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	10/07/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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
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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 - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLAINCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on observation, interview, record review and review of facility policy, the facility did not ensure residents were adequately supervised and did not ensure staff responded appropriately to a door alarm on the Buckeye unit to mitigate accident risk for Resident #49. This affected one resident (#49) out of three residents reviewed for accidents/hazards and had the potential to affect an additional 29 residents residing on the Buckeye unit (Residents #4, #52, #68, #59, #24, #57, #44, #45, #7, #26, #25, #51, #21, #12, #27, #47, #23, #29, #55, #65, #61, #33, #71, #8, #40, #56, #48, #11 and #35). The facility census was 71. Findings include: Review of Resident #49 ' s medical record revealed an admission date of 02/23/2005 with diagnoses including paranoid schizophrenia, bipolar with severe psychotic features, neoplasm of endocrine glands, dementia with psychotic disturbance, muscle wasting, cognitive communication deficit, chronic kidney disease, age related cataract, anxiety disorder, obsessive compulsive disorder, dissociative identity disorder, and brief psychotic disorder. Resident #49 had a court appointed legal guardian. Review of Preadmission Screening/Resident Review (PAS/RR) dated 02/23/2005 revealed Resident #49 was admitted to the facility and was not able to return to community living due to poor safety awareness, mental health fluctuated, and Resident #49 required frequent monitoring, interventions and twenty-four-hour supervision to ensure safety. Review of plan of care date initiated 12/17/17 revealed Resident #49 had behavior problems that consisted of short tempered, and pushed buttons on code pads at doors, and wandered into other ' s rooms on a daily basis. Interventions included administering medications per physician order. Observe for mental status and behavior changes when new medication started or with new changes in dosage. Psych referral as needed. When Resident #49 was pushing buttons on code pads outside of doors it was best to let resident finish, and resident would return to appropriate unit without incident. A revision on 03/20/23 revealed Resident #49 was an elopement risk due to impaired cognition and competence, however, Resident #49 did not exhibit exit seeking behavior. Interventions included distract Resident #49 from wandering by offering pleasant diversions, structured activities, food, conversation, television and a book. Identify patterns of wandering, divert as needed and interview as appropriate. A revision on 08/21/23 revealed Resident #49 could go on a leave of absence without restrictions. Intervention included leave of absence per physician orders.Review of the Minimum Data Set (MDS) 3.0 quarterly assessment dated [DATE] revealed Resident #49 ' s cognition was intact with a Brief Interview Mental Score of 15 out of 15. Resident #49 had psychosis delusions present and wandered daily. Resident #49 did not need a mobility device and was independent to walk 150 feet once standing. Review of physician orders start date 08/23/25 and end date of 09/27/25 revealed Resident #49 could go out on a leave of absence with medication per nursing judgment. Review of an Elopement Review dated 08/24/25 revealed Resident #49 was low risk for elopement with an elopement score of eight. Review of a physician order start date of 09/27/25 revealed Resident #49 may go out on a leave of absence with supervision. Review of an Elopement Review dated 09/27/25 revealed Resident #49 was high risk for elopement with an elopement score of 10. Review of an Elopement Review assessment dated [DATE] revealed Resident #49 was ambulatory and had predisposing diagnosis of paranoid schizophrenia and bipolar disorder. Mental status was cognitively intact, and Resident #49 was responsive to redirection and cues. Resident #49 had an elopement episode in the past three months on 09/27/25. There was no medical cause increasing confusion, there was no psychological cause. Resident #49 was moved to secure unit. Review of a Medical Visit assessment , dated 10/01/25 , written by Physician Assistant (PA) #371, revealed Resident #49 had a recent elopement. Resident #49 was seen on 10/01/25 after she had eloped over the weekend. PA #371 assessed Resident #49 as alert , and in no distress. Resident #49 stated to PA #371 she left to inquire about moving to another facility next door. Resident #49 denied current desire to leave the facility. Review of plan of care, revision date 09/27/25, revealed Resident #49 was at risk for elopement due to impaired cognition and competence. Intervention included reside on a secured unit. Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television or a book. Identify pattern of wandering, divert as needed and intervene as appropriate. Leave of absence with supervision was updated. Review of the facility document titled Witness Statement Form, dated 09/27/25, written by certified nurse assistant (CNA) #373 revealed she came out of room one on the Buckeye unit and