VERMONT

Department of Disabilities, Aging and Independent Living
Division of Licensing and Protection
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AGENCY OF HUMAN SERVICES

Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

November 6, 2025

Laurie Griswold, Manager
Willows Of Windsor
121 State Street
Windsor, VT 05089-1213

Dear Ms. Griswold:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **October 6, 2025.** Please post this document in a prominent place in your facility.

We may follow up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

If you have any questions, please feel free to contact me at (802) 585-0995.

Sincerely,

Carolyn Scott, LMHC, MS
State Long Term Care Manager
Division of Licensing & Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0044	A. BUILDING: _____ B. WING _____	C 10/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWS OF WINDSOR	121 STATE STREET WINDSOR, VT 05089

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments On 10/6/25 the Division of Licensing and Protection conducted an unannounced on-site annual re-licensing survey and an investigation of one complaint. One deficiency was identified as immediate jeopardy to at least one resident of the home requiring the home to develop an immediate Plan of correction (IPOC). The IPOC was submitted and approved by the licensing agency on 10-6-25. The following deficiencies were identified:	R100		
R105 SS=F	5.2.a Uniform Consumer Disclosure-Admit Agreements The licensee upon initial licensure must state the services it can and will provide, the public programs or benefits that it accepts or delivers, the policies that affect a resident's ability to remain in the home, and any other relevant information. (1) The uniform consumer disclosure must be completed on a form provided by the licensing agency and must be kept on file by the licensee. (2) The uniform consumer disclosure must include a statement describing the daily, weekly or monthly rate to be charged, a description of the services that are covered in the rate and all other applicable financial issues. (3) The uniform consumer disclosure must include a statement that rates are subject to change, including rate changes due to increased care needs,and describe the situations in which the changes (s) could occur. (4) The uniform consumer disclosure must be provided; i. to residents prior to or at admission and at any time it is changed or is requested by the resident; and	R105		

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R105	Continued From page 1 ii. to the public upon request (5) The availability of a uniform consumer disclosure must be noted prominently in all marketing brochures and written materials. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there is a failure to implement use of the Uniform Consumer Disclosure form provided by the licensing agency to state the services the home can and will provide, public programs and benefits accepted or delivered by the home, policies that affect a resident's ability to return to the home, and other relevant information as required. Findings include: Policies and procedures governing provision of Uniform Consumer Disclosure statements have not been developed by the home. A completed Uniform Consumer Disclosure form was not on file at the home as of 10/6/25. Per record review, four residents (Residents #1, #2, #3 and #4) have been admitted to the home since April 1, 2025 when the Vermont Residential Care Home and Assisted Living Residence Licensing Rules went into effect including the requirement for the home to provide a completed copy of a completed Uniform Consumer Disclosure form to residents prior to or at admission, at any time it is changed, and upon resident or public request. During the survey	R105		

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R105	Continued From page 2 conducted on 10/6/25, the Owner/Manager indicated they were unaware of this licensing rule and confirmed use of the Uniform Consumer Disclosure form provided by the licensing agency had not been implemented by the home.	R105		
R142 SS=J	5.5.d General Care A home must provide each resident with adequate supervision and must facilitate obtaining assistive devices sufficient to prevent accidents, and/or to mitigate risk of injury due to accidents. This REQUIREMENT is not met as evidenced by: Based on staff and resident interviews and record review there is a failure to provide adequate supervision to mitigate the risk of injuries for one applicable resident (Resident #1). Findings include: The home's Nursing Overview policy states, "Every staff member will monitor each resident closely through observation. Every staff member is responsible to monitor our residents in accordance with their individual needs and as described in their specific care plan. "The General Supervision section of the home's Admission Agreement provided by the Owner/Manager for review states, "General Supervision here includes ... Monitoring your activities to prevent harm to you." The Nursing Care section of the Admission Agreement states, "We will call on our nurse as necessary if a resident's condition warrants it. Including if ...your ability to care for yourself appears to be deteriorating."	R142		

