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	04/10/2025

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46195 Based on record reviews, interviews, review of care conference attendance records and facility policy review, the facility failed to ensure residents and/or their representatives were invited to care conferences as required. This affected four residents (#22, #28, #39, and #54) out of four residents reviewed for care plan meetings. The facility census was 66. Findings include: 1. Review of the medical record for Resident #54 revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease (COPD), chronic respiratory failure with hypoxia, dementia, heart failure, cognitive communication deficit, schizophrenia, and disorientation. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed when asked how important it was to have family or a close friend involved in discussion about her care, Resident #54 answered it was very important. Review of the modification of quarterly MDS assessment dated [DATE] revealed Resident #54 was moderately impaired cognitively; altered level of consciousness behavior was present but fluctuated; rejected care four to six days during the assessment reference period; and was independent for walking up to 150 feet. Review of the Letters of Guardianship dated 10/06/15 from the probate of Mahoning County revealed Resident #54 had been deemed incompetent and Guardian #809 had been appointed guardian of person only for an indefinite time period for Resident #54. Interview on 04/07/25 at 11:08 A.M. with Resident #54 revealed the resident stated I don't go to care plan meetings, and my family doesn't either. Interview on 04/07/25 at 2:50 P.M. with Guardian #809, who was also the daughter of Resident #54, revealed she had never been invited or attended a care conference. She went on to state she was in the process of moving the resident into another facility since the facility had not been living up to her expectations. Further review of the progress notes from 03/04/24 to 04/10/25 revealed there was no documented evidence that Resident #54 or Guardian #809 had been invited to the care conferences. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility document titled Care Conference Form V2-V2, dated 02/26/24, 05/23/24, 08/26/24, 10/28/24, and 02/13/25 in Resident #54's medical record revealed there was no documented evidence Resident #54 or Guardian #809 had attended or refused to attend any of those care conferences. 2. Review of the medical record for Resident #22 revealed an admitted [DATE]. Diagnoses included schizoaffective disorder bipolar type, cirrhosis of the liver, type two diabetes mellitus, cognitive communication deficit, altered mental status, vascular dementia, anxiety disorder, and major depressive disorder. Review of the MDS assessment dated [DATE] revealed Resident #22 was cognitively intact; inattention, disorganized thinking, and altered level of consciousness was present but fluctuated; rejection of care occurred daily; and the resident was mainly independent for activities of daily care and mobility. Review of the legal guardian paperwork, dated 07/21/23, from the Probate Court of [NAME] County, revealed Resident #22 was deemed incompetent, and Guardian #810 had been appointed guardian of person only for an indefinite time period for Resident #22. Review of facility document titled Care Conference Form V2-V2 dated 03/11/24, 06/10/24, 09/10/24, 12/12/24, 01/30/25, and 04/02/25 revealed there was no documented evidence Resident #22 had attended or had refused to attend, and the only care conference Guardian #810 was documented to have attended was on 09/10/24. Further review of the progress notes from 04/04/24 to 04/10/25 revealed there was no documented evidence Resident #22 or Guardian #810 had been invited to the care conferences Interview on 04/08/25 at 4:37 P.M. with Social Service Designee (SSD) #516 revealed the care conference meetings were scheduled based off the MDS assessment schedule. He stated he would go down to talk to the residents the day before or the day of the meeting to let them know about the meeting. For the responsible parties and guardians, he would look at the MDS schedule and try and get a hold of someone to let them know when the care conference had been scheduled. He stated he did not document who he had been able to contact and who he was unable to contact in regard to the meetings. He went on to state he would make a mental note of who he had contacted and who still needed to be contacted in regard to the care conference meetings. He confirmed there was no documented evidence of how and when residents and responsible parties/guardians were invited to care conferences. Interview on 04/09/25 at 2:57 P.M. with Guardian #810 stated the facility was not reaching out to him when care conferences were being held. He stated the only way he was getting notification of when care conferences were being held was when he reached out to the facility and asked when the next care conference was being held. Guardian #810 stated he was not aware a care conference for Resident #22 had been held on 04/03/25. He was unsure if Resident #22 had ever been invited to care conference but was not sure if she would agree to attend. 