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| 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 02/13/2026 |
| NAME OF PROVIDER OR SUPPLIER Willow Woods Rehabilitation and Nursing | | STREET ADDRESS, CITY, STATE, ZIP CODE 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) |
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| <p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of the facility policy, the facility failed to ensure residents rooms were clean and homelike. This affected five residents (#49, #52, #60, #67, and #72) out of 11 residents reviewed for physical environment. The facility census was 73. Findings include: 1. Review of the medical record for Resident #49 revealed an admission date of 01/09/26. Diagnoses included unspecified mental disorder due to known physiological condition, difficulty walking not elsewhere classified, anxiety disorder, impulsive disorder, major depression recurrent, and obsessive-compulsive disorder. Further review of Resident #49's medical record revealed the admission Minimum Data Set (MDS) assessment, dated 01/18/26, which indicated the resident was cognitively intact. Observation during an environmental tour on 02/13/26 from 12:23 P.M. to 12:40 P.M. with Maintenance Director (MD) #369 revealed in Resident #49's room, there were two windows side by side on the back wall which looked out onto the facility's parking lot. Each window had a blind and each of the blinds were fully extended yet the blinds were not long enough to fully cover the windows leaving an approximate four-inch gap between the bottom of the blind and the windowsill on both windows. At the time of observation, MD #369 confirmed the blinds did not go completely down to the windowsills, and the windows looked out onto the facility parking lot so anyone could look into the resident's room via the window view. Interview on 02/13/26 at 1:41 P.M. with Resident #49 revealed that since the blinds did not completely cover the whole window in his room, he was unable to achieve a dark room, which he preferred for sleeping. As a result, the resident voiced his ability to sleep had been negatively affected. He also voiced concerns regarding privacy, since he felt others were able to look into his room from the parking lot. Review of facility map revealed Resident #49's room faced the facility parking lot and the resident's windows were within view of anyone who entered the facility. 2. Review of the medical record for Resident #72 revealed an admission date of 12/24/25. Diagnoses included noninfective gastroenteritis and colitis, ulcerative colitis, anxiety disorder, abdominal pain, diarrhea, and diverticulitis of intestine without perforation. Further review of Resident #72's medical record revealed a Medicare five day MDS assessment, dated 01/08/26, indicated the resident was cognitively intact. Observation during an environmental tour on 02/13/26 from 12:23 P.M. to 12:40 P.M. with MD #369 revealed in Resident #72's room, there were two windows side by side on the back wall which looked out onto the parking lot. Each window had a blind and each of the blinds were fully extended yet the blinds were not long enough to fully cover the window which left an approximate an eight inch gap between the bottom of the blind and the windowsill for the left window and a twelve inch gap between the bottom of the blind and the windowsill for the right window. There were various dark brown stains on the resident's privacy curtain. At the time of observation, MD #369 confirmed the blind did not go completely down to the windowsill and the windows looked out onto the parking lot, and the privacy curtain needed</p> <p>(continued on next page)</p> |

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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| FORM CMS-2567 (02/99) Previous Versions Obsolete | Event ID: | Facility ID: 365708 |
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| <p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>cleaned. Interview on 02/13/26 at 2:27 P.M. with Resident #72 revealed her blinds were open all the time, and at home, she kept her blinds closed since she liked the room dark. She stated sometimes she worried that others could look into her window and see her using the bedside commode and other times she felt she was being watched through her window. Observation at the time of interview revealed sitting to the right of the window on the back wall of the room was a bedside commode. Review of facility map revealed Resident #72's room faced the facility parking lot, and the resident's windows were within view of anyone who entered the facility. 3. Review of the medical record for Resident #60 revealed an admission date of 07/12/21. Diagnoses included Alzheimer's disease, hemiplegia affecting left dominant side, anxiety disorder, major depressive disorder, and chronic kidney disease. Further review of Resident #60's medical record revealed an annual Minimum Data Set (MDS) assessment, dated 01/02/26, which indicated the resident was cognitively intact. Interview with Resident #60 on 02/13/26 at 10:10 A.M. revealed she was not sure how often her room was getting cleaned since she hadn't seen anyone coming in to clean her room. She stated the privacy curtain was a mess and it hadn't been cleaned since she had been there. She stated her room wasn't getting dusted, and the blinds didn't go all the way down. Since the blinds didn't extend the full length of the window, she had to pull the privacy curtain between her bed and the window to block the sunlight from shining into her face. She also stated not having the blinds being able to fully cover the window bothered her because she felt people could look into her room. Observation at the time of the interview revealed the blinds were fully extended but left a gap between the bottom of the blinds and the windowsills and the sunlight coming into the resident's room was shining toward the resident, who was laying in her bed, which was to the right of the window, with the head of the bed on the same back wall as the window. If the privacy curtain hadn't been pulled, the sun would have