

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365681	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/22/2024
NAME OF PROVIDER OR SUPPLIER Windsor Lane Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 355 Windsor Lane Gibsonburg, OH 43431	

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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31638</p> <p>THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY.</p> <p>Based on record review, staff interview, resident interview, and facility policy review, the facility failed to ensure a resident was free from physical abuse. This affected two residents (#2 and #3) of three reviewed for abuse. The facility census was 68.</p> <p>Findings include:</p> <p>1. Review of Resident #2's medical record revealed an admitted [DATE]. Diagnoses included morbid obesity, lymphedema, and chronic pain.</p> <p>Review of Resident #2's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed intact cognition and the resident had no negative behaviors.</p> <p>Review of Resident #2's care plan revealed she was at risk for mood issues due to a diagnosis of depression and anxiety.</p> <p>Review of Resident #2's progress note dated 11/05/24 revealed an incident happened on 11/02/24 between approximately 12:30 P.M. to 1:30 P.M. The altercation was between two residents (#2 and #3) and unwitnessed by the nurse. When the writer saw the patient, she was wheeling herself inside the building. The nurse asked what happened and the resident verbalized, He called me a fat bitch, referring to the resident involved in the incident. The nurse asked if she did any physical harm to the other resident and she did not admit anything to the writer. The writer advised Resident #2 to stay away from Resident #3 in order to not escalate the situation furthermore. Resident #2 agreed and wheeled self away from the other resident. No further altercation happened within the whole shift. The nurse advised the resident to inform the nurse for any assistance needed.</p> <p>2. Review of Resident #3's medical record revealed an admitted [DATE]. Diagnoses included morbid obesity, congestive heart failure, and pulmonary edema.</p> <p>Review of Resident #3's MDS assessment dated [DATE] revealed he had an intact cognition and no negative behaviors.</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
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #3's care plan revealed the resident was at risk for mood issues related to pain and being in a long term care facility.</p> <p>Review of Resident #3's progress note dated 11/05/24 revealed an altercation occurred between two residents (#2, #3) on 11/02/24 between approximately 12:30 P.M. and 1:30 P.M. The incident was unwitnessed by the nurse. When the nurse arrived to the area of the incident, the nurse asked Resident #3 what happened. Resident #3 explained to the nurse in an angry manner that it started when the materials for a party were placed on the dinner table without them knowing and it interrupted the area that they were using for lunch. Resident #3 informed the nurse that Resident #2 grabbed his left arm and ran her wheelchair into his left lower extremity. At that moment the nurse checked on the resident and no marks, bruises, or wounds were noted. At that time Resident #3 was offered and advised to stay away from the Resident #2 in order not to escalate the situation and he agreed. Resident #3 then wheeled himself inside the building to his room. The nurse offered him to be seen in the emergency room and call authorities, but he verbalized, No it is not needed, but next time I will if this happens again. Resident #3 was checked after an hour while sitting outside and verbalized, I'm feeling better. There was no discomfort at that time. Resident #3 was made aware to call the nurse for any assistance needed. The Certified Nurse Practitioner was made aware.</p> <p>Review of Resident #3's progress note dated 11/05/24 revealed the resident reported to nurse that he had an open area to left lower extremity. The site was assessed and pink drainage was noted. The resident explained that another resident had ran into him with her wheelchair. The site measured 1.5 centimeter (cm) by (x) 1 cm x less than 0.5 cm. The area was cleansed with normal saline, patted dry, and covered with a border dressing. The nurse updated the physician and a new order was received for treatment to cleanse the wound with normal saline, pat dry, and apply a dressing. The resident was made aware.</p> <p>Interview with Resident #2 on 11/22/24 at 8:20 A.M. revealed when she had a party, Resident #3 was bothered and had to make rude comments. She was planning a birthday party on 11/02/24 when Resident #3 became annoyed because the party supplies were on a dining room table which he normally sat at for lunch. He took pictures of the decorations and supplies. After hearing about his taking the photos, Resident #2 confronted Resident #3 outside. After having a verbal confrontation Resident #2 was leaving to return into the building when Resident #3 called her a fat (derogatory word). Resident #2 admitted to grabbing Resident #3's arm and warned him to not call her that again. Resident #3 told her he was going to punch her if she didn't let go of him. At that point staff intervened and requested she return into the facility.