51521 3. Review of the medical record revealed Resident #28 was admitted on [DATE] with a diagnosis of COPD, cognitive communication deficit, unspecified dementia, unspecified severity with other behavioral disturbance, and anxiety disorder. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the admission MDS assessment dated [DATE] revealed Resident #28 had moderate cognitive impairment. Review of the care plan dated 03/12/25 revealed Resident #28 had impaired cognitive function and dementia or impaired thought processes. Interventions included communication with the resident's family/caregivers/ regarding resident's capabilities and needs. Monitor, document, report ant changes in cognitive function, specifically changes in decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, and mental status. Record review revealed Resident #28 and/or Resident #28's representative have not been invited to care conferences and have not been involved in participating in his care. Resident #28 and/or his resident representative had not been informed of changes in care. The care conference form from 10/07/24 indicated that social services, activities and rehabilitation services attended, and review of the care conference form from 03/25/25 revealed that registered nurse, activities, and nursing administration attended. Interview on 04/09/25 at 8:08 A.M. with Resident #28's Power of Attorney (POA) granddaughter, revealed she had never been invited to care conference meetings and was usually not informed of any changes to the resident's care or changes in appointments. She has never been to a care conference for her grandfather and does not know what is going on with his care. She has had issues with her grandfather missing appointments. She was not happy with the care and was looking to move him. 4. Review of the medical record revealed Resident #30 was admitted on [DATE]. Diagnoses included unspecified dementia, unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Review of the MDS dated [DATE] indicated Resident #30 had a mild cognitive impairment. Review of the care plan dated 03/24/25 revealed Resident #30 had impaired cognitive function or impaired thought processes secondary to diagnosis of dementia. Interventions included communication, and using the resident's preferred name. Identify yourself at each interaction. Face the resident when speaking, and make eye contact. Reduce any distractions. Monitor, document, report any changes in cognitive function, specifically changes in decision making ability, memory, recall, and general awareness, difficulty expressing self, consciousness and mental status. Record Review of the care conferences from May 2024 to March 2025 revealed the care conference on 05/23/24 revealed the social worker, activities, and nursing administration attended. The care conference on 08/26/24 revealed the social worker, activities, and nursing administration attended. The care conference on 03/03/25 revealed activities attended. There was no documented evidence that Resident #30 and/or her representative had attended care conferences. Interview on 04/08/25 at 03:00 P.M. with Dietary Manager #538 revealed she had attended care conferences in the past but, due to staffing challenges, she hasn't been able to attend the meetings recently. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 04/08/25 at 3:54 P.M. with Dietitian #579 revealed, she will come in as needed. She attended high risk meetings via phone and reviewed the building off site unless she came in when needed. She stated she does not attend care conferences; someone from dietary attends care conferences. Interview on 04/08/25 at 4:37 P.M. with SSD #516 revealed the care conference meetings were scheduled based off the MDS assessment schedule. He stated he would go down to talk to the residents the day before or the day of the meeting to let them know about the meeting. For the responsible parties and guardians, he would look at the MDS schedule and try and get a hold of someone to let them know when the care conference had been scheduled. He stated he did not document who he had been able to contact and who he was unable to contact in regard to the meetings. He went on to state he would make a mental note of who he had contacted and who still needed to be contacted in regard to the care conference meetings. He confirmed there was no documented evidence of how and when residents and responsible parties/guardians were invited to care conferences. Review of the facility policy Resident Participation-Assessment/Care Plans, revised December 2016, revealed a seven-day notice of the care planning conference would be provided to the resident and his or her representative. The social service director or designee would be responsible for notifying the representative/representative and for maintaining records of such notices. Notices included the name of each person contacted; the date he or she was contacted; the method of contact (mail, telephone, or email); input from the residents or representatives if they were not able to attend; and refusal of participation if applicable.

