

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365669	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2025
NAME OF PROVIDER OR SUPPLIER Four Winds Nursing Facility		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0569</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death.</p> <p>07316</p> <p>Based on review of resident personal fund records and staff interview, the facility failed to ensure that a resident/responsible party was notified when the amount in their account reached \$200 less than the resource limit for one person and that, if the amount in the account reaches the resource limit (\$2000) the resident may lose eligibility for Medicaid. This affected one (Resident #23) of 45 residents whose funds were handled by the facility. The facility census was 75.</p> <p>Findings include:</p> <p>Resident #23's personal funds were handled by the facility. Review of a transaction history for Resident #23 revealed on 06/18/24 the balance went to \$1904.15. (\$200 less than the resource limit). The amount in the account remained above \$1800.00 through 03/20/25. The current balance was \$2076.79. The resident was on Medicaid.</p> <p>Interview with Corporate Administrator #100 on 3/20/25 at 2:20 P.M. confirmed Resident #23's balance had been above \$1800.00 since 06/18/24. She confirmed the resident/representative had not been notified of the balance being \$200 less than the resource limit until 03/18/25. She stated the notification should have occurred within the month of June 2024. She confirmed the notification was not timely.</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
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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>07316</p> <p>Based on review of a facility investigation report, policy review, and staff interview, the facility failed to have evidence that an allegation of emotional/verbal abuse was thoroughly investigated. This affected one (Resident #32) of 75 residents residing in the facility.</p> <p>Findings include:</p> <p>Review of a facility Self Reported Incident Form revealed on 01/14/25 Resident #32 reported to a nurse that she was afraid of Nursing Assistant #138 giving her a shower the next day due to a previous incident when that nursing assistant helped her in the shower and an incident in her room. Resident #32 stated that Nursing Assistant #138 wanted her to reach for something in the shower and Resident #32 stated she was too weak. Resident #32 stated that Nursing Assistant #138 told her she was not that weak and that she couldn't stand her. Resident #32 also said Nursing Assistant #138 called her a name but she can't remember what it was. Resident #32 stated Nursing Assistant #138 was also rude to her one time in her room when she reported to her nurse that her room mate needed help. The facility categorized the allegation as an allegation of emotional/verbal abuse.</p> <p>Nursing Assistant #138 was suspended during the investigation. A statement was taken from Nursing Assistant #138 and she stated she had never been rude to this resident or any other resident. Multiple additional resident interviews were conducted and no resident reported any sort of verbal/physical abuse, neglect, or mistreatment by staff. It was noted in the investigation that Resident #32 had a diagnosis of Paranoid Schizophrenia and had made accusations that people were out to get her on a previous stay at the facility. She had a history of delusions, hallucinations, and paranoia.</p> <p>The facility documented that the allegation was unsubstantiated. However, there was no evidence the facility interviewed any other facility staff who had worked that day or who had worked with Nursing Assistant #138. Nursing Assistant #138 was removed from providing care to Resident #32 at any other time.</p> <p>Review of the facility policy titled Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property dated 03/30/12 and last revised 01/25/25 revealed all incidents and allegations of abuse must be reported immediately to the administrator. Once the Administrator is notified, an investigation of the allegation will be conducted. Investigation protocol included interviewing all witnesses. Witnesses generally include anyone who witnessed or heard the incident, came in close contact with the resident the day of the incident, and employees who worked closely with the accused employee and/or alleged victim the day of the incident. If there are no direct witnesses, then the interviews may be expanded. For example, consider interviews with all employees on the shift or the unit.</p> <p>Interview with Corporate Administrator #100 on 03/19/25 at 10:55 A.M. confirmed there was no evidence of any other staff interviews conducted during the investigation for Resident #32. She confirmed other staff interviews should have been conducted.