</p> <p>Interview with Resident #4 on 11/22/24 at 9:23 A.M. revealed he witnessed the altercation between Residents #2 and #3. He and Resident #2 were in the dining room and activities came in and put boxes on the table where the residents were sitting so they moved into the north dining room. Later he and Resident #3 were outside and Resident #2 came up and asked Resident #3 why he was always (explicit word) with her parties. Resident #3 told her to leave but she came back and ran her wheelchair into Resident #3 and grabbed his arm. The two residents continued to curse at each other. Once the staff came out, Resident #2 let go of Resident #3 and returned inside of the building.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with Certified Nurse Aide (CNA) #300 on 11/22/24 at 9:31 A.M. revealed she witnessed the incident between Residents #2 and #3 from inside the facility. She stated she heard a lot of yelling coming from the parking lot and saw the residents in a verbal altercation. Then Resident #2 grabbed Resident #3's arm and would not let go. Another CNA intervened and separated the residents. Management then arrived on the scene.</p> <p>Interview with Resident #3 on 11/22/24 at 10:03 A.M. stated he was outside and he saw saw a couple aides push a cart and one carrying party supplies into the facility for Resident #2. Those items were placed on the dining room table where he sat. Resident #2 was asked by activities to move to another table. The Resident Council rules state that nothing can be decorated during meal times. If there was a party or event the staff must wait until after a meal service to set up. Resident #3 then took a picture on his phone of the hot plates and supplies as it was before 1:00 P.M. After lunch he and Resident #4 went outside. Resident #2 came over to him and she was screaming and cussing. Resident #3 informed her to go back inside the building. Resident #2 then ran her motorized wheelchair into Resident #3's leg which took skin off the bottom of his leg. She grabbed his arm and she attempted to stand up. Resident #3 told her to remove her hands from him and she jerked his arm around. Resident #3 threatened to hit Resident #2 if she did not let go of him. Resident #2 scratched his arm in three places with her fingernails. After staff intervened, Resident #2 returned to the building. He was not going to report this to the police until Resident #2 posted statements regarding him on social media. Resident #3 then called the police and filed charges.</p> <p>Interview with Housekeeper #400 on 11/22/24 at 11:03 A.M. revealed she was in the parking lot taking trash out when she heard Resident #2 scream. Resident #2 then took her electric wheelchair and headed toward Resident #3, ran into his left leg, and grabbed his left arm. The CNA from the memory care unit came out and stopped the altercation.</p> <p>Interview with the Director of Nursing (DON) on 11/22/24 at 11:32 A.M. revealed interventions were put into place and both residents were educated on avoiding each other. The Ombudsman also stepped in and spoke to the resident. The physician ordered anger management classes for Resident #2. Daily monitoring, staff education, and resident assessments were completed. Care plans were updated regarding the potential to demonstrate verbal or physical behaviors.</p> <p>Interview with CNA #310 on 11/22/24 at 11:43 A.M. revealed she was working on the memory care unit, which has large windows, and heard the verbal altercation between Residents #2 and #3. The residents were swearing at each other. Resident #2 began leaving the area when Resident #3 called her a derogatory name. At that point Resident #2 ran her motorized wheelchair into Resident #3's left leg and grabbed his left arm. The CNA stated she attempted to get in between the residents and backed up Resident #2's wheelchair by using the joystick. At that time the DON came out to see what was happening and the CNA then moved away from the incident.</p> <p>Review of an email from the local police department dated 11/21/24 revealed there was no police report at that time because it was not completed. The county prosecutor had the information and was reviewing the case.</p> <p>Review of the Self-Reported Incident (SRI) dated 11/04/24 revealed the facility substantiated abuse and Resident #3 wanted to press charges against Resident #2.</p> <p>(continued on next page)</p>		

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<p>F 0600</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, Abuse, Neglect, Exploitation and Misappropriation of Resident Property: dated 2016 revealed abuse was the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting in physical harm, pain, or mental anguish. Windsor Lane Health Care and Rehabilitation Center will not tolerate Abuse, Neglect, Exploitation of it's residents or the Misappropriation of Resident property</p> <p>The deficient practice was corrected on 11/07/24 when the facility implemented the following corrective actions:</p> <p>11/02/24 Residents #2 and #3 were separated by the DON</p> <p>11/02/24 Residents were educated on the abuse policy by the DON</p> <p>11/05/24 Psychiatric Services provided for Resident #2</p> <p>11/05/24 All staff educated on the abuse policy</p> <p>11/07/24 and 11/08/24 All resident care plans were updated regarding the potential to demonstrate verbal or physical behaviors</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00159726.</p>		