

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365460	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/14/2026
NAME OF PROVIDER OR SUPPLIER Windsor Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1735 Belmont Avenue Youngstown, OH 44504	

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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** THIS DEFICIENCY IS AN INCIDENCE OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY.Based on record review, Self-Reported Incident (SRI) review and interview, the facility failed to ensure residents were free from misappropriation. This finding affected four (Residents #49, #55, #56 and #57) of four residents identified during the investigation of diversion of narcotics. Findings include: Review of Resident #49's medical record revealed the resident was admitted on [DATE] with diagnoses including quadriplegia, chronic pain syndrome and anemia. Review of Resident #49's Annual Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition. Review of Resident #49's physician orders revealed an order dated [DATE] for Oxycodone 10 milligrams (mg) give one tablet every four hours as needed for pain. Review of Resident #55's medical record revealed the resident was admitted on [DATE] with diagnoses including malignant neoplasm of the left breast, morbid obesity, and generalized anxiety disorder. Review of Resident #55's Quarterly MDS 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition. Review of Resident #55's physician orders revealed an order dated [DATE] for Oxycodone 4 mg one tablet every four hours as needed for moderate to severe pain. Review of Resident #56's closed medical record revealed the resident was admitted on [DATE], readmitted on [DATE] and discharged on [DATE] with diagnoses including malignant neoplasm of the bronchus, bipolar disorder and disorder of the brain. Resident #56 expired in the facility on [DATE]. Review of Resident #56's Quarterly MDS 3.0 assessment dated [DATE] revealed the resident exhibited a memory problem. Review of Resident #56's physician orders revealed an order dated [DATE] for Oxycodone 5 mg one tablet four times a day for moderate to severe pain; and an order dated [DATE] for Oxycodone 10 mg every four hours as needed for increased pain. Review of Resident #57's closed medical record revealed the resident was admitted on [DATE] and discharged on [DATE] with diagnoses including chronic obstructive pulmonary disease, essential hypertension, and muscle wasting. Resident #57 was discharged home on 07/21/25. Review of Resident #57's admission MDS 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition. Review of Resident #57's physician orders revealed an order dated [DATE] for Oxycodone 5 mg give one to tablets by mouth every four hours as needed for pain. Review of the Misappropriation SRI Tracking #263185 dated [DATE] revealed LPN Agency #812 misappropriated narcotics from Residents #49, #55, #56 and #57. The investigation determined Resident #49 was missing an unknown amount of Oxycodone narcotic pain tablets due to LPN Agency #812 forging signatures of other nursing staff on the resident's narcotic flow record; Resident #55 was missing seven Oxycodone narcotic pain tablets; Resident #56 was missing 30 Oxycodone narcotic pain tablets; and Resident #57 was missing an unknown amount of Oxycodone narcotic pain tablets because LPN Agency #812 took the remaining Oxycodone card and narcotic flow record from the facility. Interviews on [DATE] at 12:23 P.M. with Regional Administrator #811 and Registered Nurse (RN) #813 confirmed the above findings. Review of the Resident Abuse Prevention Practices policy revised 10/2022 revealed it was the policy of the</p> <p>(continued on next page)</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 365460	If continuation sheet Page 1 of 2

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>company to protect all residents from mistreatment, neglect, abuse, and misappropriation of resident property. This includes protection from verbal, mental, physical, emotional, or financial abuse by staff, families, residents, visitors or outside ancillary service employees or in any situation that would be harmful to the resident. The deficiency was corrected on [DATE] when the facility implemented the following corrective actions: On [DATE], the Administrator and Director of Nursing (DON) immediately removed Licensed Practical Nurse (LPN) Agency #812 from the staffing schedules. On [DATE], SRI tracking #263185 was reported to the State agency by the Administrator and an investigation was conducted which included witness statements and was substantiated for misappropriation of narcotics. On [DATE], the Administrator and DON conducted a Quality Assurance Performance Improvement (QAPI) AD Hoc meeting to review and develop a plan of action for the medication diversion. On [DATE], the DON and/or Designee completed narcotic counts on all residents and determined four residents including Residents #49, #55, #56 and #57 were missing narcotics and/or narcotic flow records. On [DATE], the Administrator contacted the nursing agency concerning LPN Agency #812's involvement in the missing narcotics and narcotic flow records. On [DATE], the Administrator contacted the local police department involving LPN Agency #812's involvement in missing narcotics and narcotic flow records. On [DATE], the Administrator submitted a report with the Ohio Board of Nursing regarding LPN Agency #812's involvement in the missing narcotics and narcotic flow records. On [DATE], the Administrator and DON sent other nursing staff for drug testing including LPNs #814, #815, #816, #817, #818, #819 and #820. On [DATE], the DON/Clinical Designee in-serviced all staff on Abuse, Neglect and misappropriation. Resident #49's oxycodone medication was replaced on [DATE]; and Resident #55's Oxycodone medication was replaced on [DATE]. Residents #56 and #57 were discharged from the facility. From [DATE] to [DATE], the DON/Designee in-serviced all staff on the correct medication administration policy and procedure including narcotic flow records. The DON/Designee conducted Audits daily for one week then three times a week for three weeks.</p>		