

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 02/11/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365769	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2024
NAME OF PROVIDER OR SUPPLIER Willows at Willard The		STREET ADDRESS, CITY, STATE, ZIP CODE 1050 Neal Zick Road Willard, OH 44890	
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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44454 Based on observation, medical record review and staff interview, the facility failed to ensure beds were maintain in a safe and functional manner. This affected one (#166) of one resident reviewed for physical environment. The facility census was 63. Findings include: Review of the medical record revealed Resident #166 admitted to the facility on [DATE]. Diagnoses included hypertension, gastroesophageal reflux disease, hyperlipidemia, arthritis, anxiety and depression. Observation on 11/18/24 at 10:45 A.M. revealed Resident #166 was sitting up in a wheelchair located in their room. The headboard and footboard attached to Resident #166's bed were both slanting outward from the bed frame. Concurrent interview with Resident #166 revealed the bed had been that way since admission to the facility. Interview on 11/18/24 at 10:48 A.M. with Registered Nurse (RN) #457 verified the headboard and footboard of Resident #166's bed were slanted outward and that was not how the bed was supposed to be. RN #457 reported they would check with maintenance to see what was wrong with the bed.		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35033 Based on medical record review, observation, staff interview and review of facility policy, the facility failed to complete wound care treatments per physician orders. This affected one (#28) of one resident reviewed for pressure ulcers. The facility census was 63. Findings include: Review of the medical record for Resident #28 revealed an admitted [DATE]. Diagnoses included Alzheimer's disease, vascular dementia, chronic kidney disease and polyneuropathy. Review of the quarterly Minimum Data Set (MDS) assessment, dated 09/09/24, revealed Resident #28 had no pressure ulcers. The resident had severely impaired cognition. Review of a wound progress note dated 09/19/24 revealed Resident #28 had a stage three pressure ulcer measuring 2.5 centimeters (cm) in length by four cm in width with a depth of 0.1 cm. The wound had light exudate, no odor, no undermining and no tunneling. The wound was 100 percent (%) granulation tissue with irregular wound edges. Review of a physician order dated 11/13/24 revealed an order to cleanse the right heel with Anasept Cleanser, dry, apply skin prep to peri wound, cut hydrogel impregnated gauze to size of eschar only and cover with dry bordered dressing daily. Review of the treatment administration record (TAR) revealed the right heel treatment was documented as completed on 11/19/24 by Licensed Practical Nurse (LPN) #475. Observation on 11/20/24 at 8:46 A.M. with LPN #401 of wound care for Resident #28 revealed the wound dressing in place was dated 11/18/24. LPN #401 confirmed the dressing was dated 11/18/24. LPN #401 revealed the dressing should be changed daily. Further observation revealed the resident had an unstageable pressure ulcer to the right heel with 100% eschar. The wound measured four cm in length by 2.5 cm in width with an undetermined depth with minimal serosanguinous drainage. The surrounding skin was dry and pink. Interview on 11/20/24 at 2:36 P.M. with LPN #475 verified she had not completed Resident #28's wound dressing change on 11/19/24 but documented she had completed the treatment. Review of the facility policy titled Guidelines for General Wound and Skin Care, revised 02/23/23, revealed no guidelines for completing wound care per physician orders.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 44454 Based on observation, medical record review, staff interview and review of facility policy, the facility failed to ensure hazardous chemicals were securely stored. This had the potential to affect seventeen residents (#4, #6, #10, #11, #24, #25, #34, #37, #39, #40, #46, #47, #48, #50, #52, #55, and #169) who were identified by the facility as independently mobile and cognitively impaired. The facility census was 63. Findings include: Observation on 11/20/24 at 9:12 A.M. of a storage closet located behind a nursing desk near the beginning of the 100-hall revealed the door to the storage closet was unlocked. Located inside of the storage closet, and within reach, were a can of disinfectant spray, which was labeled for caution and as hazardous to humans and animals; a container of germicidal disposable wipes, which were labeled for caution and to keep out of reach; and a bottle of disinfectant solution, which was labeled for caution and to keep out of reach. Interview on 11/20/24 at 9:17 A.M. with Registered Nurse (RN) #446 verified the storage closet was unlocked. RN #446 reported the door to the storage closet was kept unlocked and RN #446 was unsure of whether the door was required to be locked. A follow-up interview on 11/20/24 at 10:31 A.M. with RN #446 verified the door to the storage closet was supposed to be locked.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35033 Based on observation, medical record review, staff interview and review of facility policy, the facility failed to ensure oxygen administration was completed per physician orders. This affected one (#5) of one resident reviewed for respiratory care. The facility census was 63. Findings include: Review of the medical record for Resident #5 revealed an admitted [DATE]. Diagnoses included heart failure and shortness of breath. Review of the Minimum Data Set (MDS) assessment, dated 09/18/24, revealed Resident #5 had intact cognition. Review of the physician orders dated 03/08/24 revealed Resident #5 was ordered oxygen at two liters per minute per nasal cannula as needed for oxygen saturation levels less than 92 percent. Observation on 11/18/24 at 9:40 A.M. revealed Resident #5's oxygen administration rate was set at four liters per minute. Observation on 11/19/24 at 1:19 P.M. revealed Resident #5's oxygen administration rate was still set at four liters per minute. Interview on 11/19/24 at 1:19 P.M. with Licensed Practical Nurse (LPN) #475 verified Resident #5's oxygen rate was set at four liters per minute and should have been set at two liters per minute. Review of the facility policy titled Administration of Oxygen, revised May 2018, revealed to verify physician order for the procedure and the oxygen setting must be set and adjusted by a licensed nurse.		