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R142	Continued From page 3 Per record review Resident #1's diagnoses include mental health conditions, digestive system conditions, a condition that impacts their mobility, and chronic pain. Per review of the Service Plan on file, Resident #1 requires the use of a walker without assistance in the home, a wheelchair while in the community, and the assistance of one person while on outings. Resident #1's Service Plan indicates Resident #1's shopping is "done by others", and states Resident #1's short term and long term memory are impaired. Per staff interviews and record review, Resident #1 has a history of unsafe behaviors related to alcohol intoxication in the community. Progress Notes dated 6/28/25 and 7/11/25 indicate on 6/27/25 Staff discovered wine in Resident #1's room, and poured it down the sink. In response, Resident #1 left the home and was later found intoxicated behind a local store and was escorted back to the home by police. Progress Notes also document an incident on 9/4/25 when Resident #1 utilized public transportation to travel to a local supermarket and was subsequently found intoxicated on the ground with a half bottle of wine. Per record review, Resident #1's Care Plan and Service Plan were not updated to include identification of resident needs and safety concerns related to these incidents, and do not include goals and interventions to ensure adequate monitoring, supervision, and staff response to Resident #1's behaviors. Per record review, a Sign In/Sign Out Sheet indicates Resident #1 left the home to go to a local store at 2:48 PM on 9/30/25, and the words "Never returned" are written beside the sign-in section this entry by staff. Per review of a	R142		

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R142	Continued From page 4 Progress Note written by the home's Registered Nurse on 9/30/25, on return from the store Staff observed Resident #1 outside the home attempting to conceal a partially consumed bottle of wine. The Progress Note states Staff informed Resident #1 of the home's "NO DRINKING" policy, and Resident #1 responded by stating "I will drink if I want to" and walking away from the home using their walker at approximately 3:30 PM. This Progress Note states the local police were notified that Resident #1 "had been drinking". Per interview with the Owner/Manager and Registered Nurse commencing at 2:57 PM on 10/6/25, Resident #1 did not return to the home on the night of 9/30/25. During this interview the Registered Nurse confirmed they were present during this incident and stated they called the home in the morning after not receiving any communication from Staff during the night about Resident #1. Per the Owner/ Manager, Resident #1 was found by emergency personnel at a local convenience store "drunk and throwing things at people" and stated the convenience store "called the police after Resident #1 had slept there all night". At 3:23 PM on 10/6/25 the Registered Nurse confirmed no one in the home knew Resident #1's whereabouts from the time they walked away from the home at approximately 3:30 PM on 9/30/25 until 1:00 PM on 10/1/25 when the hospital notified the home that Resident #1 was in the Emergency Department. Per the hospital's Final Report, Resident #1 was admitted for Hypothermia due to sleeping outside in 35-degree Fahrenheit weather without cold protection and Rhabdomyolysis "consistent with being down for an extended period of time". Rhabdomyolysis	R142		

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R142	Continued From page 5	R142		

results from muscle tissue breakdown and release of muscle fiber into the bloodstream, which is a significant risk for kidney damage. In addition to falls and loss of consciousness without being able to get up for an extended period of time, Hypothermia is also a risk for Rhabdomyolysis. The hospital's Final Report also notes Resident #1 had consumed "2 bottles of wine (20 standard drinks) " the night before admission, and reported Resident #1 had 2 episodes of "Coffee Ground Emesis" (dark colored vomit indicative of internal bleeding) likely due to alcohol use. Resident #1 was hospitalized for 2 days, then discharged back to the home.

During interviews conducted on the afternoon of 10/6/25, staff on duty stated room checks are supposed to be done every two hours and confirmed room checks are not documented. One staff reported the scheduled room checks are typically only done during the night shift. During the interview commencing at 2:57 PM on 10/6/25, the Owner/Manager confirmed staff are required to do room checks every 2 hours on all shifts and confirmed the previous method for documenting checks is no longer used at the home. During this interview the Owner/Manager stated Resident #1 "was never missing", and confirmed staff did not do checks to monitor for Resident #1's return from the store on the night of 9/30/25 because they "already knew" Resident #1 was gone and had not come back. When asked what corrective actions have been implemented in response to the incident on 9/30/25 the Registered Nurse stated they are checking Resident #1's vital signs now. The Owner /Manager stated the home was not providing increased supervision for Resident #1 because they were "never a flight risk".