</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31404</p> <p>Based on staff interview, and record review the facility failed to provide bed-hold notifications when residents were transferred out of the facility. This affected three (Resident #24, #50, and #71) of three residents reviewed for bed-hold notices. The facility census was 75.</p> <p>1. Record review of Resident #24 revealed an admitted [DATE] with pertinent diagnoses of: influenza, pneumonia, contusion of the abdominal wall, acute respiratory failure with hypoxia, atrial fibrillation, cerebral infarction due to thrombosis, difficulty in walking, muscle weakness, type two diabetes mellitus, pancytopenia, dysarthria following cerebral infarction, and hemiplegia and hemiparesis following unspecified cerebral infarction.</p> <p>Review of the 02/26/25 five day Minimum Data Set (MDS) assessment revealed the resident was cognitively intact and did not use any mobility devices. The resident was occasionally incontinent of bladder and was not rated for bowel use.</p> <p>Review of progress notes dated 02/08/25 at 6:29 P.M. revealed resident not feeling well. Blood pressure 177/129, temperature 100.7 Fahrenheit, Respirations 19. Tylenol given as needed order Doctor notified. Order to send to emergency room received.</p> <p>Review of the medical record on 03/19/25 revealed no evidence a bed hold notice was given for the transfer on 02/08/25.</p> <p>Interview with Corporate Administrator #100 on 03/20/25 at 10:01 A.M. verified there was not a bed hold notice given to Resident #24 for his transfer on 02/08/25.</p> <p>2. Record review of Resident #50 revealed an admitted [DATE] with pertinent diagnoses of: chronic obstructive pulmonary disease, acute post-hemorrhagic anemia, lobar anemia, myocardial infarction, acute respiratory failure with hypoxia, cardiomyopathy, hypertension, congestive heart failure, chronic kidney disease, and depression.</p> <p>Review of the 02/24/25 admission Minimum Data Set (MDS) assessment revealed the resident was moderately cognitively impaired and used a walker to aid in mobility. The resident had an indwelling urinary catheter and was frequently incontinent of bowel.</p> <p>Review of the progress notes dated 03/12/25 at 9:37 P.M. revealed Resident #50 went to hospital per family request, family took resident due to hemoglobin level.</p> <p>Review of the progress notes dated 03/13/25 at 4:39 A.M. revealed Resident #50 returned back to facility, family brought back stated resident got one unit of blood.</p> <p>Review of the medical record on 03/19/25 revealed no evidence a bed hold notice was given for the transfer on 03/12/25.</p> <p>(continued on next page)</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with Corporate Administrator #100 on 03/20/25 at 10:01 A.M. verified there was not a bed hold notice given to Resident #50 for his transfer on 03/12 /25.</p> <p>07316</p> <p>3. Review of the closed medical record for Resident #71 revealed an admitted [DATE] and diagnoses including metabolic encephalopathy, diabetes, dementia, and cellulitis of the left leg.</p> <p>Review of nurses notes on 02/15/25 at 5:17 P.M. revealed the resident was noted to be gurgling and wheezing bilaterally. Vital signs were blood pressure 90/48, pulse 128, respirations 24, temperature 99.2 and oxygen saturation 94%. The resident's daughter was visiting and wanted the resident sent to the hospital. The physician was notified and the resident was sent to the hospital. The resident was admitted with pneumonia and Flu A.</p> <p>At the time of the transfer, there was no evidence the facility provided the resident or resident representative a written notice which specified the duration of the bed-hold policy.</p> <p>This was confirmed by Corporate Administrator #100 on 03/19/25 at 9:00 A.M.</p>

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34299</p> <p>Based on record review and interview the facility failed to complete an updated Pre Admission Screening and Resident Review (PASARR) for Resident #14 when a new antidepressant medication was added and failed to complete an updated PASARR for Resident #23 with a new diagnosis of anxiety. This affected two (Resident #14 and #23) of four residents reviewed for PASARR. The facility census was 75.</p> <p>Findings include:</p> <p>1. Review of the medical record of Resident #14 revealed an admitted [DATE] with diagnoses including dementia (04/12/23), delusional disorder (02/27/24), unspecified psychosis (12/21/23), unspecified mood disorder (04/12/23) and depression (12/27/22).</p> <p>Review of the physician orders dated 03/24 revealed Resident #14 was ordered on 02/21/25 depakote sprinkles delayed release (anticonvulsant used for mood disorders) 125 milligrams (mg) by mouth one time daily for unspecified mood disorder, on 01/12/25 mirtazapine (antidepressant) 15 mg by mouth at bedtime for weight loss and on 01/24/25 zoloft (antidepressant) 25 mg by mouth daily for depression.