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	04/08/2026

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, review of menus/spreadsheets, and interview, the facility failed to ensure staff were adequately trained regarding scoop/portion sizes and failed to have sufficient tools available to accurately measure portion sizes. This had the potential to affect ten residents (Residents #6, #8, #19, #22, #28, #35, #36, #45, #62, and #69) who had orders for mechanical soft diets and 53 residents (Residents #1, #2, #3, #5, #7, #10, #11, #12, #13, #14, #15, #16, #17, #18, #20, #23, #24, #25, #26, #27, #29, #30, #31, #33, #37, #39, #42, #43, #44, #46, #48, #51, #52, #55, #56, #58, #59, #60, #61, #63, #65, #66, #68, #71, #72, #73, #74, #75, #77, #79, #84, #86, and #87) as residents who received regular texture food. The facility census was 73.Findings include:Observations on 03/31/26 between 4:18 P.M. and 5:23 P.M. revealed the following as [NAME] #368 was placing scoops and utensils in the food for serving, she placed a size 16 scoop (equivalent to two ounces) in the mechanical soft meat. While doing so, [NAME] #368 referred to the scoop as three ounces. Dietary Manager #400 overheard and verified with a chart posted on the wall that a size 16 scoop was only two ounces. [NAME] #368 continued to refer to the #16 scoop as three ounces. At first, Dietary Manager #400 stated it would be okay because it would be served on a hoagie bun. After discussing the nutritional difference between the meat and bread and the fact a roll was already on the menu to be served for residents receiving mechanical soft diet, Dietary Manager #400 stated residents on mechanical soft diets should not receive the hoagie anyway and provided rolls to be provided for residents on mechanical soft diets. After reviewing the menu, Dietary Manager #400 stated residents on mechanical soft diets were supposed to receive three ounces of meat and verified the size 16 scoop [NAME] #368 still planned to use was indeed two ounces and did not follow the menu. [NAME] #369 and Dietary Manager #400 searched for a three-ounce scoop and were unable to locate one. [NAME] #369 stated she was upset because she had worked at the facility for 4.5 years and always thought the size 16 scoop was equivalent to three ounces because that was what she was taught. A one and 5/8 scoop was located with [NAME] #369 indicating she would serve one full scoop and part of another scoop to equal three ounces. Further review of the menu revealed residents on regular diets were ordered four ounces of red skin potatoes while residents with orders for mechanical soft and low concentrated sweet diets were supposed to receive four ounces of potato wedges. Observations revealed for the first tray [NAME] #369 used a utensil shaped like a spaghetti scoop to serve potato wedges. All other residents, except those with orders for pureed diets, received potato wedges with the wedges picked up with a gloved hand with no measuring completed.Dietary Manager #400 stated she looked for tongs to serve the potato wedges but could not find any.The facility identified Residents #6, #8, #19, #22, #28, #35, #36, #45, #62, and #69 as residents who received mechanical soft diets. The facility identified Residents #1, #2, #3, #5, #7, #10, #11, #12, #13, #14, #15, #16, #17, #18, #20, #23, #24, #25, #26, #27, #29, #30, #31, #32, #33, #37, #39, #42, #43, #44, #46, #48, #50, #51, #52, #55, #56, #58, #59, #60, #61, #63, #65, #66, #68, #71, #72, #73, #74, #75, #77, #79, #84, #86, and #87 as residents who received regular texture food.

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	04/08/2026

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, policy review, and interview, the facility failed to ensure food was prepared and stored in a manner to prevent contamination. This affected/had the potential to affect 53 residents (Residents #1, #2, #3, #5, #7, #10, #11, #12, #13, #14, #15, #16, #17, #18, #20, #23, #24, #25, #26, #27, #29, #30, #31, #33, #37, #39, #42, #43, #44, #46, #48, #51, #52, #55, #56, #58, #59, #60, #61, #63, #65, #66, #68, #71, #72, #73, #74, #75, #77, #79, #84, #86, and #87) of 73 residents who had orders for diets with regular texture. The facility census was 73.Findings include:1. During meal preparation and service observations on 03/31/26 between 4:18 P.M. and 5:23 P.M., [NAME] #369 was observed monitoring the temperature of foods. While taking food temperatures, the cord of the thermometer came into direct contact with potato wedges for approximately 30 seconds. The thermometer had been observed on multiple surfaces in the kitchen with only the probe part cleaned.During the dinner tray line on 03/31/26, when a plate with double portions was prepared, there was not sufficient room on the plate for all the food, so [NAME] #369 used her gloved hand she had been using to pick up hoagie buns and potato wedges to open a cupboard and obtain bowls. The inner part of the top bowl and the outside of the bottom bowl came into contact with the gloves used to open the door. [NAME] #369 returned to steam table and started handling buns and potatoes with the same gloved hand.On 03/31/26 at 5:23 P.M., Dietary Manager #400 verified the thermometer cord should not have been permitted to come into contact with food and verified [NAME] #369 should have washed her hands and changed gloves after she came into contact with cupboard instead of using the same gloves to continue to handle buns and the potato wedges.Review of the Food Safety and Sanitation policy (implementation date not listed) revealed employees were to wash their hands just before they started to work in the kitchen and after smoking, sneezing, using the restroom, handling poisonous compounds or dirty dishes and touching face, hair, other people or surfaces or items with potential for contamination. 2. On 04/02/26 at 9:50 A.M., the refrigerator on Buckeye unit was observed to contain two large Styrofoam food carry out containers and a Styrofoam bowel with Resident #25's name on them. Two of the three containers had a date of 03/01 on them. The other had a number three, but the remaining numbers were illegible. On 04/02/26 at 9:50 A.M., Licensed Practical Nurse (LPN) #311 verified two of the containers had a date of 03/01 written on them while the third container only had a three which was legible. LPN #311 stated food was only supposed to be kept for three days. Review of the facility's policy, Food Brought by Family/Visitors (no implementation date), addressed notification of staff if someone wished to provide food from an outside source. Perishable foods must be stored in resealable containers with tightly fitting lids in the refrigerator and labeled with the resident's name, the item and the use by date. The nursing staff was responsible for discarding perishable foods on or before the use by date. The facility identified Residents #1, #2, #3, #5, #7, #10, #11, #12, #13, #14, #15, #16, #17, #18, #20, #23, #24, #25, #26, #27, #29, #30, #31, #33, #37, #39, #42, #43, #44, #46, #48, #51, #52, #55, #56, #58, #59, #60, #61, #63, #65, #66, #68, #71, #72, #73, #74, #75, #77, #79, #84, #86, and #87 with orders for diets with regular texture.