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	05/20/2026

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and policy review, the facility failed to honor Resident #1's preferences to heat up leftover food items. This finding affected one (Residents #1) of nine residents reviewed for preferences. The facility census was 76.Findings include:Review of Resident #1's medical record revealed the resident was admitted on [DATE] with diagnoses including fibromyalgia, depression and anxiety disorder. Resident #1 resided on the Buckeye secured unit.Review of Resident #1's physician orders revealed an order dated 03/03/26 for a regular diet, regular texture with thin liquids consistency and a house shake (supplement) with breakfast.Review of Resident #1's Quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition.Interview on 05/18/26 at 8:35 A.M. with Resident #1 revealed staff refused to heat up leftovers and she has had to throw food out. She indicated the Director of Nursing (DON) stated it was the facility policy. When questioned, she also stated the Administrator stated the same thing and it had something to do with cross-contamination. Resident #1 stated she had asked the kitchen to heat things up for her and was told they could not heat them up. Resident #1 stated she asked staff not to bring in meals because she cannot eat them, and she orders her food from outside vendors.Interview on 05/19/26 at 7:22 A.M. with Social Service Designee (SSD) #734 revealed Resident #1 had visited the Administration office and reported to the DON that staff were not heating up the leftover food. SSD #734 confirmed the DON told the resident that staff were not allowed to heat up the leftover food per the Administrator and that the resident was to talk to the Administrator. SSD #734 was unsure of the time of the occurrence but stated it was within the last 14 days.Interview on 05/19/26 at 7:26 A.M. with Registered Nurse (RN) #744 revealed the facility had a microwave in the Pines nursing office, the therapy room and the maintenance office.Interview on 05/19/26 at 7:35 A.M. with Maintenance Director (MD) #721 confirmed the microwave in his office was his own personal microwave along with the refrigerator. MD #721 confirmed the microwaves in the therapy room and the nursing office belonged to the facility (along with the one in the kitchen).Interview on 05/19/26 at 8:25 A.M. with Resident #1 revealed the last time she talked to the Administration staff was on 05/05/26 when she went in and asked the DON about heating up the leftover food items. Resident #1 revealed the DON told her the facility staff were not able to heat up the food per the Administrator.Interview on 05/18/26 at 8:47 A.M. with the DON revealed she did not talk to any resident about heating up outside food items.Interview on 05/19/26 at 9:46 A.M. with the Administrator revealed she had told staff that food needed to be heated up in the kitchen with a temperature obtained. Review of the Foods Brought by Family/Visitors policy revised 02/2014 revealed liberalized diets will be permitted as much as possible. Staff must be aware of, and approve, foods brought to a resident by family/visitors.This deficiency represents non-compliance investigated under Master Complaint Number 3011311.