The home's failure to provide Resident #1 with

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R142	Continued From page 6 adequate supervision to mitigate risk for injury following actual injuries that occurred on the night of 9/30/25 was determined to pose an immediate threat to Resident #1's health and safety. In response to this finding the Owner/Manager submitted a plan of immediate corrective actions to monitor the time Resident #1 exits the home and ensure appropriate actions are taken when this Resident is away from the home "longer than 2 hours", "longer than 12 hours", and "upon return to the home. The Owner/Manager's Immediate Plan of Action was accepted by the State Long Term Care Manager on the evening of 10/6/25.	R142		
R196 SS=D	5.10.d (5) Medication Management Staff other than a nurse may administer PRN psychoactive medications only when the home has a written plan for the use of the PRN medication which: describes the specific behaviors the medication is intended to correct or address; identifies any known triggers for the behaviors; specifies the circumstances that indicate the use of the medication; educates the staff about what desired effects or undesired side effects the staff must monitor for; and documents the time of, reason for and specific results of the medication use. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there is a failure to develop a written plan for the administration of the PRN medication Hydroxyzine by staff other than a nurse, and a failure to document the effects of Hydroxyzine when administered as needed for Anxiety for one applicable resident (Resident #2). Findings include:	R196		

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R196	Continued From page 7 The home's PRN Psychoactive Medications policy is consistent with this licensing requirement. 1. Per record review, Resident #2 is prescribed and administered the medication Hydroxyzine as needed (PRN) for Anxiety. At 12:36 PM on 10/6/25 the Registered Nurse confirmed they had not developed a written plan for the administration of Resident #2's PRN Hydroxyzine by staff other than a nurse. 2. During a review of Resident #2's October 2024 Medication Administration Record, the Registered Nurse confirmed the effects of PRN Hydroxyzine administered to Resident #2 were not documented at 12:45 PM on 10/6/25.	R196		
R197 SS=D	5.10.d (5)(i) Medication Management Unlicensed staff must not administer anti-psychotic medications on a PRN or "as needed" basis, unless the delegating registered nurse gives verbal permission prior to administration for each dose, which must be documented. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there is a failure to ensure unlicensed staff obtain verbal permission from the Registered Nurse prior to administering the medication Hydroxyzine to one applicable resident (Resident #2) as	R197		

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R197	Continued From page 8 needed for Anxiety. Findings include: The home's PRN Psychoactive Medications policy is not consistent with this licensing requirement. Per record review Resident #2 is prescribed and utilizes medication Hydroxyzine or anxiety as needed (PRN). At 12:35 PM on 10/6/25 the Registered Nurse confirmed unlicensed staff do not obtain their permission prior to administering PRN psychoactive medications.	R197		
R210 SS=F	5.11.c Staff Services The home must provide, or arrange for the provision of, at least twelve (12) hours of training upon hire and each year to each staff person providing direct care to residents. The manager may give credit towards the required 12 hours of training upon hire, for any formal training received in the twelve months preceding the date of hire, provided the home maintains documentation of the training and ensures competency in the subject matter. The training must include, but is not limited to, the following: (1)Resident rights; (2) Fire safety and emergency evacuation; (3) Resident emergency response procedures, such as the Heimlich maneuver, accidents, police or ambulance contact and first aid; (4) Policies and procedures regarding mandatory reports of abuse, neglect and exploitation; (5) Respectful and effective interaction with residents; (6) Infection control measures, including but not limited to, hand washing, handling of linens, maintaining clean environments, blood borne	R210		