</p> <p>Review of the annual Minimum Data Set (MDS) dated [DATE] revealed Resident #14 was cognitively intact with no behaviors. Resident #14 required minimal assistance from staff to complete activities of daily living. The diagnoses listed included dementia, depression and psychotic disorder other than schizophrenia. Resident #14 received the following medications: antidepressant and anticonvulsant.</p> <p>Review of the PASARR dated 04/13/23 revealed Resident #14 had diagnoses of dementia, mood disorder, delusions and depression. Resident #14 received a mood stabilizer medication such as depakote.</p> <p>Interview on 03/20/25 at 8:31 A.M. with Regional Director #100 confirmed a new PASARR was not completed for Resident #14 with additional diagnosis of unspecified psychosis on 12/21/23 and additional medication for depression on 01/24/25.</p> <p>2. Review of the medical record of Resident #23 revealed an admitted [DATE] with diagnoses including dementia (10/13/21), unspecified psychosis (10/13/21), anxiety (12/04/24), depression (01/17/23) and paranoid personality disorder (10/13/21).</p> <p>Review of the physician orders dated 03/25 revealed Resident #23 was ordered buspirone hydrochloride (antidepressant) 5 mg by mouth two times daily for anxiety.</p> <p>Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #23 had severe cognitive impairment with inattention and disorganized thinking. Resident #23 had behaviors of wandering, and physical symptoms directed towards others. Resident #23 required moderate assistance from staff to complete activities of daily living. The diagnosis listed included dementia, anxiety, depression and psychotic disorder. Resident #23 received the following medications: antianxiety and antidepressant.</p> <p>(continued on next page)</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the PASARR completed on 08/22/24 revealed Resident #23 had diagnoses of dementia, mood disorder, personality disorder and other psychotic disorders. Resident #23 received antianxiety medication only.</p> <p>Interview on 03/20/25 at 8:31 A.M. with Regional Director #100 confirmed a new PASARR was not completed for Resident #23 with additional diagnosis of anxiety on 12/04/24.</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34299</p> <p>Based on interview, record review and facility policy, the facility failed to provide evidence of care conference meetings with Resident #14 and or the resident's representative. This affected one resident (Resident #14) of two reviewed for care planning. The facility census was 75.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #14 revealed an admitted [DATE] with diagnoses including dementia, atrial fibrillation, delusional disorder, unspecified psychosis, unspecified mood disorder and depression.</p> <p>Review of the annual Minimum Data Set (MDS) dated [DATE] revealed Resident #14 was cognitively intact with no behaviors. Resident #14 required assistance from staff to complete activities of daily living. Resident #14 was continent of bowel and bladder. Resident #14 had no pain, and had two or more falls with no injury since admission. Resident #14 had no skin impairment.</p> <p>Review of the progress notes from 07/01/24 through 03/18/25 revealed Resident #14 had documentation of medication changes, physician visits and incidents. On 07/10/24 Social Services documented a care conference was held with Resident #14 and her family.</p> <p>An interview on 03/17/25 at 1:33 P.M. with Resident #14 revealed she was not sure she had been to any meetings with facility staff such as nurse, social worker and dietary to discuss her medical care and needs and or plan for discharge.</p> <p>An interview on 03/19/25 at 9:08 A.M. with Social Services #178 stated she documented care conferences in the resident progress notes however she did keep a calendar every month of whose care conference was on what date. Social Services #178 confirmed Resident #14 had documentation of care conference on 07/10/24 and no other documentation throughout the past year.</p> <p>Review of the facility policy title Person-Centered Care Planning Policy and Procedure revised on 11/27/17 revealed the Interdisciplinary Team (IDT) shall develop and implement a care plan for each resident that included the instructions needed to provide effective and person-centered care of the resident that meets the professional standards of quality care. To the extent practicable, the participation of the resident and the resident's representative should be in attendance. An explanation must be included in the residents medical record if participation of the resident and or the resident's representative was determined not practicable.