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	05/20/2026

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 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** Based on record review, interview, and policy review, the facility failed to ensure Resident #78's care plan was revised with individualized interventions to address his behaviors. This affected one (Resident #78) out of three residents reviewed for behaviors. The facility census was 76.Findings include:A review of Resident #78's clinical record revealed an admission date of 01/29/26 with diagnoses including congestive heart failure, mood disorder, schizophrenia, pulmonary disease, diabetes mellitus, sleep apnea, and morbid obesity. Resident #78 was discharged from the facility to the hospital on [DATE] and did not return to the current facility upon his discharge from the hospital. A review of Resident #78's clinical record revealed multiple nursing progress notes dated 02/14/26 to 05/01/26 that indicated Resident #78 had behaviors including agitation, yelling/screaming at staff, accusations of being poisoned by the staff, staff threatening bodily harm, voicing distrust of staff accurately administering his medications, in medications, accusations of cleaning staff moving his belongings and was verbally abusive to the staff accusing staff of messing with his food, refusing care. A review of Resident #78's care plan indicated Resident #78 exhibited behavioral symptoms such as accusatory statements, verbal aggression, noncompliance with care and medication administration recommendations related to his diagnoses of schizophrenia and mood disorder. The goal of the plan of care was Resident #78 would not harm himself or others through the review date 07/28/26, and Resident #78's safety would be maintained through the review date 07/28/26. Interventions included: -Contract with the resident as needed. -Document all behaviors. Attempt to identify patterns to target interventions. -Notify supervising nurses of noted negative behaviors, accusatory statements, verbal aggression, non-compliance with care. -Offer foods of choice (within dietary orders) to reduce episodes of negative behavior and risk for all or injury. An interview with Registered Nurse (RN) #733 on 05/18/26 at 3:43 P.M. stated Resident #78 had behavior and complained to the staff accusing them of changing his medications and was distrustful of medications administered. RN #733 stated Resident #78 needed to watch the nurses dispense the medications from the original packaging into a medication cup or he would refuse to consume the medications. RN #733 verified there was no intervention in his plan of care for all the nurses to provide the same intervention during medication administration to prevent Resident #78's refusal to consume his medications. An interview with RN #748 on 05/19/26 at 6:20 A.M. agreed Resident #78 was particular about his medication administration and needed to watch the nurses dispense his medications in a medication cup or he would refuse to take the medications. RN #748 stated two housekeeping staff members needed to be present while cleaning Resident #78's room due to accusations of stealing and/or looking through his personal belongings. RN #478 verified the interventions in his care plan were not individualized to include strategies some of the staff were using to address Resident #78's behaviors. (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	05/20/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with Certified Nursing Assistant (CNA) #749 on 05/19/26 at 6:53 A.M. revealed two staff members needed to be present when staff provided direct care for Resident #78 due to his accusations of staff abusing him and other accusations. An interview with Administrator on 05/19/26 at 10:27 A.M. verified the above findings and agreed Resident #78's care plan needed to revised to include individualized interventions to address his behaviors. A review of the facility policy titled Care Plan, Comprehensive Person-Centered dated 2001 indicated the policy was a comprehensive, person-centered care plan that included measurable objectives and timetables to meet the residents' physical, psychosocial and functional needs was developed and implemented for each resident. The interdisciplinary team, in conjunction with the resident and his/her representative, develops and implements a comprehensive, person-centered care plan for each resident. The comprehensive, person-centered care plan included measurable objectives and timeframes; describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including: -services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment; -any specialized services to be provided because of PASARR recommendations; and -which professional services are responsible for each element of care; includes the resident's stated goals upon admission and desired outcomes; builds on the resident's strengths; and reflects currently recognized standards of practice for problem areas and conditions. This deficiency is an incidental finding discovered during the course of the complaint investigation.

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	05/20/2026

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, policy review, and interview, the facility failed to ensure Resident #20 was provided adequate incontinence care. This finding affected one (Resident #20) of three residents reviewed for incontinence care. The facility census was 76.Findings include:Review of Resident #20's medical record revealed the resident was admitted on [DATE] with diagnoses including schizoaffective disorder, muscle wasting and hypothyroidism. Resident #20 resided on the Buckeye secured unit.Review of Resident #20's Quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited severe cognitive impairment and was always incontinent of bowel and bladder.Observation on 05/18/26 at 6:56 A.M. with Certified Nursing Assistant (CNA) #732 and CNA #769 of Resident #20's morning activities of daily living including the resident's incontinence care revealed the staff used disposable wipes to cleanse the resident's peri area and coccyx. The staff stated they could not dry the resident because they did not have towels or washcloths available for use.Observations on 05/18/26 at 6:59 A.M. with CNA #769 of the first and second linen closet on the Buckeye secured unit revealed several sheets and blankets but no towels and no washcloths.Attempted interview on 05/18/26 at 7:00 A.M. with Resident #20 and the resident was not interviewable.Interview on 05/18/26 at 7:00 A.M. with CNA #732 revealed there were no linens for staff use on a regular basis. CNA #732 confirmed they had to make do with what they had and confirmed the facility did not have towels to dry Resident #20 following incontinence care.Interview on 05/19/26 at 9:46 A.M. with the Administrator revealed she was aware the facility was running low on linens, and new linens were ordered.Review of the Incontinence Care policy revised 09/2010 revealed the staff and practitioners will appropriately screen for, and manage, individuals with urinary incontinence. The physician and staff will provide appropriate services and treatment to help residents restore or improve bladder function and prevent urinary tract infections to the extent possible.This deficiency represents non-compliance investigated under Complaint Number 2998651.