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R210	Continued From page 9 pathogens and universal precautions; (7) General supervision and care of residents; (8)Communication strategies, person-centered care, challenging behaviors and understanding dementia; (9) Recognition of and sensitivity to different cultures, belief systems, abilities, gender identities, sexual orientation; and (10) Trauma-informed care. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there is a failure to provide documentation which demonstrates completion of required trainings for 5 out of 5 sampled staff. Findings include: The home's Staff Services policy includes an outdated Vermont Residential Care Home licensing regulation which is not consistent with the current training requirements for all direct care staff upon hire and yearly thereafter as defined in the Vermont Residential Care Home and Assisted Living Residence Licensing Rules effective April 1, 2025. At 12:16 PM on 10/6/25 the Owner/Manager of the home was requested to provide documentation of the required trainings completed upon hire and yearly thereafter. Following this and subsequent requests on the afternoon of 10/6/25, the Owner Manager failed to provide the requested documentation for all 5 sampled staff. This finding was confirmed by the Owner/Director at 5:50 PM on 10/6/25.	R210		

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R229	Continued From page 10	R229		
R229 SS=D	5.12.c (3) Records/Reports A home must file the following reports with the licensing agency: Any unexplained absence of a resident from a home for more than two (2) hours must be reported to the police, legal representative and family, if any. The incident must be reported to the licensing agency within twelve (12) hours of disappearance, followed by a written report within forty-eight (48) hours, a copy of which must be maintained. This REQUIREMENT is not met as evidenced by: Per record review and staff interview there is a failure to notify the family and the licensing agency regarding one applicable resident's unexplained absence from the home (Resident #1). Findings include: Policies and procedures for reporting unexplained resident absences have not been developed by the home. Per record review Resident #1 is diagnosed with a mental health condition, digestive system conditions, and a condition that impacts their mobility and causes pain. Per review of the Service Plan on file, Resident #1 has short- and long-term memory impairment. This Service Plan also states Resident #1 requires the use of a walker in the home, a wheelchair while in the community, the assistance of one person while on outings; and states shopping is "done by others" for Resident #1.	R229		

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R229	Continued From page 11 Per record review, a Sign In/Sign Out Sheet indicates Resident #1 left the home to go to a local store at 2:48 PM on 9/30/25, and the words "Never returned" are written beside the sign in section of this entry by staff. Per review of a Progress Note written by the home's Registered Nurse on 9/30/25, Staff observed Resident #1 outside the home with an open bottle of wine. The Progress Note states Staff informed Resident #1 of the home's "NO DRINKING' policy" and Resident #1 responded stating "I will drink if I want to", then walked away from the home with their walker at approximately 3:30 PM. Per interview with the Owner/Manager and Registered Nurse commencing at 2:57 PM on 10/6/25, Resident #1 did not return to the home on the night of 9/30/25. Per interview At 3:23 PM on 10/6/25, the Registered Nurse confirmed no one in the home knew Resident #1's whereabouts from the time they walked away from the home at approximately 3:30 PM on 9/30/25 until 1:00 PM on 10/1/25 when the hospital notified the home that Resident #1 was in the Emergency Department. Per the Hospital's Final Report, Resident #1 was admitted for Hypothermia due to sleeping outside in 35-degree Fahrenheit weather without cold protection and Rhabdomyolysis "consistent with being down for an extended period of time". On the afternoon of 10/6/25 the Registered Nurse confirmed Resident #1 was hospitalized for 2 days, then discharged back to the home.	R229		
R342 SS=F	5.15 Policies and Procedures Each home must have written policies and procedures that govern all services provided by	R342		

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R342	Continued From page 12 the home. A copy must be available at the home for review upon request by residents and their representatives, advocacy organizations and the licensing agency. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there is a failure to develop policies and procedures governing all services provided by the home. Findings include: During the survey conducted on 10/6/25 the Owner/Manager was requested to provide copies of policies and procedures related to potential deficiencies identified through observation, staff and resident interviews, and record review. During interviews conducted on 10/6/25, the Owner Manager confirmed policies and procedures governing services provided had not been developed. This finding was additionally substantiated through Surveyor review of a digital copy of the home's policies and procedures manual provided by via email at 10:16 AM on 10/7/25. Per staff interview and record review policies and procedures governing the following areas of service have not been developed by the home: * Use of the Uniform Consumer Disclosure Form provided by the licensing agency *Water temperatures in resident accessible areas *Maintenance of the Residential Living Environment *Secure storage of chemicals *Secure storage of resident's records and personal information *Current licensing requirements for staff training	R342		