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34299</p> <p>Based on observation, interview, record review and facility policy the facility failed to ensure Resident #26 fluid restriction had breakdown of the amount of fluids for each department daily. This affected one resident (Resident #26) of one reviewed for hydration. The facility census was 75.</p> <p>Findings include:</p> <p>Review of the medical record of Resident #26 revealed an admitted [DATE] with diagnoses including dementia, depression, hypothyroidism, anxiety, psychosis, chronic pain syndrome, and iron deficient anemia.</p> <p>Review of the physician orders dated 03/25 revealed Resident #26 was on a regular diet, regular texture with thin liquids. Resident #26 had an order for fluid restriction of 3500 milliliters (ml) per day and monitor intake and output due to excessive fluid intake.</p> <p>Review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) dated 01/25, 02/25 and 03/25 revealed no breakdown of the amount of fluids to be provided by each department.</p> <p>Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #26 was cognitively intact with no behaviors. Resident #14 required minimum assistance from the staff to complete activities of daily living. Resident #14 required a set up for all meals. Resident #14 was on a therapeutic diet with no weight loss noted.</p> <p>Review of the plan of care revised on 12/20/24 revealed Resident #26 had a nutritional problem or potential problem related to advanced age, chronic disease, variable meal acceptance, and fluid restriction of 3500 ml due to excessive fluid intake. The goal was to maintain adequate nutritional status as evidenced by consuming at least 75% of atleast two meals daily through review date. The interventions included limit fluids to 3500 ml per day, monitor intake and output, monitor for signs and symptoms of dehydration, obtain and monitor labs as ordered, provide diet as ordered and dietitian to make recommendations as needed.</p> <p>Review of the quarterly nutritional review dated 01/20/25 revealed Resident #26 received a regular diet, regular texture, thin liquids with a 3500 ml fluid restriction per day. Resident #26 meal intakes varied with 50-100% of meals consumed. Recommendations included to provide fluid breakdown per meal/medication pass.</p> <p>Review of the Certified Nursing Assistant (CNA) documentation for the past 30 days revealed the CNA's documented meal fluid intake daily.</p> <p>Observations of Resident #26 during the annual survey of four day revealed resident did not have a water pitcher at bedside.</p> <p>Interview on 03/17/25 at 3:40 P.M. Resident #26 stated she had to ask someone for something to drink when she wanted something.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 03/19/25 at 10:07 A.M. with CNA #105 revealed Resident #26 was on a fluid restriction and was not able to have a water pitcher at bedside. CNA #105 stated Resident #26 asks for a drink every few minutes and the aids had to monitor how much the resident drank. CNA # 105 confirmed the CNA's document the fluid amount with meals only.</p> <p>Interview on 03/19/25 at 10:11 A.M. with Registered Nurse (RN) #150 confirmed Resident #26 was on a fluid restriction of 3500 ml per day and the nurses did not document how much fluids were administered during medication administration. RN #150 also confirmed there was not a breakdown of fluid administration for nursing and dietary in the medical record.</p> <p>Review of the facility policy titled Fluid Restriction revised on 12/17/18 revealed resident's with physician orders for fluid restrictions will receive the prescribed amount of fluids within a 24-hour timeframe. The nursing and dining services department will determine how much fluid each department will provide and at what times.</p>

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34299</p> <p>Based on interview, record review and facility policy the facility failed to ensure Resident #14 had an appropriate diagnosis for the use of long term antibiotic. This affected one (Resident #14) of one resident reviewed for antibiotic use. The facility census was 75.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #14 revealed an admitted [DATE] with diagnoses including dementia, atrial fibrillation, delusional disorder, unspecified psychosis, unspecified mood disorder and depression.</p> <p>Review of the annual Minimum Data Set (MDS) dated [DATE] revealed Resident #14 was cognitively intact with no behaviors. Resident #14 required assistance from staff to complete activities of daily living. Resident #14 was continent of bowel and bladder. Resident #14 had no pain, and had two or more falls with no injury since admission. Resident #14 had no skin impairment. Resident #14 received an antibiotic medication.</p> <p>Review of the physician orders dated 03/25 revealed Resident #14 had an order for cefdinir (antibiotic) 300 milligrams (mg) by mouth daily for prophylaxis.