indicated mild to no cognitive impairment, were interviewed by the Assistant Director of Nursing/LPN #17 and abuse questionnaire was completed. Residents with a BIMS score of 12 or below which indicated moderate to severe cognitive impairment, received a skin assessment completed by the wound nurse and Director of Nursing. There were no concerns identified regarding abuse. On 04/08/25 the administrator and regional director of clinical services conducted a root cause analysis with the vice president of clinical services. The root cause was found to be failure to appropriately deescalate and manage behaviors. On 04/08/25 an ad hoc Quality Assurance and Performance Improvement (QAPI) meeting was held which included the medical director, administrator, director of nursing, assistant director of nursing, social services director, dietary manager, maintenance director, CNA supervisor, activities director, and human resources director. The QAPI meeting was held to review the root cause analysis and facility interventions. On 04/08/25 all facility staff received training on abuse and de-escalation which included tips, tools, and reminders for immediate reporting as well as notifying a manager of any resident with increased agitation. The training was completed by the department managers of nursing, CNAs, dietary, laundry and housekeeping. Training was completed in-person and telephonically. This was confirmed via review of sign in sheets. (continued on next page)

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	04/29/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/09/25 management began conducting random pop in visits during off hours one to two times per week for observations of any concerns or issues. This would continue for four weeks then randomly On 04/14/25 audits of 10 residents per week for four weeks for signs or symptoms of abuse commenced. The audits were completed on 04/14/25 and 04/21/25. No abuse concerns were identified. Interviews on 04/28/25 and 04/29/25 with LPN #114, LPN #117, and CNA #100 revealed they were knowledgeable regarding the facility policies and procedures regarding abuse and de-escalation of residents having catastrophic reactions. On 04/28/25 three additional residents (#11, #19, #27) were sampled and reviewed for abuse. No concerns were identified.