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46195 Based on record reviews, observations, interviews and facility policy review, the facility failed to ensure Resident #32 was free from a physical restraint. This affected one resident (t #32) out of 16 residents reviewed for restraints. The facility identified no residents as having a physical restraint. The facility census was 66. Findings include: Review of medical record for Resident #32 revealed an admitted [DATE]. Diagnoses included schizoaffective disorder bipolar type, intellectual disabilities, wedge compression fracture of unspecified vertebra, osteoarthritis, mood disorder, disorders of psychological development, and history of falling. Review of care plan dated 09/21/24 revealed Resident #32 was at risk for falls related to fracture of lumbar/thoracic vertebrae, history of repeated falls, impaired safety awareness, and impaired cognition. Interventions included anticipate and meet the resident's needs; be sure the resident's call light was within reach and encourage the resident to use it for assistance as needed; encourage appropriate footwear while in the wheelchair; and ensure the environment was safe which included floors being free from spills, a workable and reachable call light, bed in low position at night, and personal items within reach. Review of quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #32 was severely impaired cognitively; exhibited inattention, disorganized thinking, and altered level of consciousness which was continuously present and did not fluctuate; had no behaviors; was dependent on staff for all activities of daily living except required setup or cleanup assistance for eating; was dependent on staff for all mobility except required staff supervision or touch assistance to wheel 50 feet in manual wheelchair; had no falls since prior assessment; and no physical restraints were being used. Observation on 04/07/25 at 11:24 A.M. revealed Resident #32 was awake and lying in her bed, and the side of the bed was placed against the left side wall with the resident's head facing the back wall. On the side of the bed not against the wall, a blue wedge cushion had been placed between the mattress and the bed frame with the narrow part of the cushion closer to the middle of the mattress and the wider part of the cushion toward the edge of the mattress which resulted in an elevation of the edge of the mattress. Interview at the time of observation with Resident #32 revealed the resident had impaired cognition and was unable to be interviewed. Interview at the time of observation with Registered Nurse (RN) #549 confirmed the wedge cushion had been placed between the mattress and the bed frame, and the wedge cushion was being used to prevent Resident #32 from falling out of bed. Further review of Resident #32's medical record revealed there was no order for the wedge cushion, and nothing was noted in the resident's care plan indicating the reason for the wedge cushion. Observation on 04/08/25 at 9:14 A.M. revealed the blue wedge cushion remained between Resident #32's bedframe and the mattress. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/08/25 at 1:03 P.M. with Certified Nursing Assistant (CNA) #573 revealed the wedge cushion was placed between the mattress and the bed frame to help keep Resident #32 on her side and to prevent her from falling out of the bed. He stated if the wedge cushion was placed between the resident and the mattress, the resident would remove it. Interview on 04/08/25 at 3:12 P.M. with CNA #515 and CNA #500 revealed Resident #32 would try and climb out of her bed, and to prevent Resident #32 from hurting herself, the wedge was placed between the mattress and the bed frame. Interview on 04/09/25 at 11:02 A.M. with the Director of Nursing (DON) revealed Resident #32 would get uncomfortable and needed more support in her back from her wedge compression fracture of the thoracic vertebra, which was why the facility was using the wedge cushion for comfort. She stated the wedge cushion was not supposed to be placed between the mattress and the bed frame. The DON stated a restraint prevented a resident from moving and went on to confirm having the wedge cushion placed between the bedframe and mattress on one side of the bed and the bed against the wall on the other side of the bed could restrict Resident #32's movement. Review of the facility policy Resident Rights, revised December 2016, revealed residents had a right to be free from physical restraints not required to treat a resident's symptoms.

