

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  515085	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/30/2025
NAME OF PROVIDER OR SUPPLIER  Willows Center		STREET ADDRESS, CITY, STATE, ZIP CODE 723 Summers Street Parkersburg, WV 26101	

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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>Based on record review, staff interview, and family interview the facility failed to inform the Medical power of Attorney (MPOA) of appointments for Resident #46. This failed practice was found true for (1) one of (3) three residents reviewed. Resident identifiers # 46, Facility Census 91. Findings included: Resident # 46 Medical Power of Attorney(MPOA): During a phone interview on 10/29/25 at 11:40 AM, (statement written as reported) The MPOA, for Resident #46 stated, The first time the van driver took him (Resident #46), to a Dr. appointment, wearing a wander guard bracelet and left him without checking to see if I was there was in October of 2024. I found out he had an appointment when I received a phone call from the Dr's office letting me know he was there and stated they were surprised I wasn't with him. They know me there and know that I am always with him. She also stated it happened on January 9, 2025 and January 28 2025. She stated she then complained to the Director Of Nursing (DON) on January 29, 2025 and didn't hear back from her until 02/02/25. The DON told her the Van driver had been transferred and would no longer be driving for this facility. Record Reviews: -Based on record reviews of Resident #46's Progress notes and the transfer appointment logs, it was verified that resident #46 had been transported to Neurology appointments on 01/09/2025, and 01/29/2025 The Progress notes stated Resident #46 was transferred with staff present. Corporate Coordinator interview: During an interview with the Facility Corporate Coordinator on 10/28/25 at 2:44 PM, he acknowledged the facility should have made sure Resident's MPOA was notified of Resident #46's appointment and the resident was left at the appointment without staff present and provided a copy of employee statement who drove the van, dated 2/8/25, stating On 01/29/25, he became ill after dropping resident #46 off, notified the facility, and left to go to the local emergency room. The Corporate Coordinator was not able provide any information or statements for the appointment incident on 01/09/25.</p>

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:  515085	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/30/2025
NAME OF PROVIDER OR SUPPLIER  Willows Center		STREET ADDRESS, CITY, STATE, ZIP CODE  723 Summers Street Parkersburg, WV 26101	
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)		
<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>Based on record review, resident representative interview, and staff interviews, the facility failed to process and investigate a reported grievance. This was true for (1) of (3 ) residents sampled Resident Identifier: #46 Facility Census: 91 Findings Included:a) Per The Facility Grievance Policy, the grievance officer will oversee grievances through conclusion leading any necessary investigations by the facility, issuing written decisions to the patient, and coordinating with state and federal agencies.b) In an interview with resident # 46's MPOA on 10/28/25 at 2:20pm, she stated the facility had transported Resident # 46 to an appointment more than once without notifying her in advance of the appointments. She stated the first time was in October of 2024. On 01/09/2025 and on 01/29/25. the van driver dropped him off without making sure she was there for him. She stated she called and complained directly to facility Director of Nursing. c) Record reviews:-On 10/28/25 at 03:45 PM, During record review the grievance form, there were not any grievances/complaints from Resident #46's MPOA logged in r/t the above listed dates.-Based on record reviews of Resident #46's Progress notes and the transfer appointment logs, it was verified that resident #46 had been transported to appointments on 01/09/2025, and 01/29/2025 The Progress notes stated Resident #46 was transferred with staff present. Staff Interviews:d) In an interview with the Facility Corporate Coordinator on 10/28/25 at 2:44 PM, he acknowledged the grievances were not logged into the grievance log and was not able to provide a completed copy of the grievance form or a completed investigation Corporate Coordinator interview:During an interview with the Facility Corporate Coordinator on 10/28/25 at 2:44 PM, he acknowledged the facility should have made sure Resident's MPOA was notified of Resident #46's appointments and that the resident was left at the appointments without staff present and provided a copy of employee statement who drove the van, dated 2/8/25, stating On 01/29/25, he became ill after dropping resident #46 off, notified the facility, and left to go to the local emergency room. The Corporate Coordinator was not able provide any information or statements for the appointment incident on 01/09/25.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  515085	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/30/2025
NAME OF PROVIDER OR SUPPLIER  Willows Center		STREET ADDRESS, CITY, STATE, ZIP CODE  723 Summers Street Parkersburg, WV 26101	
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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on observation, record review, and staff interviews, the facility failed to ensure professional care and standards of practice were followed in regards to meal time supervision for resident #4. This was true for one (1) of (3) residents reviewed. Resident Identifiers: # 4, # 61, and # 27 . Facility Census: 91Findings Included:a) Observation:-During an observation of meal pass on 10/29/25 at 12:44PM, Resident # 4 was served his meal by employee identifier # 60. She assisted in setting up his tray and drink and left the resident's room.b) Record Review:-Based on a review of resident #4's meal ticket and his care plan, It was ordered to have supervision at mealtimes.-A review of Facility, Meal Service Policy Practice Standards, 3.2. 2, Assure the correct meal is served and 3.2.5 If the patient requires assistance, sit next to patient while assisting to eat or do not deliver tray until assistance can be provided.c) Staff Interviews:-During an interview with the Facility Corporate Coordinator, on 10/29/25 at 1:25PM, He acknowledged the care plan and the meal ticket stated Resident #4 should have had staff supervision while eating his meal. -During an interview with staff identifier # 60 On 10/29/2025 at 1:35 PM, she stated she did not see resident #4's meal ticket had supervision written on it. -During an interview with staff identifier # 103 on 10/29/25 at 1:40PM, she stated she had documented resident #4's as delivered and acknowledged that Resident #4's meal should have been supervised.</p>		