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 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on observation, review of dietary schedules, review of posted mealtimes, and interview, the facility failed to ensure sufficient dietary staff to ensure meals were delivered in the scheduled time frame. This had the potential to affect all 73 residents residing in the facility. Findings include:1. Observations on 03/30/26 at 7:05 A.M., Dietary Aide #365 verified breakfast was scheduled to arrive on the Maple unit at 7:30 A.M., at the Pines rooms at 7:55 A.M. and in the Pines dining room at 8:10 A.M. This was consistent with posted tentative times for meals to arrive on the units.On 03/30/26, breakfast arrived on the Maple unit at 8:07 A.M.On 04/02/26 at 9:28 A.M., the cart containing the Pines dining room and Pines room meals arrived.On 04/02/26 at 9:05 A.M., [NAME] #370 and [NAME] #371 verified it was difficult to get meals out to the units at the scheduled times when there were two dietary staff working. Sometimes, like that day, there was a third person sent to the dietary department to provide assistance. The assistant that day, Certified Nursing Assistant (CNA) #332, arrived at 8:00 A.M. (1/2 hour after the first cart was scheduled to be delivered). Cooks #370 and #371 revealed when there were three regularly scheduled dietary staff working on Fridays and Saturdays they could deliver meals on time. Review of dietary schedules revealed on Mondays and Wednesdays, there were two dietary aides and/or cooks scheduled to work the 6:00 A.M. to 2:00 P.M. shift.2. Review of the tentative mealtimes for lunch revealed the Maple unit was scheduled for delivery at 11:30 A.M., Buckeye dining room was scheduled for delivery around 11:25 A.M., Pines rooms at 11:55 A.M. and Pines dining room at 12:10 P.M. Observations on 04/02/26 at 12:17 P.M. revealed dietary staff were still preparing the cart for Maple unit. On 04/02/26 at 12:30 P.M., Residents #3, #32, and #84 were observed sitting in the Buckeye dining room complaining about how hungry they were with one of them stating she was starving.On 04/02/26 at 12:53 P.M., the cart containing the trays for Pines rooms and dining room left the kitchen. The cart arrived to the Pines dining room at 12:55 P.M. The cart arrived on the Pines unit for those who ate in their rooms at 12:58 P.M. The last tray was served at 1:10 P.M. [NAME] #370 stated dietary appreciated when they were provided extra assistance from other departments, but it took extra time to get meals out because the staff from the other departments needed more direction of what to do verses having somebody who was already trained in the kitchen.

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

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, interviews and facility policy review, the facility failed to secure one of three medication storage rooms (Pines Unit) to prevent potential unauthorized resident entry. This had the potential to affect 25 residents (#1, #6, #7, #10, #15, #20, #23, #24, #25, #27, #31, #37, #39, #40, #43, #45, #49, #50, #52, #61, #63, #69, #72, #79, and #87) residing on the Pines Unit. The facility census was 73.Findings include:During observations conducted on 03/30/26 at 5:50 A.M., Licensed Practical Nurse (LPN) #382 left the facility before the arrival of scheduled oncoming staff for the Pines Unit. The medication storage room on that unit was left unsecured and accessible (it was unknown what time she left or how long the medications were left unsecured). Followˆup observations at 6:00 A.M. confirmed that medications were not secured inside the room, and several medications were left on the countertop, making them accessible to any resident entering the room. There were no residents observed around the medication storage room or the countertop at the time of the observation. At 6:01 A.M., LPN #341 was interviewed and stated that all medication storage rooms were required to remain locked at all times. LPN #341 acknowledged that the Pines Unit medication room had not been secured as required.An interview conducted on 03/30/26 at 11:20 A.M. with the Director of Nursing (DON) revealed that the DON was informed of the unsecured medication room and the unsecured medications. The DON confirmed that, according to facility policy, all medication storage rooms must remain locked and secured at all times. The DON also reported that LPN #382 was no longer employed by the facility.A review of the facility's Medication Labeling and Storage policy, dated 2001, indicated that all medications and biologicals must be stored in a locked cabinet, cart, or medication room that is inaccessible to residents and visitors. Access to medication keys is limited to authorized personnel only.

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.

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 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.

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 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. Based on review of personal funds balance, quarterly statements, and interview, the facility did not ensure residents with balances over $1800 received notifications to spend down. This affected two residents (#8 and #45) out of five residents reviewed for personal funds. The facility census was 73.Findings include:Review of the quarterly statement dated 02/18/26 revealed Resident #8 had accumulated a balance of $5496.14 as of 01/02/26, $4892.15 as of 02/02/26 and a balance of $6133.00 as of 02/18/26. Review of the quarterly statement dated 02/18/26 revealed Resident #45 had accumulated a balance of $3289.76 as of 01/02/26 and $4558.80 as of 02/18/26. Interview on 04/06/26 at 9:51 A.M. with Business Office Manager (BOM) #301 revealed she was unable to provide documentation showing the residents and/or residents' representatives were provided written notice to spend down personal funds as required.

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 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation and interview, the facility failed to post required nurse staffing information. This had the potential to affect all 73 residents residing in the facility.Findings include:On 03/30/26 at 6:05 A.M. revealed the only nurse staffing information posted was dated 03/27/26.On 03/30/26 at 6:05 A.M., Licensed Practical Nurse (LPN) #314 verified the posted staffing information was dated 03/27/26.