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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** 44810 Based on record review, interview and review of the facility policies, the facility failed to ensure an accurate care plan for Resident #1. This affected one resident (#1) of two residents reviewed for care plans. The facility census was 66. Findings include: Review of the medical record for Resident #1 revealed an admitted [DATE]. Diagnoses included schizophrenia, type two diabetes mellitus, and cerebral infarction. Review of the physician's order dated 01/19/25 revealed that Resident #1 required the assistance of one staff member for transfers. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident #1 had intact cognition. Resident #1 required extensive assistance for all activities of daily living. Resident #1 was frequently incontinent of urine and bowel. Review of the care plan dated 04/08/25 revealed that Resident #1 had no focus area for incontinence care and no interventions for incontinence. Interview on 04/09/25 at 9:07 A.M. with the MDS Registered Nurse (RN) #530 confirmed that Resident #1 was incontinent, and he had no care plan interventions related to incontinence. Review of the facility policy care plans, comprehensive person-centered, revised December 2016, revealed a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46195 Based on record reviews, interviews, review of care conference attendance records and facility policy review, the facility failed to ensure a member of the food and services staff, which was part of the interdisciplinary team, attended care conferences as required. This affected four residents (#22, #28, #39, and #54) out of four residents reviewed for care plan meetings. The facility census was 66. Findings include: 1. Review of the medical record for Resident #54 revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease (COPD), chronic respiratory failure with hypoxia, dementia, heart failure, cognitive communication deficit, schizophrenia, and disorientation. Review of the modification of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #54 was moderately cognitively impaired; altered level of consciousness behavior was present but fluctuated; rejected care four to six days during the assessment reference period; and was independent for walking up to 150 feet. Review of the facility document titled Care Conference Form v2-V2, dated 02/26/24, 05/23/24, 08/26/24, 10/28/24, and 02/13/25 in Resident #54's medical record revealed there was no documented evidence that a representative from food and nutrition services staff attended the meetings. Interview on 04/08/25 at 3:00 P.M. with Dietary Manager #538 revealed she had attended care conferences in the past but due to staffing challenges, she hasn't been able to attend the care conference meetings recently. Interview on 04/08/24 at 3:54 P.M. with Dietitian #808 revealed she did not attend care conferences and stated someone from the facility dietary staff should be attending the care conferences. Interview on 04/08/25 at 4:37 P.M. with Social Service Designee (SSD) #516 confirmed no one from dietary had been attending the care conference meetings, and the Director of Nursing (DON) had been filling out the dietary section of the Care Conference Form V2-V2. 2. Review of the medical record for Resident #22 revealed an admitted [DATE]. Diagnoses included schizoaffective disorder bipolar type, cirrhosis of the liver, type two diabetes mellitus, cognitive communication deficit, altered mental status, vascular dementia, anxiety disorder, and major depressive disorder. Review of the MDS assessment dated [DATE] revealed Resident #22 was cognitively intact; inattention, disorganized thinking, and altered level of consciousness was present but fluctuated; rejection of care occurred daily; was mainly independent for activities of daily care and mobility. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility document titled Care Conference Form V2-V2 dated 03/11/24, 06/10/24, 09/10/24, 12/12/24, 01/30/25, and 04/02/25 revealed there was no documented evidence that a member from the food and nutrition services staff attended the meetings. Interview on 04/08/25 at 3:00 P.M. with Dietary Manager #538 revealed she had attended care conferences in the past but due to staffing challenges, she hasn't been able to attend the care conference meetings recently. Interview on 04/08/24 at 3:54 P.M. with Dietitian #808 revealed she did not attend care conferences and stated someone from the facility dietary staff should be attending the care conferences. Interview on 04/08/25 at 4:37 P.M. with SSD #516 confirmed no one from dietary had been attending the care conference meetings, and the DON had been filling out the dietary section of the Care Conference Form V2-V2. 