STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155228	A. Building B. Wing	10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willows of Richmond	2070 Chester Blvd Richmond, IN 47374

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on interview and record review, the facility failed to assure a grievance was forwarded to the grievance official for a lost item for 1 of 4 residents reviewed for grievances.(Resident B) Findings include:The clinical record for Resident B was reviewed on 10/14/25 at 1:30 p.m. The diagnoses included, but were not limited to, hypertension and flaccid hemiplegia (a condition where one side of the body experiences weakness and loss of muscle tone).The Annual Minimum Data Set (MDS) assessment, dated 9/5/25, indicated Resident B was cognitively intact.During an interview with Resident B, on 10/14/25 at 2:05 p.m., the resident indicated they had lost their cell phone a couple of months ago. The resident had told nursing staff about the lost phone, but no one had ever followed up with her about it. Resident B indicated she would have to go to the nurse's station to make or receive any phone calls.During an interview with Certified Nursing Assistant (CNA) 2 on 10/14/25 at 2:18 p.m. CNA 2 indicated Resident B did have a cell phone (flip phone) that she would use and a couple of months ago, The resident had indicated they did not know where their cell phone was at. CNA 2 indicated she had not filed a grievance form for Resident B, but she told the Social Service Director (SSD) about the missing cell phone.During an interview with the SSD on 10/14/25 at 2:25 p.m., they indicated they could not remember if CNA 2 had told them about Resident B having a missing phone. The SSD indicated a grievance form was never filled out for Resident B's missing cell phone. The person receiving the grievance was who needed to fill out a grievance form and then it would be given to herself or placed under her door (if she was gone) to follow up on.The plan of care for Resident B, dated 11/14/24, indicated Resident B enjoyed activities such as talking with her family on the phone.The Resident and Family Grievances policy was provided by the Director of Nursing (DON) on 10/15/25 at 12:46 p.m. It indicated,.1. The Grievance Official is responsible for overseeing the grievance process; receiving and tracking grievances through to their conclusion; leading any necessary investigations by the facility.6. Grievances may be voiced in the following forums: a. Verbal complaint to a staff member.8. Procedure: b. The staff member receiving the grievance will record the nature and specifics of the grievance on the designated grievance form.c. Forward the grievance form to the Grievance Official as soon as practicable.e. The Grievance Official, or designee, will keep the resident appropriately apprised of progress towards resolution of the grievances. This citation relates to intake 26398823.1-7(a)(2)

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