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47057 Based on medical record review, review of nurse practitioner (NP) progress notes, staff interview and review of facility policy review, the facility failed to ensure required physician visits were completed. This affected six (#5, #11, #19, #28, #31 and #40) of six residents reviewed for physician visits. The facility census was 63. Findings include: 1. Review of the medical record for Resident #11 revealed an admitted [DATE] with diagnoses including cellulitis and dementia. Review of the quarterly Minimum Data Set (MDS) assessment, dated 11/01/24, revealed Resident #11 was cognitively impaired. Further review of the medical record revealed Resident #11 was seen by the NP at least monthly from 01/15/24 through 11/08/24. There was no evidence of a physician visit with the resident from 01/15/24 through 11/20/24. 2. Review of the medical record for Resident #19 revealed an admitted [DATE] with diagnoses including urinary retention, acute kidney failure and urinary obstruction. Review of the annual MDS assessment, dated 09/26/24, revealed Resident #19 was cognitively intact. Further review of the medical record revealed Resident #19 was seen by the NP at least monthly from 11/20/23 through 11/08/24. There was no evidence of a physician visit with the resident from 01/15/24 through 11/20/24. 44454 3. Review of the medical record revealed Resident #31 was admitted to the facility on [DATE]. Diagnoses included chronic kidney disease, anemia, metabolic encephalopathy, intervertebral disc degeneration, major depressive disorder, bilateral primary osteoarthritis of hip, mild protein-calorie malnutrition, dementia, constipation, weakness, altered mental status, pain, unsteadiness on feet, age-related physical debility, anxiety disorder, and overactive bladder. Review of the quarterly MDS assessment, dated 09/10/24, revealed the resident had severely impaired cognition. Further review of the medical record revealed Resident #31 was seen by the NP at least monthly from 10/11/23 through 11/08/24. There was no evidence of a physician visit with the resident from 10/11/23 through 11/20/24. 4. Review of the medical record revealed Resident #40 was admitted to the facility on [DATE]. Diagnoses included dementia, hypothyroidism, hyperlipidemia, hypertension, muscle weakness, need for assistance with personal care and chronic kidney disease. Review of the annual MDS assessment, dated 10/18/24, revealed the resident had impaired cognition. Further review of the medical record revealed Resident #40 was seen by the NP at least monthly from 10/11/23 through 11/08/24. There was no evidence of a physician visit with the resident from 10/11/23 through 11/20/24. (continued on next page)		

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	35033 5. Review of the medical record for Resident #5 revealed an admitted [DATE]. Diagnoses included heart failure and shortness of breath. Review of the MDS assessment, dated 09/18/24, revealed the resident had intact cognition. Further review of the medical record revealed Resident #5 was seen by the NP at least monthly from 10/11/23 through 11/08/24. There was no evidence of a physician visit with the resident from 10/11/23 through 11/20/24. 6. Review of the medical record for Resident #28 revealed an admitted [DATE]. Diagnoses included Alzheimer's disease, vascular dementia, chronic kidney disease and polyneuropathy. Review of the quarterly MDS assessment, dated 09/09/24, revealed the resident had severely impaired cognition. Further review of the medical record revealed Resident #28 was seen at least monthly by the NP from 10/27/23 through 10/21/24. There was no evidence the resident had been seen by the physician from 10/01/23 through 11/20/24. Interview on 11/21/24 at 12:22 P.M. with the Director of Nursing (DON) revealed the DON stated the six residents were seen by the physician; however, the facility had no evidence, including progress notes or other documentation, to confirm the visits occurred. Review of the facility policy titled Guidelines for Physician Services, revised 05/11/16, revealed the resident's attending physician was responsible for conducting required routine visits and delegating and supervising follow-up visits from NPs or physician assistants to ensure the resident received quality care and medical treatments.