</p> <p>Review of the facility provided nursing note dated 04/23/23 at 1:30 P.M. the nurse noted Resident #14 son requested the antibiotic medication cefdinir be reordered due to the resident urologist ordered the medication for colonized bladder/chronic urinary tract infections. The nurse spoke with physician and the medication was reordered. There were no indications in the past year, per nursing progress notes, the resident had signs and symptoms of urinary tract infection.</p> <p>The plan of care did not address the antibiotic medication or long term use of the medication.</p> <p>There were no physician notes from specialist or urologist noted in Resident #14 medical record.</p> <p>Review of the monthly medication pharmacy review revealed no recommendations for Resident #14 related to the use of the antibiotic</p> <p>The attending physician was not available to speak to surveyor as he was on vacation. However the facility provided the following dictated note. Review of physician note dated 03/19/25 revealed Resident #14 had recurrent urinary tract infections and was on long term antibiotic therapy for prophylaxis. Resident #14 had history of repeat admissions to the hospital before being admitted to the facility with sepsis related to urinary tract infections. The residents family stated that the specialist told them the resident needed to be on prophylactic antibiotics the rest of her life.</p> <p>Interview on 03/19/25 at 3:46 P.M. with Director of Nursing (DON) # 5 confirmed Resident #14 was on an antibiotic with no diagnosis other than prophylaxis. DON #5 also confirmed Resident #14 did not see a urologist and the facility had no documentation from a urologist related to the antibiotic.</p> <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility policy titled Antibiotic Stewardship revised on 02/17/22 revealed all antibiotic orders will include the following information. A specific prescribing order with dose and duration, a progress note explaining the reason for the antibiotic, if a culture and sensitivity was performed and results were obtained re-evaluate to ensure proper spectrum coverage and orders that may not follow the standards of practice for prescribing antibiotics would be referred to the Chief Clinical Advisor for review and recommendations.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31404</p> <p>Based on observation, record review, staff interview, and policy review, the facility failed to follow an infection control program to help prevent the development and transmission of communicable diseases and infections when staff did not change gloves after handling soiled wound packing for Resident #45. This affected one (Resident #45) of one resident reviewed for pressure ulcers. The facility census was 75.</p> <p>Findings include:</p> <p>Record review of Resident #45 revealed an admitted [DATE] with pertinent diagnoses of: chronic obstructive pulmonary disease, type two diabetes mellitus, chronic respiratory failure, chronic kidney disease stage 4, dependence on renal dialysis, pressure ulcer of sacral region stage 4, atherosclerotic heart disease, atrial fibrillation, osteomyelitis, pleural effusion, acquired absence of right great toe, GI hemorrhage, resistance to vancomycin, anemia, viral hepatitis, hypothyroidism, hyperlipidemia, major depressive disorder, anxiety disorder, polyneuropathy, acute MI, gout, Charcot's joint, dysphagia, retention of urine, thrombocytopenia, colostomy status, retention of urine, and chronic pain.</p> <p>Review of the 12/18/24 quarterly Minimum Data Set (MDS) revealed the Resident #45 was cognitively intact and used a wheelchair to aid in mobility. The Resident required substantial maximal assistance.</p> <p>Review of a Physician Order dated 02/21/25 revealed Wound #6: Cleanse wound to sacrum with soap and water, pat dry, pack cavity at inferior part of wound with iodofom 1/4 inch, apply calcium alginate, and cover with a border gauze every day shift for wound care.</p> <p>Observation of pressure ulcer dressing change on 03/19/25 at 10:04 A.M. revealed Registered Nurse (RN) #116 gathered supplies including iodofom packing, calcium alginate, border gauze, soap and water, scissors, and tape. RN #116 washed her hands, put on gloves and put on a gown. There was no dressing in place on the coccyx wound so she removed the soiled iodofom packing from inside the wound, and did not remove her gloves after touching the soiled packing. RN #116 washed the wound with soap and water with the gauze, RN #116 stuck her fingers in the bottle of iodofom and cut a strip with the same dirty gloves. The nurse then removed her soiled gloves and used hand sanitizer and put on clean gloves. RN #116 got a new iodofom strip out of the bottle and cut it with scissors and packed the coccyx wound with iodofom. The nurse used a cotton swab and applied calcium alginate to the wound then put on a dressing.</p> <p>Interview with RN #116 on 03/19/25 at 10:20 A.M. verified she did not change gloves after removing soiled packing and then cleaned wound with soap and water and then reached soiled gloved fingers into iodofom packing container.</p> <p>Review of the facility Dressing Change policy revised 02/01/25 revealed Put on clean gloves. Remove old dressings carefully, touching only the edges and discard. Disinfect hands and change gloves. Provide wound care cleaning and treatment applications per physician's orders. Apply dressing, not touching wound or resident surface of dressing.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365669	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2025