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	05/20/2026

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, record review, policy review, and interview the facility failed to ensure Resident #29 and Resident #59's medications were administered as ordered by the physician resulting in a six percent error rate. This affected two out of five residents observed during medication administration. The facility census was 76.Findings include:An observation of four nurses (Registered Nurse (RN) #733, RN #744 and Licensed Practical Nurse (LPN) #746, LPN #747) administer 30 medications to five residents (Resident #12, Resident #29, Resident #57, Resident #59, Resident #76) with 31 opportunities for error revealed two medication errors were observed resulting in a six percent error rate. 1. A review of Resident #59's clinical record revealed an admission date of 12/30/24 with diagnoses including malnutrition, pleural effusion, cognitive communication deficit, cerebral infarction (stroke), transient ischemic attack (temporary blockage of blood flow to the brain), spastic hemiplegia affecting the right side (muscle weakness or stiffness affecting one side of the body), dysphagia (difficulty swallowing), hyperlipidemia (high cholesterol), constipation, aortic valve stenosis, mental disorder, and aphasia (difficulty speaking, understanding, reading and writing). A review of Resident #59's physician orders dated 05/01/26 to 05/31/26 indicated to administer the following medications scheduled to administer in the morning: -Aspirin 81 milligrams (mg) (blood thinner) delayed release by mouth. -Clopidogrel bisulfate 75 mg (antiplatelet) by mouth. -MiraLAX (polyethylene glycol 3350) oral packet 17 grams (gr) (laxative) mixed in 4 to 8 ounces of water by mouth. -Tamsulosin hydrochloride capsule 0.4 mg (treats enlarged prostate) by mouth. -Gabapentin 100 mg (controls seizures and manages nerve pain) by mouth. And a physician order indicated oxycodone 5 mg/325 mg (opioid pain medication) to administer one tablet orally as needed for pain. An observation on 05/18/26 at 9:53 A.M. of RN #733 administer the above listed medications to Resident #59 revealed a failure to measure the ethylene glycol 3350 powder correctly. RN #733 obtained a plastic bottle of ethylene glycol 3350 from the medication cart. RN #733 then poured the ethylene glycol powder into the cap of the plastic bottle up to the first line on the white inner liner of the cap. RN #733 then attempted to mix the measured powder in a cup of water when she was stopped and asked to read the directions on the ethylene glycol 3350 plastic bottle. The directions indicated to fill the ethylene glycol powder to the top of the inner white line of the cap for 17 gr dosage of the ethylene glycol powder. When the inner white liner of the cap of the ethylene glycol 3350 powder was inspected there was an arrow pointing to the top line of the inner white liner indicating to fill the powder to the top of the inner liner of the cap. An interview with RN #733 on 05/18/26 at 10:00 A.M. revealed RN #733 agreed she had not measured the ethylene glycol 3350 powder correctly. (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	05/20/2026