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R342	Continued From page 13 upon hire and annually thereafter *Completion of staff criminal record and abuse registry checks *Resident access to an operable telephone with emergency numbers at all times *Obtaining the Registered Nurse's permission prior to administration of PRN psychoactive medications *Reporting of Unexplained Resident Absences On the afternoon of 10/6/25 the Owner/Manager also confirmed a copy of the home's policies and procedures manual had not been placed in an area of the home accessible to residents and visitors of the home at all times.	R342		
R394 SS=F	7.3.i Food Storage and Equipment Poisonous compounds (such as cleaning products and insecticides) must be labeled for easy identification and must not be stored in the food storage area unless they are stored in a separate, locked compartment within the food storage area. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there is a failure to ensure poisonous compounds stored in the food storage area are stored in a separate locked compartment. Findings include: The home's Food Storage and Equipment policy is consistent with this licensing requirement. At 1:33 PM on 10/6/25 the food storage room, which is also utilized as a medication room and laundry room, was observed with laundry	R394		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0044	A. BUILDING: _____ B. WING _____	C 10/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWS OF WINDSOR	121 STATE STREET WINDSOR, VT 05089

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R394	Continued From page 14 detergent and dishwashing detergent stored on the floor beneath the open framework shelving unit used to store food and beverages. At countertop in this room was observed with laundry detergent and a box of Bounce Dryer Sheets which was open and without a cover. An unlocked storage cabinet in this room was filled with cleaning chemicals including disinfectant sprays and wipes, furniture polish, a gallon of OdoBan odor eliminating sanitizer, a can of Comet cleaning powder, and boxes of dryer sheets. This finding was confirmed by the Med Tech on duty at 1:37 PM on 10/6/25.	R394		
R403 SS=F	9.1.c Environment The home must ensure that the resident environment remains as free of accident hazards as possible. Maintaining a safe environment must include the safe storage and clear labeling of chemical agents, which must include secure storage of such agents if the home has residents with cognitive impairment. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there is a failure to ensure safe secure storage of chemical agents in resident accessible areas of the home. Findings include: Policies and procedures governing safe and secure storage of chemical agents have not been developed by the home. Residents of the home have varying abilities to	R403		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0044	A. BUILDING: _____ B. WING _____	C 10/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWS OF WINDSOR	121 STATE STREET WINDSOR, VT 05089

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R403	Continued From page 15 safely manage access to chemical agents. During a tour of the resident environment commencing at 12:47 PM on 10/6/25 unsecured chemical agents were observed to be unsecured in resident accessible areas including: 1. A shared resident bathroom in the basement was observed with a spray bottle of a cleaning product that appeared to be glass cleaner in an unlocked cabinet under the sink. An unlocked bathroom beside the Owner's office was observed with cleaning chemicals including spray bottles of cleaner/degreaser and glass cleaner, carpet/room deodorizer and a gallon of bleach. 2. An unlocked storage area contained unsecured gallons of paint, cans of varnish and wood stain, paint thinner, leather cleaner, cans of all purpose cement for sealing pipes, bottles of Blaster and WD40 spray lubricant, Minwax, and Zep carpet cleaner. 3. A spray can of WD40 and a nicotine vape pen belonging to a staff member were observed to be accessible to residents in an unsecured kitchen closet. The kitchen is open to the home's main entrance and separated from the dining room by a wooden gate which was observed to be open on entrance and during the survey. These findings were confirmed by the Owner/Manager on the afternoon of 10/6/25.	R403		
R430 SS=F	9.6.d Plumbing Hot water temperatures must not exceed 120 degrees Fahrenheit in resident areas.	R430		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0044	A. BUILDING: _____ B. WING _____	C 10/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWS OF WINDSOR	121 STATE STREET WINDSOR, VT 05089

