STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365669	A. Building B. Wing	05/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Four Winds Nursing Facility	215 Seth Avenue Jackson, OH 45640

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record reviews, resident and staff interviews, review of facilities investigation report and facilities policy and procedure, the facility failed to report an allegations of staff to resident abuse to the State Agency. This affected four (#54, #62, #136 and #146) of four residents reviewed for abuse. The facility census was 72. Findings include: 1. Review of records for Resident #54 revealed an admission date of 03/19/26 with diagnoses that included but are not limited to acute embolism and thrombosis of deep veins of left lower extremity, muscular dystrophy, and intra-abdominal and pelvic swelling.Review of the Significant Change Minimum Data Set (MDS) 3.0 assessment completed on 05/01/26 for Resident #54 revealed a Brief Interview for Mental Status (BIMS) score of 13 out of 15 suggesting cognitive intactness.2. Review of records for Resident #62 revealed an admission date of 02/02/26 with diagnoses that included but are not limited to heart failure, cerebral vascular disease, and major depressive disorder Review of the Quarterly MDS completed on 05/01/26 for Resident #62 revealed a BIMS score of 08 out of 15 indicating moderate cognitive impairment.3. Review of records for Resident #136 revealed an admission date of 12/09/25 with diagnoses that included but are not limited to type 2 diabetes, supraventricular tachycardia, and displaced fracture of cervical neck of right humerus Review of the Quarterly MDS for Resident #136 completed on 03/11/26 revealed a BIMS score of 15 out of 15 indicating cognitive intactness.4. Review of records for Resident #146 revealed an admission date of 12/11/25 with diagnoses that included but are not limited to intracranial injury with loss of consciousness, type 2 diabetes, and dysphagia.Review of the Quarterly MDS assessment on 03/18/2026 for Resident #146 revealed a BIMS of 11 out of 15 suggesting moderate cognitive impairment.Interview with Licensed Practical Nurse (LPN) #168 on 05/18/26 at 11:12 A.M. revealed that LPN #184 is not allowed in the Resident #62's room per the residents wishes due to her being rough and mean. LPN #168 stated that multiple residents have made complaints about LPN #184 having a bad attitude and bad bedside manner.Interview with Certified Nursing Assistance (CNA) #140 on 05/18/26 at 11:17 A.M. revealed that residents have complained about LPN #184 refusing to provide care and having no bedside manner.Interview with CNA #110 on 05/18/26 at 11:18 A.M. revealed that a lot of residents have complained about LPN #184 being rude.Interview with Resident #54 on 05/18/26 at 11:20 A.M. revealed that LPN #184 is mean and hateful.Interview with LPN #160 on 05/18/26 at 11:30 A.M. revealed that there are multiple residents (Resident #54, #62, and #136) refuse to allow LPN #184 in their room due to her bad attitude. LPN #160 stated that LPN #184 was recently suspended over situations involving residents that were reported to Human Resources by staff.Interview with Human Resources #254 on 05/18/26 at 2:01 P.M. revealed that LPN #184 was suspended on 03/11/26 due to complaints from residents pertaining to attitude and rudeness. Review of facilities investigation file revealed no self reported incident (SRI) was reported to the State Agency. During investigation interviews, Resident #146 also complained about LPN #184's attitude. Interview with Director of Nursing (DON) #158 on 05/18/26 at 3:36 P.M. revealed that Resident #62's daughter came forward stating that LPN #184 was rude to her mom. Confirmed that no SRI's were reported to the State Agency. Review of the facility policy, Abuse, Mistreatment, Neglect, Exploitation, and Misappropriation of Resident Property, revised on 01/25/2025 revealed the Executive Director or Administrator will notify the appropriate state reporting agency.

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. Based on record reviews, resident and staff interviews, review of facilities investigation report and facilities policy and procedure, the facility failed to have documented evidence that an allegation of abuse was thoroughly investigated for residents. This affected four (#54, #62, #136 and #146) of four residents reviewed for abuse. The facility census was 72. Findings include:1. Review of records for Resident #54 revealed an admission date of 03/19/26 with diagnoses that included but are not limited to acute embolism and thrombosis of deep veins of left lower extremity, muscular dystrophy, and intra-abdominal and pelvic swelling.Review of the Significant Change Minimum Data Set (MDS) 3.0 assessment completed on 05/01/26 for Resident #54 revealed a Brief Interview for Mental Status (BIMS) score of 13 out of 15 suggesting cognitive intactness.2. Review of records for Resident #62 revealed an admission date of 02/02/26 with diagnoses that included but are not limited to heart failure, cerebral vascular disease, and major depressive disorder Review of the Quarterly MDS completed on 05/01/26 for Resident #62 revealed a BIMS score of 08 out of 15 indicating moderate cognitive impairment.3. Review of records for Resident #136 revealed an admission date of 12/09/25 with diagnoses that included but are not limited to type 2 diabetes, supraventricular tachycardia, and displaced fracture of cervical neck of right humerus Review of the Quarterly MDS for Resident #136 completed on 03/11/26 revealed a BIMS score of 15 out of 15 indicating cognitive intactness.4. Review of records for Resident #146 revealed an admission date of 12/11/25 with diagnoses that included but are not limited to intracranial injury with loss of consciousness, type 2 diabetes, and dysphagia.Review of the Quarterly MDS assessment on 03/18/2026 for Resident #146 revealed a BIMS of 11 out of 15 suggesting moderate cognitive impairment.Interview with Licensed Practical Nurse (LPN) #168 on 05/18/26 at 11:12 A.M. revealed that LPN #184 is not allowed in the Resident #62's room per the residents wishes due to her being rough and mean. LPN #168 stated that multiple residents have made complaints about LPN #184 having a bad attitude and bad bedside manner.Interview on 05/18/2026 at 11:17 A.M. with Certified Nursing Assistant (CNA) #140 revealed that residents have complained about LPN #184 refusing to provide care and having no bedside manners.Interview on 05/18/2026 at 11:18 A.M. with CNA #110 revealed that a lot of residents have complained about LPN #184 primarily about her being rude. Interview with Resident #54 on 05/18/2026 at 11:20 A.M. revealed that LPN #184 is mean and hateful.Interview with LPN #160 on 05/18/26 at 11:30 A.M. revealed that there are multiple residents (Resident #54, #62, and #136) refuse to allow LPN #184 in their room due to her bad attitude. LPN #160 stated that LPN #184 was recently suspended over situations involving residents that were reported to Human Resources by staff.Interview with Human Resources #254 on 05/18/26 at 2:01 P.M. revealed that LPN #184 was suspended on 03/11/26 due to complaints from residents pertaining to attitude and rudeness. Review of investigation file and suspension for LPN #184 revealed interviews were not done with all the residents and no interviews with other staff members.Interview with Director of Nursing (DON) #158 on 05/18/26 at 3:36 P.M. revealed that Resident #62's daughter came forward stating that LPN #184 was rude to her mom. An investigation was then conducted that involved interviewing other residents but not interviewing Resident #184 or interviewing other staff members. During investigation interviews, Resident #146 also complained about LPN #184's attitude. DON confirmed interviews were not completed with all residents and all staff. Review of the facility policy, Abuse, Mistreatment, Neglect, Exploitation, and Misappropriation of Resident Property, revised on 01/25/2025 revealed the investigation protocol includes interviewing the resident, the accused, and all witness. Witnesses generally include anyone who: witnessed or heard the incident; came in close contact with the residents on the day of the incident (including other residents, family members); and employees who worked closely with the accused employees and/or alleged victims the day of the incident.