NAME OF PROVIDER OR SUPPLIER Four Winds Nursing Facility		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Implement a program that monitors antibiotic use.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 07316</p> <p>Based on medical record review, policy review, and staff interview, the facility failed to implement their antibiotic stewardship program that included antibiotic use protocols to ensure residents did not receive antibiotics when they were not warranted. This affected four (Residents #27, #45, #65, and #126) of six residents reviewed for antibiotic use. The facility census was 75.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #126 revealed an admitted [DATE]. The plan of care stated the resident was receiving hospice services for end stage congestive heart failure.</p> <p>Review of nurses notes revealed on 01/13/25 at 6:57 P.M. a new order was received for an antibiotic (Macrobid) due to a urinary tract infection (UTI). There were no symptoms of a UTI documented in the record. A physician's order stated to start Macrobid 100 milligrams twice daily for seven days on 01/14/25 for a UTI. Review of the medication administration record revealed the resident received the Macrobid from 01/14/25 to 01/21/25 for a total of 15 doses.</p> <p>Review of a McGeer Criteria for Infection Surveillance Checklist for Resident #126 dated 01/13/25 revealed the criteria for a UTI was not met.</p> <p>Interview with the Director of Nursing on 03/19/25 at 3:30 P.M. revealed that hospice ordered the antibiotic. She confirmed there was no documentation of any symptoms of a UTI. She confirmed a urinalysis and urine culture were not completed. She confirmed the UTI criteria was not met to justify the use of an antibiotic for this resident.</p> <p>2. Review of the medical record for Resident #65 revealed an admitted [DATE] and diagnoses including diabetes, congestive heart failure, and post hemorrhagic anemia.</p> <p>Review of nurses notes revealed on 01/16/25 at 9:54 A.M. the resident went on a leave of absence with her family. On 01/16/25 at 1:48 P.M. the note stated the resident returned and had been seen by another physician. A new order was received for an antibiotic (Doxycycline) 100 milligrams twice daily for seven days for a UTI. There were no symptoms of a UTI documented in the medical record. On 01/17/25 at 10:01 A.M. it was documented that the resident denied pain or burning with urination. There was no foul odor noted and the resident was afebrile. Review of the medication administration record revealed the resident received the antibiotic from 01/16/25 to 01/23/25 for a total of 14 doses.</p> <p>Review of the McGeer Criteria for Infection Surveillance Checklist revealed it stated Resident #65 did not meet the criteria for a UTI.</p> <p>Interview with the Director of Nursing on 03/19/25 at 3:30 P.M. revealed Resident #65's family took her out of the facility to another physician who ordered an antibiotic. She confirmed there were no symptoms of a UTI documented and there was no evidence the resident had a urinalysis or urine culture completed. She confirmed the resident did not meet the criteria for treatment of a UTI.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Four Winds Nursing Facility		STREET ADDRESS, CITY, STATE, ZIP CODE 215 Seth Avenue Jackson, OH 45640	
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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. Review of the medical record for Resident #27 revealed an admitted [DATE] and diagnoses including dementia, hypertension, and diabetes.</p> <p>Review of nurses notes revealed a late entry for 11/30/24 at 11:20 A.M. indicating the resident was very confused, staring off and hard to orient. The resident was sent to the hospital for evaluation.</p> <p>Review of a hospital note 11/30/24 revealed lab results were unremarkable besides a urinalysis that was positive for a UTI. She will be given an injection of Rocephin (antibiotic) for the UTI and give a prescription for Keflex (another antibiotic) for outpatient treatment. The resident returned from the hospital on 11/30/24 at 3:27 P.M. There were no urinary symptoms of a UTI documented in the medical record.