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R430	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there is a failure to ensure water temper at maintained at or below 120 degrees Fahrenheit in areas of the home accessible to residents. Findings include: Policies and Procedures governing hot water temperatures in resident accessible areas of the home have not been developed. On the afternoon of 10/6/25 water temperatures in areas of the home accessible to residents were observed to be above 120 degrees Fahrenheit as follows: 1. Basement shared resident bathroom 131.9 2. Basement bathroom beside the manager's office 139.8 3. Upstairs Bathroom beside staircase 139.6 4. Upstairs Bathroom Near Kitchen 127.0 5. Kitchen Sink 130.6 These findings were confirmed by the Owner/Manager on the afternoon of 10/6/25. Following a repairs made to the home's water heating system on the afternoon of 10/6/25 water temperatures were confirmed to be maintained at or below 120 degrees Fahrenheit.	R430		
R443 SS=F	9.11.d Disaster and Emergency Preparedness There must be an operable telephone on each floor of the home, available to residents at all times. A list of emergency telephone numbers must be posted by each telephone. This REQUIREMENT is not met as evidenced by:	R443		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0044	A. BUILDING: _____ B. WING _____	C 10/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWS OF WINDSOR	121 STATE STREET WINDSOR, VT 05089

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R443	Continued From page 17 Based on observation and staff interview there is a failure to ensure residents have access to an operable telephone with emergency numbers posted beside it on all floors of the home at all times. Findings include: Policies and procedures consistent with this licensing requirement have not been developed by the home. During a tour of the home commencing at 12:47 PM on 10/6/25 it was observed that an operable phone was not accessible to residents in the basement level of the home at all times, and the operable phone accessible to residents at all times on the main level of the home did not have a list of emergency phone numbers posted beside it. This finding was confirmed by the Owner/Manager on the afternoon of 10/6/25.	R443		

Deficiency Statement an of Correction (POC)

Survey Date: 10/06/2025

Facility Name: Willows of Windsor Sonnary

Deficiency Tag	How the deficiency was corrected	How other potential residents identified, and corrective action taken	Date corrected	System changes to ensure compliance of the regulation	Who will monitor to ensure compliance
R ~~000~~	IJ	Immediate POC			
R 105	Uniform Consume				
R 142	General Care	Adequate Supervision			
R 196	PRN psychoactive	written PLs			
R 197	PRN antipsychotic				
R 210	Staff Services	education			
R 227	Records/Reports	≠ notify			
R 342	Policies + Procedures				
R 394	Food storage	+ Equipment			
R 403	Environment	(shared BR, unlocked storage, WD 40)			
R 430	Plumbing				
R 443	Disaster + Emergency	Phone L stairs			

Deficiency Statement Plan of Correction (POC)

Survey Date: 10/06/2025

Facility Name: Willows of Windsor

Deficiency Tag	How the deficiency was corrected	How other potential residents identified, and corrective action taken	Date corrected	System changes to ensure compliance of the regulation	Who will monitor to ensure compliance
R100	Immediate plan of correction was submitted	Habits of when residents leave and return will be monitored	10/7/25	Policy and forms implemented	Owner
R105	Completed copy of a completed Uniform Consumer Disclosure form was given to Resident 1,2,3,4	No other residents were identified No other corrective action	10/21/25	All new residents will be given a copy of the Uniform Consumer Disclosure. A copy will be posted upstairs and any time changes are made it will be updated	Owner

R105 accepted by LTCM on 11-6-2025

Deficiency Statement **an of Correction (POC)**

Survey Date: 10/06/2025

Facility Name: Willows of Windsor

Deficiency Tag	How the deficiency was corrected	How other potential residents identified, and corrective action taken	Date corrected	System changes to ensure compliance of the regulation	Who will monitor to ensure compliance
R142	A policy was implemented and a written plan for resident #1	Habits of all residents who leave will be monitored Sign out book will be checked NOTE: Only (1) other resident leaves on [redacted] own accord. Resident gone 2-4 hours + returns	~~10/6/25~~ 10/7/25 SMF	Monitor the time residents leave	Caregivers
R196	A written plan for the administration of the PRN Hydroxyzine for Resident #2 Psychoactive med was done	All PRN meds will not be given until the nurse is contacted	~~10/6~~ 10/7/25	No PRN meds to be given without consent from nurse. staff will try other ways to reduce anxiety first and document Staff educated	Nurse

