STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155089	A. Building B. Wing	07/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willows of New Castle	1023 N 20th St New Castle, IN 47362

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to prevent a resident from eloping (leaving the facility without others being aware or giving permission) through the resident's room window for 1 of 3 residents reviewed for elopement. (Resident B) The deficient practice was corrected on 7-23-25, prior to the start of the survey, and was therefore past noncompliance. The facility had completed a physical assessment of the resident after the elopement, placed her on one-on-one direct supervision by facility staff, began an immediate investigation of the elopement, conducted interviews with facility staff regarding the elopement, conducted education with all staff on elopement policy and what to do in the event of an elopement, conducted an elopement drill, conducted an audit of all exit doors and alarms, ensured all windows were secured to not allow an opening more than six (6) inches and completed new assessments on all residents for wandering and elopement risks. Care plans were updated to reflect any residents which were indicated to be an elopement risk. Resident B remained under direct supervision until she was discharged to an area facility with a secured memory care unit. Findings include:The facility submitted a reportable incident to the Indiana Department of Health's Long-Term Care (IDOH-LTC) division on 7-18-25, which indicated Resident B had been found on 7-18-25, outside facility, on facility grounds at 3:10 p.m. Prior to incident, at 3pm [3:00 p.m.], resident and staff member [were in the resident's] in room attempting to make phone call to daughter. It indicated a therapy staff member had observed the resident outside of the facility. Licensed nurse immediately notified, and head to toe assessment completed. Vital signs within normal limits. Resident was clothed appropriately. Current temp 82 degrees. Resident [NAME] [sic] back inside of facility and offered refreshments. No distress noted. Staff interviews and investigation [were] initiated. Family, MD [medical provider], ED [Executive Director], ombudsman notified of incident. No injuries noted. 1:1 [one-on-one direct supervision] will now be provided by staff. All pertinent information will be added to 5- day follow up. Family and MD in agreement with plan of care. A 5-day follow-up report was sent to the IDOH-LTC division on 7-23-25, which indicated Resident B had been discharged to a local facility with a secured memory care unit. It indicated Resident B had sustained a non-emergent skin tear during her elopement. It indicated the facility had conducted an investigation which included, but was not limited to, staff statements related to the elopement, all staff were educated on the facility's elopement policy, an elopement drill had been conducted successfully, the maintenance department had conducted an audit of all exit doors and alarms with no issues identified, windows were secured to not allow opening more than six (6) inches and the Minimum Data Set (MDS) Coordinator had completed new assessments on all residents for wandering and elopement risks. In an interview on 7-28-25 at 12:15 p.m., with the ED, she indicated Resident B had been experiencing escalating behaviors in the weeks prior to the elopement, for which the facility had involved psychiatric services and her primary care doctor, as well as the resident's family. The ED indicated a urinalysis had (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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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	been obtained with the results being negative. There were several med changes. At the time she eloped, she was on 15-minute checks and then we advanced those to 1:1 after the elopement out of her window. She had been sent out a time or two [to psychiatric facilities] for behaviors. My guess is that her dementia was advancing and she is now in a safer environment. A social services progress note, dated 7-16-25 at 2:56 p.m., indicated a family member of Resident B had scheduled a tour with a local facility to visit their memory care unit, related to possibly transferring Resident B to that facility's memory care unit. In an interview on 7-28-25 at 2:48 p.m., with the Director of Nursing (DON), she indicated Resident B remained on every 15- minute visual checks prior to the elopement. She indicated on the night shift of 7-17-25 through 7-18-25, the nursing staff had someone sitting with her and I think the reason they had charted she was on 1:1's during the night, was she seemed to need more attention. The morning of 7-18, she was actually on every 15-minute checks. The staff member who had been sitting with her [on the afternoon of 7-18-25] came back to the room and found the screen broken out of the window. Of course, after that, she was [placed] on 1:1's until she was discharged . The clinical record of Resident B was reviewed on 7-28-25 at 11:47 a.m. Her diagnoses included, but were not limited to, early onset Alzheimer's disease, dementia, hallucinations, unspecified psychosis and depression. A review of her most recent MDS assessment, dated 6-18-25, indicated she was moderately cognitively impaired, did display wandering behaviors, which were unchanged from the previous assessment time frame. It indicated she was independently ambulatory with the use of a walker and had no falls since the last assessment time frame. Elopement risk assessments, dated 6-16-25 and 7-18-25, indicated she was at risk for elopement. A care plan for Resident B, developed on 3-31-25 and updated on 7-11-25 and 7-18-25, indicated she wanders aimlessly trying to enter doors.refuses to wear wander guard [security device used to assist in provision of safe boundaries]. Another care plan was developed on 6-9-24 and updated on 8-9-24, indicated Resident B had impaired cognition as evidenced by diagnoses of dementia and Alzheimer's disease and via cognitive assessments. On 7-28-25 at 1:20 p.m., the ED provided a copy of an undated policy entitled, Missing/Wandering Resident. This policy indicated it purpose was to locate the missing or wandering resident as soon as possible. It indicated the administrative team and charge nurse are to be notified immediately when a resident is missing. The administrative team and/or charge nurse will organize a thorough search of the premises. Notification will be made to all staff of the potentially missing resident.[including] the name and description of the missing resident.will include the clothing worn, if the resident is ambulatory or uses a wheelchair/walker, and any other information that may be useful.If the resident is not located on the premises, a more extensive search will be conducted as directed by the Administrator/DON. As appropriate, the Administrator will notify the resident's family, the police authorities, the Indiana State Board of Health, Adult Protective Services and the Ombudsman.Once the resident is located.Administrator/DON will conduct a reassessment of events to determine whether present placement is appropriate for the resident's needs and condition. The resident will have an Elopement Risk Assessment completed to assess his/her current risk.The Care Plan will be updated and reviewed for new interventions initiated related to the elopement. Family, resident, and staff will be notified of the new interventions initiated. This citation relates to Complaint 2566622. 3.1-45(a)(1)3.1-45(a)(2)