shined directly into the resident's face. Observation during an environmental tour on 02/13/26 from 12:23 P.M. to 12:40 P.M. with MD #369 revealed in Resident #60's room, there were two windows side by side on the back wall which looked out onto the facility parking lot. Each window had a blind and each of the blinds were fully extended yet the blinds were not long enough to fully cover the room, which left an approximately eight-inch gap between the bottom of the blinds and the windowsills. There were broken slats on the blinds, and the windowsill had a build up of dirt and debris which included remnants of what appeared to be dried up flower petals. There were various colored stains on the resident's privacy curtain and the dresser, which had a TV sitting on it, had a visible layer of white dust on both the top of the dresser and the black base of the television. At the time of observation, MD #369 confirmed the blinds did not go completely down to the windowsill and were broken, the windows faced the facility parking lot, the privacy curtain needed washed, and the room needed dusted. Review of facility map revealed Resident #60's room faced the facility parking lot, and the resident's windows were within view of anyone who entered the facility. 4. Review of the medical record for Resident #52 revealed an admission date of 12/28/25. Diagnoses included acute and chronic respiratory failure, chronic obstructive pulmonary disease, personal history of other mental or behavioral disorders, idiopathic sleep related nonobstructive alveolar hypoventilation, and obstructive sleep apnea. Further review of Resident #52's medical record revealed a quarterly MDS assessment, dated 01/27/26, which indicated the resident was cognitively intact and had trouble falling or staying asleep or sleeping too much seven to eleven days of the past two weeks of the assessment reference period. Interview on 02/13/26 at 10:01 A.M. with Resident #52 revealed his blinds were broken and didn't go all the way down the window, which had affected his ability to sleep. He also indicated he had concerns with his room not being private since the blinds didn't fully cover the windows. Observation at the time of the interview revealed the</p> <p>(continued on next page)</p> | | |

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| <p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>had seen a privacy curtain being cleaned. She also voiced concern about the length of the blinds in the residents' windows not fully covering the window which would provide a lack of privacy, especially for those resident rooms that faced the parking lot. Interview on 02/13/26 at 11:05 A.M. with Licensed Practical Nurse (LPN) #341 revealed the residents' rooms were not being dusted as often as they should since she has seen a buildup of dirt on the windowsills and dust on the tops of the dressers where the televisions sat. When it came to the cleaning of privacy curtains, she believed maintenance took them down and laundry washed them, but she was unsure of the last time she had seen one cleaned. She voiced concerns that some of the blinds in the residents' rooms do not go all the way down to cover the entire window which could affect the residents' privacy, especially for those residents' rooms which faced the parking lot. Interview on 02/13/26 at 11:20 A.M. with CNA #301 revealed she didn't feel residents' rooms were getting cleaned as thoroughly as they should since she had seen an accumulation of dead bugs and debris on windowsills and an accumulation of dust under the areas where the television sat. When it came to who cleaned privacy curtains, CNA #301 indicated it was housekeeping's responsibility to take them down and for laundry to wash them. CNA #301 indicated overall the privacy curtains were filthy and since she started almost two years ago, she had never seen a privacy curtain taken down to be cleaned. CNA #301 also indicated blinds in some of the residents' rooms were broken or didn't fully cover the window, which could affect the resident's privacy, and some residents needed to pull a privacy curtain between the window and them so it would block the sunlight from shining into their eyes. Interview on 02/13/26 at 11:33 A.M. with CNA #321 revealed sometimes when housekeeping was short, he would see residents' rooms not getting dusted like they should. When it came to the cleaning of privacy curtains, he indicated if he asked housekeeping to take a privacy curtain down to have it cleaned, it would be taken down to be cleaned, but he then went on to state it had been a while since he had seen a privacy curtain cleaned. Interview on 02/13/26 at 12:03 P.M. with Laundry #360 revealed she didn't know how frequently privacy curtains were being washed. She stated that when a privacy curtain was brought down to laundry, she would make sure it was washed. She voiced years ago the facility did have a schedule for when privacy curtains were to be cleaned, but currently there was no cleaning schedule for the privacy curtains. Interview on 2/13/26 at 12:07 P.M. with MD #369 revealed when it came to when privacy curtains were cleaned, there wasn't a cleaning schedule for when privacy curtains would be cleaned, and the curtains were only cleaned as needed. An additional interview on 02/13/26 at 12:40 P.M. after the environmental observation had been completed with Maintenance Director #369 confirmed many of the privacy curtains needed cleaned, residents' rooms were not being dusted as often as they should, and many of the blinds were too short and didn't completely cover the window and/or were broken. Interview on 02/13/26 at 5:00 P.M. with the Administrator confirmed rooms should be dusted, privacy curtains should be cleaned, and window blinds should be able to extend the full length of the window and shouldn't be broken. Review of facility policy titled Homelike Environment, revised February 2021, revealed the facility would provide a safe, clean, comfortable, and homelike environment with comfortable lighting with minimum glare. This deficiency represents noncompliance investigated under Complaint Number 2713771.</p> | | |