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44454 Based on resident interview, family interview, staff interview and medical record review, the facility failed to ensure medications were available for administration as physician ordered. This affected one (#168) of one resident reviewed for medication administration. The facility census was 63. Findings include: Review of the medical record revealed Resident #168 was admitted to the facility on [DATE]. Diagnoses included history of severe sepsis and becoming unstable, weakness, history of urinary tract infection (UTI), history of acute kidney injury on chronic kidney disease and chronic kidney disease. Review of the admission assessment dated [DATE] revealed Resident #168 was alert and oriented with no documented memory impairment or cognitive issues. Review of the nursing progress notes dated 11/13/24 and timed 4:50 P.M. revealed Resident #168 was admitted to the facility after being admitted to the hospital for diagnoses including severe sepsis, UTI and septic shock. The resident was on antibiotic therapy for severe sepsis and UTI. Review of a physician order dated 11/13/24 revealed an order for Caspofungin (used to treat fungal infections) to be administered every day between 6:00 A.M. and 10:00 A.M. The medication was started in the hospital on 11/08/24 and had a stop date of 11/21/24. Review of the nursing progress note dated 11/14/24 and timed 3:27 P.M. revealed the Caspofungin was unavailable and Resident #168 missed the dose of medication scheduled for 11/14/24. The medication end date was changed to 11/22/24 and the medication was scheduled for delivery to the facility on [DATE]. Review of the medication administration record (MAR) for November 2024 revealed Resident #168 did not receive the Caspofungin on 11/14/24 due to the medication being unavailable. Interview on 11/18/24 at 11:20 A.M. with Resident #168 and the resident's daughter revealed the resident was discovered to have a yeast infection and sepsis while in the hospital. The resident was supposed to receive IV antibiotics for 14 days. The medication was started in the hospital and was to continue at the facility. Resident #168 missed a dose of medication on 11/14/24 due to the facility not having the medication available. Interview on 11/20/24 at approximately 4:02 P.M. with the Director of Nursing (DON) verified Resident #168 did not receive the Caspofungin per physician order on 11/14/24 due to the facility not yet having the medication from the pharmacy.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35033 Based on observation, medical record review, staff interview and review of facility policy, the facility failed to ensure medications were not left unattended. This affected one (#27) of one resident reviewed for medication storage. The facility census was 63. Findings include: Review of the medical record for Resident #27 revealed an admitted [DATE]. Diagnoses included dyarthria (slurred speech) following cerebral infarction (stroke), dysphagia (difficulty swallowing), atrial fibrillation and mild cognitive impairment. Review of the quarterly Minimum Data Set (MDS) assessment, dated 09/06/24, revealed Resident #27 had intact cognition. Review of the physician orders revealed no orders for Resident #27 to self-administer medications. Review of the plan of care initiated 09/16/20 revealed Resident #27 had impaired swallowing related to dysphagia. Interventions included to observe resident closely for signs of choking and/or aspiration. Observation on 11/18/24 at 2:01 P.M. revealed Resident #27 in her room, sitting in her wheelchair, with the bedside table in front of her. On the bedside table were seven medications on a towel. There were no staff present in Resident #27's room. Interview on 11/18/24 at 2:01 P.M. with Registered Nurse (RN) #513 verified the seven medications were left, unattended, with Resident #27. RN #513 revealed she always left the resident's medication with her. Interview on 11/20/24 at 7:16 A.M. with the Director of Nursing (DON) verified Resident #27 had no orders to self-administer medications. The DON revealed she was not aware the nurse was leaving medications in the resident's room. Review of the facility policy titled Medication Administration General Guidelines, revised November 2018, revealed medications were administered at the time they were prepared, and the resident was always observed after administration to ensure the dose was completely ingested.		