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. A review of Resident #29's clinical record revealed an admission date of 01/31/24 with diagnoses including chronic respiratory failure, malnutrition, chronic obstructive pulmonary disease, gastroesophageal reflux disease, diabetes mellitus type II, hyperlipidemia, hypertension (high blood pressure), obstructive sleep apnea, dysphagia, cognitive communication deficit, and chronic venous hypertension. A review of Resident #29's physician orders dated 05/01/26 to 05/31/26 indicted to administer the following medications scheduled to administer in the morning: -Ascorbic acid 500 mg (Vitamin C supplement) by mouth. -Atorvastatin calcium 10 mg (lowers cholesterol) by mouth. -Docusate sodium 100 mg (stool softener) by mouth. -Ferrous sulfate 325 mg (iron supplement) by mouth. -Folic acid 1 mg (supplement) by mouth. -Multivitamin 1 tablet (supplement) by mouth. -Pantoprazole sodium (Protonix) 40 mg (decreases stomach acid) by mouth. -Thiamine hydrochloride 100 mg (Vitamin B1 supplement) by mouth. -Vitamin B6 50 mg (supplement) by mouth. -Zinc 50 mg (supplement) by mouth. An observation on 05/19/26 at 7:38 A.M. of RN #744 administer medications to Resident #29 revealed RN #744 failed to administer zinc 50 mg supplement by mouth as ordered by the physician. RN #744 administered the other above listed medications but had not administered the zinc medication. An interview with RN #744 on 05/19/26 at 8:02 A.M. agreed she had not administered 50 mg zinc by mouth as ordered by the physician. A review of the facility policy titled Administering Medications revised April 2019 indicated medications were administered in a safe and timely manner, and as prescribed. Under the Policy Interpretation and Implementation section item number 4 indicated medications were administered in accordance with the prescriber orders. Including any required time frame. This deficiency represents non-compliance investigated under Complaint Number 2993659.

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	05/20/2026

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, record review and interview, the facility failed to ensure a clean and sanitary environment in good repair. This finding affected 16 residents (#1, #7, #9, #16, #20, #24, #33, #35, #38, #40, #45, #56, #57, #65, #75 and #76) of 34 residents who reside on the Buckeye secured unit and had the potential to affect all the residents in the facility. The facility census was 76.Findings include:1. Tour of the Buckeye secured unit on 05/18/26 at 8:07 A.M. with Maintenance Director (MD) #721 of the resident rooms revealed: - Scrape damage and missing paint on the wall surfaces of Resident #75's room.- Scrape damage and missing paint on the wall surfaces of Resident #1's room and missing molding.- Scrape damage and missing paint on the wall surfaces of Resident #20's room.- Scrape damage and missing paint on the wall surfaces of Residents #40 and #45's room.- Scrape damage and missing paint on the wall surfaces of Residents #7 and #38's room.- Scrape damage and missing paint on the wall surfaces of Resident #33's room.- Scrape damage and missing paint on the wall surfaces of Residents #9 and #16's room.- Scrape damage and missing paint on the wall surfaces of Resident #76's room.- Scrape damage and missing paint on the wall surfaces of Residents #35, #65 and #57's room.- Scrape damage and missing paint on the wall surfaces of Resident #56's room.- Scrape damage and missing paint on the wall surfaces of Resident #24's room, as well as a broken closet door. Interview on 05/18/26 at 8:20 A.M. with MD #721 revealed he was only one person, and the facility took away his assistant. MD #721 confirmed the resident rooms on the Buckeye unit required maintenance. 2. A tour of the facility on 05/18/26 from 8:30 A.M. to 9:00 A.M. revealed the floors throughout the facility common areas, including the hallways, dining areas and gathering areas in the facility revealed the floors were sticky, scuffed, with dried liquid spills, ground in dirt and debris present throughout the facility and resident care areas. An interview with Housekeeper #769 on 05/19/26 at 7:06 A.M. verified the floors in the facility had been neglected and were sticky with dried spills and debris. Housekeeper #769 stated he was responsible for ensuring the floors were cleaned. Housekeeper #769 stated he had been off work due to illness and there was nobody assigned to take over his job duties while he was sick. Housekeeper #769 stated the facility did not have a machine to buff the floors and the floors appeared dull and scratched throughout the facility in need of deep cleaning. Review of the Homelike Environment policy revised 02/2021 revealed residents were provided with a safe, clean, comfortable homelike environment and encouraged to use their personal belongings to the extent possible. This deficiency represents non-compliance investigated under Complaint Number 2998651.