STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365785	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willowood Care Center of Brunswick	1186 Hadcock Rd Brunswick, OH 44212

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. (continued on next page)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff and resident interview, and observation, the facility failed to ensure a resident who was dependent on staff with toileting received timely incontinence care. This affected one (#40) of three residents reviewed for incontinence care. The facility census was 72. Findings include: Review of the medical record for Resident #40 revealed an admission date 09/04/25. Diagnoses included congestive heart failure, dementia, anxiety, and depression. Review of the plan of care dated 09/15/25 revealed Resident #40 had a bladder incontinence focus area related to dementia. Interventions included to change when adult brief was soiled and as needed and check the resident every two hours for incontinence.Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #40 was cognitively intact. Resident #40 required partial to moderate assistance with toileting and was frequently incontinent of bladder. Observation on 12/03/25 at 8:14 A.M. revealed Resident #40's call light was displayed on the call light bar on 500-hall. Interview on 12/03/25 at 8:29 A.M. with Resident #40 stated she had been waiting for assistance for an hour and a half. She stated she had to go to the bathroom and put her call light on. No one came and she got up to the side of the bed and wet her bed. She stated she had to get herself up in her wheelchair. She tried to get to the bathroom and had another accident in her wheelchair. She did pull the call light in her bathroom also. She stated she saw a staff in the hall and yelled hey, hey and the staff person responded that they will be back but has not come back. Resident #40 was still waiting for assistance. Observation at this time revealed the pad on her bed was saturated with urine and her call light was turned on beside the bed and in the bathroom.Observation on 12/03/25 at 8:34 A.M. revealed the call light bar above the exit door on 500-hall was not displaying any room numbers just flashing asterisks and did not have the room number flashing. Interview on 12/03/25 at 8:52 A.M. with Certified Nurse Assistant (CNA) #304 stated she did not know Resident #40's call light was on and she had to finish passing breakfast trays.Observation on 12/03/25 at 9:05 A.M. of Resident #40's incontinence care with CNA #304 revealed Resident #40's pad on her bed was saturated with urine. Resident #40 was assisted into the bathroom to get cleaned up with CNA #304. Resident #40's adult brief was full of urine, her gown was wet and the cushion in her wheelchair was wet with urine.Interviews with CNA #304 and CNA #305 on 12/03/25 at 9:17 A.M. stated they did not know Resident #40's call light was on. CNA #305 stated she came in around 6:50 A.M. and made her rounds and no one needed assistance at that time. CNA #305 stated she was busy with getting showers, assisting with breakfast and did not know Resident #40's call light was on. Interview on 12/03/25 at 9:30 A.M. with the Assistant Director of Nursing (ADON) #500 revealed she has not been made aware that the call light bar on the wall that displays which call light was turned on for the room number was not working correctly all the time. Observation of the call light bar at this time with ADON #500 revealed the call light bar was working and showed call lights were on and where. After a few minutes, the call light bar went black and started flashing asterisks across it and not the call light that was still on. ADON #500 verified 45 minutes was too long to wait to get assistance and verified the call light bar on the 500 hall was not functioning correctly. ADON #500 stated the aide should be looking at both call light bars, the one on the 500 and 600 halls and should have answered Resident #40's call light timely. This deficiency represents non-compliance investigated under Complaint Number 2661310.