51521 3. Review of the medical record for Resident # 28 revealed an admitted [DATE] with diagnoses including COPD, cognitive communication deficit, unspecified dementia, unspecified severity with other behavioral disturbance and anxiety disorder. Review of the admission MDS assessment dated [DATE] revealed Resident # 28 had moderate cognitive impairment. Review of the care plan dated 03/12/25 for Resident # 28 revealed he had impaired cognitive function and dementia or impaired thought processes. Interventions included communication with the resident's family/caregivers/ regarding the resident's capabilities and needs. Monitor, document, report any changes in cognitive function, specifically changes in decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, and mental status. Record review revealed no documented evidence Resident #28 or Resident #28's representative was invited to care conferences or participated in his care planning. Review of the care conference form dated 10/07/24 indicated that social services, activities and rehabilitation services attended, and review of the care conference form dated 03/25/25 revealed that registered nurse, activities, and nursing administration attended. Interview on 04/08/25 at 3:00 P.M. with Dietary Manager #538 revealed she had attended care conferences in the past but due to staffing challenges, she hasn't been able to attend the care conference meetings recently. Interview on 04/08/24 at 3:54 P.M. with Dietitian #808 revealed she did not attend care conferences and stated someone from the facility dietary staff should be attending the care conferences. Interview on 04/08/25 at 4:37 P.M. with SSD #516 confirmed no one from dietary had been attending the care conference meetings, and the DON had been filling out the dietary section of the Care Conference Form V2-V2. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Review of the medical record for Resident # 30 revealed an admitted [DATE]. Diagnoses included unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Review of the MDS assessment dated [DATE] revealed Resident #30 had a mild cognitive impairment. Review of the care conference forms dated 05/23/24 and 08/26/24 revealed the social worker, activities, and nursing administration attended. There was no documented evidence Resident #30 or Resident #30's representative attended the care conference. Review of the care conference form dated 03/03/25 revealed activities attended. There was no documented evidence Resident #30 or Resident #30's representative attended the care conference. Interview on 04/08/25 at 3:00 P.M. with Dietary Manager #538 revealed she had attended care conferences in the past but due to staffing challenges, she hasn't been able to attend the care conference meetings recently. Interview on 04/08/24 at 3:54 P.M. with Dietitian #808 revealed she did not attend care conferences and stated someone from the facility dietary staff should be attending the care conferences. Interview on 04/08/25 at 4:37 P.M. with SSD #516 confirmed no one from dietary had been attending the care conference meetings, and the DON had been filling out the dietary section of the Care Conference Form V2-V2. Review of facility policy Care Plans, Comprehensive Person-Centered, revised December 2016, revealed the interdisciplinary (IDT) team in conjunction with the resident and his/her family or legal representative, would develop and implement a comprehensive, person-centered plan for each resident. The IDT included a member of the food and nutrition services staff.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46195 Based on record review, interviews and facility policy review, the facility failed to ensure a physician ordered fluid restriction was monitored and followed for Resident #37. This affected one resident (#37) out of 16 residents reviewed for following physicians' orders. The facility identified three residents (#1, #37, and #59) as being on a fluid restriction. The facility census was 66. Findings include: Review of the medical record for Resident #37 revealed an admitted [DATE]. Diagnoses included dementia with other behavioral disturbance, hypo-osmolality (a decrease in the osmolality of the body fluids which increases body fluid volume and decreases solute volume) and hyponatremia (a condition in which the concentration of sodium in the blood is abnormally low. Sodium is an electrolyte which helps regulate the water that's in and around the cells), personal history of traumatic brain injury, personality and behavioral disorders due to known physiological condition, pseudobulbar affect (a condition characterized by episodes of sudden uncontrollable and inappropriate laughing and crying), intermittent explosive disorder, and schizoaffective disorder bipolar type. Review of Resident #37's physician's orders revealed and order dated 03/21/23 for sodium chloride tablet one gram (an electrolyte that is used to treat or prevent sodium loss) with directions to give two tablets by mouth three times a day related to hypo-osmolality and hyponatremia and an order dated 07/24/24 for a Regular diet, Regular texture, Thin/Regular (liquids) consistency 1500 ml (milliliter) fluid restriction. Review of Resident #37's care plan dated 06/07/23 revealed the resident had hyponatremia and was receiving supplementation (sodium chloride). Interventions included fluid restriction as ordered; give medications as ordered; monitor vital signs as per orders and notify the physician of significant abnormalities; obtain and monitor lab/diagnostic work as ordered, report results to the physician, and follow up as indicated. Review of the quarterly Minimum Data Set (MDS) assessment 03/31/25 revealed Resident #37 was severely impaired cognitively; inattention, disorganized thinking and altered level of consciousness was present but fluctuated; exhibited verbal behavioral symptoms four to six days and other behavioral symptoms not directed toward others one to three days during the assessment reference period; had not rejected care; required setup or clean up assistance from staff for eating; was independent to walk ten feet; and was on a therapeutic diet. Further review of Resident #37's medical record revealed a full dietary assessment titled Nutritional Assessment Review, dated 08/19/24, indicated the resident was on a 1500 ml fluid restriction for hyponatremia. The resident's estimated nutritional needs were 2440 calories, 81-97 grams protein, and 1500 ml fluids. There was no indication of how the fluid restriction would be dispersed between nursing and dietary. Review of the quarterly nutrition assessment titled Dietary Review, dated 04/02/25 and authored by Dietitian #808, revealed the resident was on a regular diet with a 1500 ml with no indication how the fluid restriction would be dispersed between nursing and dietary. (continued on next page)

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	365708	A. Building B. Wing	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willow Woods Rehabilitation and Nursing	9625 Market Street North Lima, OH 44452

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #37's medication administration record (MAR) for February, March, and April 2025 revealed the resident was receiving his sodium chloride as ordered and each 12 hour nurse shift was acknowledging on the MAR the resident was on a 1500 ml fluid restriction, but there were no further instructions on how much fluids each nursing shift was allowed to give the resident or how much fluids each nursing shift had given the resident during their 12 hour shift. Interview on 04/08/25 at 3:17 P.M. with Registered Nurse (RN) #549 and the Director of Nursing (DON) revealed RN #549 confirmed nursing was acknowledging in the MAR Resident #37 was on a 1500 ml fluid restriction, but they were not tracking how much fluids were being provided by nursing and dietary. The DON and RN #549 both confirmed without tracking, it would be difficult to determine if the facility was staying in compliance with the fluid restriction. Interview on 04/08/25 at 3:45 P.M. with Dietary [NAME] #566 revealed if a resident was on a fluid restriction, the only thing being limited from dietary was the fluids placed on the meal tray. She stated a person on a fluid restriction would receive everything on the main menu which could include soups, gelatin, pudding, and ice cream. Interview on 04/08/25 at 3:46 P.M. with Dietary Manager #538 stated if a resident was on a fluid restriction the only change on their dietary tray would be the resident would receive only one eight-ounce beverage each meal. She stated the resident would receive items from the main meal which could include soups, gelatin, pudding, and ice cream. Interview on 04/08/25 at 3:54 P.M. with Dietitian #808 revealed usually the nurse provided the breakdown for a fluid restriction unless they were unclear of the process. She stated she was not sure if nursing was aware of the amount of fluids dietary was providing and how much fluids dietary was providing for residents on a fluid restriction. She stated she would get back to the state surveyor with the answers. As of 9:47 A.M. on 04/10/25 Dietitian #808 had never gotten back to the state surveyor with her answers to how nursing was aware of how much fluids dietary was providing and how much fluids dietary was providing for residents on a fluid restriction. Based on the undated facility policy Fluid Restriction revealed the fluid restriction would be served as ordered by physician. The fluids provided would be shared by dietary and nursing using a fluid restriction breakdown. Only those foods that were liquid at room temperature would be calculated into the fluid restriction. Nursing would implement input/output records for any resident placed on a fluid restriction for the dietitian to review on a monthly basis.