</p> <p>The resident was seen by the physician on 12/05/24 who stated the resident denied any current urinary symptoms.</p> <p>There was no evidence the facility received the results of the urine culture obtained on 11/30/24 and completed on 12/02/24 until 12/11/24. A nurses note on 12/11/24 at 10:54 A.M. stated the hospital was called to obtain the results of the urine culture from the emergency room visit. The urine culture results were sent to the physician on 12/11/24 and an order was obtained for another antibiotic (Levaquin 500 milligrams daily for seven days).</p> <p>Review of the urine culture results of 12/02/24 revealed Keflex was not listed on the results as an antibiotic that would be effective against the UTI of >100,000 Escherichia Coli bacteria. However, the Escherichia Coli was noted to be sensitive to Levaquin.</p> <p>Review of the medication administration record revealed the resident received Keflex 500 milligrams from 12/01/24 to 12/06/24 for a total of 10 doses. She also received Levaquin from 12/12/24 to 12/17/24 for a total of six doses.</p> <p>There was no documentation in the medical record to indicate why the resident was treated with two different antibiotics.</p> <p>Interview with the Director of Nursing on 03/20/25 at 8:10 A.M. confirmed the resident was treated with Keflex before the urine culture results were obtained. She confirmed the facility did not attempt to obtain the urine culture results (completed 12/02/24) until 12/11/24. She stated the facility should have obtained them sooner. She confirmed there was no documentation as to why the resident was started on another antibiotic on 12/11/24. She confirmed the resident had no urinary symptoms of a UTI documented in the medical record.</p> <p>The McGeer Criteria for Infection Surveillance Checklist for Resident #27 stated the date of infection was 12/12/24. However, the form was not completed and did not indicate if the criteria was met for a UTI or not.</p> <p>Interview with the Director of Nursing on 03/19/25 at 3:30 P.M. confirmed the facility was not properly completing the McGeer's criteria forms to ensure that antibiotics were being prescribed appropriately.</p> <p>(continued on next page)</p>		

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

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>31404</p> <p>4. Record review of Resident #45 revealed an admitted [DATE] with pertinent diagnoses of: COPD, type two diabetes mellitus, chronic respiratory failure, chronic kidney disease stage four, dependence on renal dialysis, pressure ulcer of sacral region stage 4, atherosclerotic heart disease, atrial fibrillation, osteomyelitis, pleural effusion, acquired absence of right great toe, GI hemorrhage, resistance to vancomycin, anemia, viral hepatitis, hypothyroidism, hyperlipidemia, major depressive disorder, anxiety disorder, polyneuropathy, gout, Charcot's joint, dysphagia, retention of urine, thrombocytopenia, colostomy status, retention of urine, and chronic pain.</p> <p>Review of the 12/18/24 quarterly Minimum Data Set (MDS) revealed the resident was cognitively intact and used a wheelchair to aid in mobility.</p> <p>Review of a Physician Order dated 03/17/25 revealed Ciprofloxacin oral tablet 500 milligrams give one tablet by mouth two times a day for urinary tract infection for 10 Days until finished.</p> <p>Interview with Resident #35 on 03/17/25 at 1:42 P.M. revealed she went to the hospital last night for a urinary tract infection and and was prescribed antibiotics.</p> <p>Review of the 03/18/25 hospital lab culture and sensitivity on 03/20/25 revealed the Escherichia Coli organism was resistant to the ciprofloxacin prescribed for Resident #45 urinary tract infection.</p> <p>Interview with Corporate Administrator #100 on 03/20/25 at 9:55 A.M. verified the antibiotic ciprofloxacin was not an appropriate treatment for Resident #45 urinary tract infection organism.</p> <p>Review of the facility policy titled Infection Surveillance Policy dated 07/02/20 and last updated 01/13/23 revealed the McGeer Criteria will be used to define infections. Review of the facility policy titled Antibiotic Stewardship Policy and Procedure dated 09/08/17 and last updated 02/17/22 revealed the Centers for Disease Control and Prevention have identified antimicrobial resistance as a worldwide health threat and, in response, has released an antibiotic resistance solutions initiative as part of the [NAME] House's National Strategy for Combating Antibiotic Resistance. The facility is to use an interdisciplinary antibiotic stewardship team to be responsible for promoting the optimal use of antibiotics through the antibiotic stewardship program. The infection preventionist is to review all new antibiotic orders in morning meeting to discuss appropriateness of need and symptoms and report to the Director of Nursing any irregularities.</p>