Pronoun redacted by DLP 11-3-2025

R142 accepted by LTCM on 11-6-2025

R196 accepted by LTCM on 11-6-2025

Deficiency Statement an of Correction (POC)

Survey Date: 10/06/2025

Facility Name: Willows of Windsor

Deficiency Tag	How the deficiency was corrected	How other potential residents identified, and corrective action taken	Date corrected	System changes to ensure compliance of the regulation	Who will monitor to ensure compliance
R 197	A written plan was implemented whereby verbal permission needed from RN prior to administration of an antipsychotic medication	All the residents on antipsychotic meds were identified. Antipsychotic behavior flow sheets initiated	10/31/25 11/1/25	Behaviors identified on The Antipsychotic Monthly flow record.	Nurse
				R197 accepted by LTCM on 11-6-2025	
R210	The initial 8 hours were completed by 5/8 staff. 2 additional hours in Nov 2 additional hours in Nov to be completed to equal 12 required hours.	The 3 staff will complete their inservice ASAP with the additional 2 hours by Nov 30	11/30/25 11/14/25 for all staff	Education element will be done per caregiver each month to equal 12 hours They will be assigned by nurse	Owner
				R210 accepted by LTCM on 11-6-2025	

Deficiency Statement an of Correction (POC)

Survey Date: 10/06/2025

Facility Name: Willows of Windsor

Deficiency Tag	How the deficiency was corrected	How other potential residents identified, and corrective action taken	Date corrected	System changes to ensure compliance of the regulation	Who will monitor to ensure compliance
R229	Policy has been developed to follow the guidelines for an unexplained absence.	No other residents have been identified	11/01/25	Continue to monitor resident sign out sheet	Owner Caregiver Nurse
R342	Policies + Procedures were implemented for all the areas under this tag R342	Uniformer Consumer Disclosure given to resident 1,2,3,4 water temperature was checked Chemicals removed + placed in cabinet Residents records + personal information securly stored Check list for new hires Phones installed	10/31/25	Checklist implemented	Owner

R229 accepted by LTCM on 11-6-2025

R342 accepted by LTCM on 11-6-2025

Deficiency Statement an of Correction (POC)

Survey Date: 10/06/2025

Facility Name: Willows of Windsor

Deficiency Tag	How the deficiency was corrected	How other potential residents identified, and corrective action taken	Date corrected	System changes to ensure compliance of the regulation	Who will monitor to ensure compliance
R394	A policy was implemented for storing poisonous compounds	All chemicals placed in cupboard away from resident accessible area	10/31/25	Locks were placed on cabinet	Owner
R403	Policy to govern safe + secure storage of chemical agents has been developed	N/A	10/28/25	Locks on chemical cabinet	All staff

R394 accepted by LTCM on 11-6-2025

R403 accepted by LTCM on 11-6-2025

Deficiency Statement Plan of Correction (POC)

Survey Date:

Facility Name:

Deficiency Tag	How the deficiency was corrected	How other potential residents identified, and corrective action taken	Date corrected	System changes to ensure compliance of the regulation	Who will monitor to ensure compliance
R430	Policies & Procedures governing hot water temperatures in resident accessible areas of the home have been developed. pg. 61	A thermometer was purchased A check list was implemented to do weekly checks	10/14/25	Monitor temps weekly	Owner
R443	Policies & Procedures have been implemented and a new phone was placed downstairs with emergency numbers posted both upstairs & downstairs p. 60	Phone downstairs with list of emergency numbers	10/31/25 11/02/25	Educated resident how phone system works Educated staff	Owner

R430 accepted by LTCM on 11-6-2025

R443 accepted by LTCM on 11-6-2025