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46195 Based on record review, observations, interviews, facility menu spreadsheets and facility policy review, the facility failed to ensure residents on a reduced concentrated sweets (RCS) diet received the appropriate dessert for lunch on 04/08/25. This affected all 11 residents (#4, #5, #7, #13, #22, #35, #39, #50, #57, #61, and #117) the facility identified as being on a RCS diet. The facility census was 66. Findings include: 1. Review of the medical record for Resident #39 revealed an admitted [DATE]. Diagnoses included schizophrenia and type two diabetes. Review of Resident #39's physician orders revealed an order dated 11/21/24 for a Reduced Calorie Sweets (RCS), Regular texture, Thin/Regular (liquids) consistency. Review of Resident #39's annual Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was mildly impaired cognitively and was receiving a therapeutic diet. Review of Resident #39's care plan dated 04/03/25 revealed the resident had the potential for alteration in nutrition and hydration related type two diabetes diagnosis and or being on a therapeutic diet. Interventions included providing diet as ordered. 2. Review of the medical record for Resident #13 revealed an admitted [DATE]. Diagnoses included schizophrenia, type two diabetes mellitus, and dysphagia (difficulty swallowing). Review of Resident #13's physician's orders revealed an order dated 12/13/24 for a NAS (No Added Salt), RCS (Reduced Calorie Sweets) diet, mechanical soft texture, thin liquids consistency. Review of Resident #13's quarterly MDS assessment dated [DATE] revealed the resident had was moderately impaired cognitively and was receiving a therapeutic and mechanically altered diet. Review of Resident #13's care plan dated 03/17/25 revealed the resident had a potential for alteration in nutrition and hydration related to having a diabetes mellitus diagnosis. Interventions included provide diet per order. 3. Review of medical record for Resident #22 revealed an admitted [DATE]. Diagnoses included schizoaffective disorder and type two diabetes mellitus. Review of Resident #22's physician's orders revealed an order, dated 03/28/23, for a Reduced Concentrated Sweets (RCS) diet, Regular texture, Thin/Regular (liquids) consistency. Review of Resident #22's quarterly MDS assessment dated [DATE] revealed the resident was mildly impaired cognitively and was receiving a therapeutic diet. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #22's care plan dated 03/07/25 revealed the resident had a potential for alteration in nutrition and hydration related to diagnosis of diabetes mellitus and being on a therapeutic diet. Interventions included provide diet as ordered. 4. Review of medical record for Resident #7 revealed an admitted [DATE]. Diagnoses included atrioventricular block (delay in the conduction of electrical current as it passes through the conduction system of the heart), systemic lupus (an autoimmune disease where the immune system attacks the connective tissue in the body), and dysphagia (difficulty swallowing). Review of Resident #7's physician orders revealed an order dated 11/01/22 for a Reduced Concentrated Sweets (RCS) diet, Mechanical Soft, Ground texture, Thin/Regular (liquids) consistency. Review of Resident #7's quarterly MDS dated [DATE] assessment revealed the resident had severe cognitive impairment and was receiving a therapeutic and mechanically altered diet. Review of Resident #7's care plan dated 03/25/25 revealed the resident had a potential for alteration in nutrition and hydration related to diagnoses of schizophrenia and lupus and the need for a therapeutic and mechanically altered diet. Interventions included provide diet per physician order. 5. Review of medical record for Resident #61 revealed an admitted [DATE]. Diagnoses included chronic respiratory failure with hypoxia (insufficient oxygen in the body), type two diabetes mellitus, and hyperlipidemia (abnormally high levels of lipids (fats) in the blood). Review of Resident #61's physician orders revealed an order, dated 01/29/25, for a Reduced Concentrated Sweets (RCS) diet, Regular texture, Thin Liquids consistency. Review of Resident #61's annual MDS assessment dated [DATE] revealed the resident had moderate cognitive impairment and was receiving a therapeutic diet. Review of Resident #61's care plan dated 01/27/25 the resident was at nutritional risk related to the diagnoses of diabetes mellitus. Interventions included providing and serving diet as ordered. 6. Review of medical record for Resident #117 revealed an admitted [DATE]. Diagnoses included schizoaffective disorder bipolar type, type two diabetes mellitus, and anxiety disorder. Review of Resident #117's physician orders revealed an order, dated 03/06/25, for Reduced Concentrated Sweets (RCS) diet, Regular texture, and Thin Liquids consistency. Review of Resident #117's admission MDS assessment dated [DATE] revealed the resident was cognitively intact and was receiving a therapeutic diet. Review of Resident #117's care plan dated 03/10/25 revealed the resident had a nutritional problem or potential nutritional problem related to diagnoses including type two diabetes mellitus and schizoaffective disorder and needing a therapeutic diet. Interventions included providing and serving diet as ordered. 7. Review of medical record for Resident #50 revealed an admitted [DATE]. Diagnoses included type two diabetes mellitus, muscle weakness, and cognitive communication deficit. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #50's physician orders revealed an order dated 12/15/22 for Reduced Concentrated Sweets (RCS) diet, Mechanical Soft texture, Thin Liquid consistency. Review of Resident #50 MDS assessment dated [DATE] revealed the resident was cognitively intact and received a therapeutic and mechanically altered diet. Review of Resident #50's care plan dated 02/09/25 revealed the resident had a potential for alteration in nutrition and hydration related to diagnosis of diabetes mellitus and being on a therapeutic and mechanically altered diet. Interventions included providing diet as ordered. 8. Review of medical record for Resident #35 revealed an admitted [DATE]. Diagnoses included Parkinsonism (an umbrella term which refers to conditions with similar movement related effects), type two diabetes mellitus, and dysphagia (difficulty swallowing). Review of Resident #35's physician orders revealed an order, dated 01/10/24, for Reduced Concentrated Sweets (RCS) diet, Mechanical Soft Texture, Nectar Thickened Fluids consistency. Review of Resident #35's quarterly MDS assessment dated [DATE] revealed the resident had severe cognitive impairment and was receiving a mechanically altered and therapeutic diet. Review of Resident #35's care plan dated 03/03/25 revealed the resident had a potential for alteration in nutrition and hydration related to diagnoses of type two diabetes, Parkinsonism, and being on a mechanically altered and therapeutic diet along with thickened liquids. Interventions included providing diet as ordered. 9. Review of medical record for Resident #57 revealed an admitted [DATE]. Diagnoses included schizoaffective disorder, type two diabetes mellitus, and anemia. Review of Resident #57's physician orders revealed an order dated 11/01/22 for Reduced Concentrated Sweets (RCS) diet, Regular texture, Thin/Regular (liquids) diet. Review of Resident #57's annual MDS assessment dated [DATE] revealed the resident was cognitively intact and was receiving a therapeutic diet. Review of Resident #57's care plan dated 02/24/25 revealed the resident had a potential for alteration in nutrition and hydration related to diabetes and being on a therapeutic diet. Interventions included providing diet per order. 10. Review of medical record for Resident #5 revealed an admitted [DATE]. Diagnoses included schizophrenia, type two diabetes mellitus, and bipolar disorder. Review of physician orders for Resident #5 revealed an order dated for Reduced Concentrated Sweets (RCS) diet, Regular texture, Thin Liquids consistency. Review of Resident #5's quarterly MDS assessment dated [DATE] revealed the resident was mildly impaired cognitively and was receiving a therapeutic diet. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #5's care plan dated 03/18/25 revealed the resident had a potential for alteration in nutrition related to diagnoses of type two diabetes mellitus, schizophrenia, and bipolar disorder. Interventions included providing diet as ordered. 11. Review of medical record for Resident #4 revealed an admitted od 07/06/04. Diagnoses included type two diabetes mellitus, chronic pancreatitis, and chronic obstructive pulmonary disease (COPD). Review of Resident #4's physician orders revealed an order dated 11/14/24 for a Reduced Concentrated Sweets (RCS) diet, Mechanical Soft Texture, Thin/Regular (liquids) consistency. Review of Resident #4's quarterly MDS assessment dated [DATE] revealed the resident was moderately impaired cognitively and was receiving a mechanically altered and therapeutic diet. Review of Resident #4's care plan dated 04/01/25 revealed the resident had potential for alteration in nutrition and hydration related to needing an altered consistency/therapeutic diet. Interventions included provide diet per physician order. 12. Review of the facility's spreadsheet titled Garden 2024-2025 F/W(Fall/Winter) Menu revealed for lunch on week (4/08/25) one three-ounce pork steak baked, four ounces of scalloped potatoes, four ounces of green peas, one dinner roll, and one two (inch) by two (inch) brownie would be served. For residents on a Reduced Concentrated Sweets (RCS) diet, four ounces of fresh fruit would be served in place of the brownie. Observations on 04/08/25 from the beginning of tray line at 11:49 A.M. to the end of tray line at 12:33 P.M. revealed residents received a brownie if they were on a regular or mechanical soft consistency diet and received a pureed brownie if they were on a puree consistency diet. There was no observation of fresh fruit on the tray line or any residents receiving fresh fruit as a dessert. Interview on 04/08/25 at 12:21 P.M. with Dietary Aide #563, who was placing the desserts on the meal trays during tray line, confirmed residents received either a brownie or a puree brownie as their dessert for the meal. Interview on 04/08/25 at 12:37 P.M. with Assistant Regional Dietary #807 stated residents on a RCS diet should have received fresh fruit as their dessert instead of the brownie. Review of the facility policy Therapeutic Diets, revised November 2015, revealed the facility would ensure residents received diets as ordered.