

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  12/11/2024
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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15816</b></p> <p>Based on observation, medical record review, staff interview, review of a facility investigation including written statements, review of facility camera footage, hospital documentation review, review of a manufacture operating manual, and facility policy review, the facility failed to ensure specialized chairs were utilized in a safe and proper manner to prevent injuries. Actual Harm occurred when Resident #01 was placed in a Broda chair (a supportive positioning chair which allows residents to tilt and recline) equipped with caster type wheels and Resident #01 was left unattended while seated in the chair, which was not assessed for use, with the caster wheels unlocked. Resident #01 proceeded to lean forward and fell from the chair resulting in the resident sustaining serious injuries including a skin tear to the right forearm, a displaced fracture of the distal right femur, and a fracture through the proximal tibia metadiaphysis and fibular neck, subsequently requiring surgical repair. This deficient practice affected one (#01) of three sampled residents reviewed for fall prevention and assistive device use in a facility census of 69.</p> <p>Findings include:</p> <p>Review of the medical record revealed Resident #01 was admitted to the facility on [DATE]. Diagnoses included dementia, cataract, hypertension, congestive heart failure, cerebral infarction, major depressive disorder, atrial fibrillation, anxiety disorder, sick sinus syndrome, cardiac pacemaker, right femur fracture, left tibia fracture, muscular dystrophy, and rheumatoid arthritis.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #01 was assessed with severe cognitive impairment, was dependent on staff for the completion of activities of daily living (ADLs) including transfers, utilized a wheelchair for mobility propelled by staff, was incontinent of bowel and bladder, and had no recorded falls.</p> <p>Review of a fall risk assessment dated [DATE] revealed Resident #01 was at high risk for falling.</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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #01's falls risk care plan dated 05/16/22 revealed Resident #01 was at risk for falls related to fall history, gait or balance, muscular dystrophy, and impaired cognition due to dementia. Interventions included staff education, therapy screening, staff to anticipate the resident's needs, place frequently used items in reach, apply nonskid footwear as the resident allows, provide assistance with ambulation, toileting, and transfers as needed, use an alarm while the resident was in a chair and check placement and function each shift, and use proper turning and transfer technique when assisting the resident. Further review revealed no intervention to include Resident #01 was able to utilize a Broda chair.</p> <p>Review of a nursing progress note dated 11/18/24 at 5:34 P.M. revealed Registered Nurse (RN) #300 was called by a certified nurse aide (CNA) from the memory care unit and was informed Resident #01 had an unwitnessed fall. RN #300 went to the memory care unit and saw the resident on the floor slightly on her side and the resident's head was supported by a CNA. RN #300 checked Resident #01's vital signs and obtained a blood pressure of 132/82 millimeters of mercury (mmHg), a pulse rate of 79 beats per minute, an oxygen saturation level of 97 percent (%), and a temperature of 97.3 degrees Fahrenheit (F). Resident #01 was asked if she had any pain and the resident verbalized pain to her head, hips, and bilateral lower extremities. The resident was moaning in pain. Resident #01 was observed with a skin tear on the right forearm with no other open wounds identified. RN #300 contacted a certified nurse practitioner (CNP) and ordered for Resident #01 to be sent to the emergency room (ER) for evaluation. Emergency medical services (EMS) were called and when EMS arrived the staff safely transferred Resident #01 from the floor to the stretcher. Resident #01's Durable Power of Attorney (DPOA) agreed for the resident to be sent to hospital and report was given to the ER.</p> <p>Review of Resident #01's hospital documentation dated 11/18/24 noted an x-ray performed in the hospital and revealed a displaced fracture of the distal right femur (upper leg bone) and a fracture through the proximal tibia metadiaphysis and fibular neck (lower leg bones). On 11/19/24, Resident #01 underwent surgical repair which included left tibial surgical internal fixation and right femur intramedullary nail retrograde placement.</p> <p>Review of CNA #200's written statement dated 11/18/24 noted CNA #200 and CNA #201 were walking back after answering a call light when they saw Resident #01's chair tipping. CNA #201 rushed to Resident #01 while CNA #200 called the nurse.</p> <p>Review of CNA #201's written statement dated 11/18/24 revealed CNA #200 and CNA #201 were walking back to the main dining area on the memory care unit when they saw Resident #01's chair tipping. CNA #201 rushed to Resident #01 while CNA #200 called the nurse.</p> <p>On 12/11/24 at 8:17 A.M., interview with CNA #200 revealed on 11/18/24 she assumed care in memory unit at 3:00 P.M. Resident #01 was seated in a Broda chair with her feet elevated halfway up. At an unknown time, CNA #200 and CNA #201 went to a resident room located outside the view of the memory care unit dining room. The CNAs entered Resident #03's room located at the end of the hall. Both CNAs were in the room approximately four (4) minutes and when exiting with CNA #201, observed Resident #01 rocking and proceeded to tip the Broda chair forward. Both CNAs attempted to prevent the resident from falling forward, but were too late and Resident #01 fell to the floor. The Broda chair was tipped on the front two wheels and the footrest. Resident #01 was lying on her side on the floor. CNA #201 stayed with the resident while CNA #200 called the nurse (RN #300) for assistance.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Observation and interview on 12/11/24 at 8:55 A.M. with the Director of Nursing (DON), during review of facility camera footage, revealed on 11/18/24 at 3:15 P.M. Resident #01 was seated in the memory care unit dining room. Resident #01 was seated in a Broda chair with the footrest partially lowered. At 3:52 P.M., CNA #200 and CNA #201 left the memory care unit dining room, and at 3:54:53 P.M. Resident #01 was noted to be alone and unattended in memory care dining room in the Broda chair. Resident #01 then leaned back and proceeded to lean forward over her legs. The Broda chair tipped forward and Resident #01 fell to the floor with the chair tipping onto footrest and front wheels. The DON verified the rear wheels were observed to be spinning and unlocked. Both CNAs were observed running into the dining room while the resident was falling forward.</p> <p>On 12/11/24 at 11:32 A.M. an additional interview with CNA #200, during observation of the Broda chair, noted the chair was equipped with four caster wheels with locking mechanisms. CNA #200 sat in the chair with the caster wheels unlocked and proceeded to move her upper body over her legs. The Broda chair was noted to tip forward and CNA #200 placed her foot to the floor to prevent tipping over. CNA #200 stated when Resident #01 was sitting in the Broda chair the wheels were unlocked due to concern of the chair being a restraint.</p> <p>On 12/11/24 at 11:40 A.M. an additional interview with the DON, during review of the Broda chair operating manual, confirmed there was no evidence contained in Resident #01's medical record indicating the Broda chair was assessed for proper use and the chair wheels where locked when Resident #01 was left unattended in the chair on 11/18/24.</p> <p>Review of an undated Broda chair operating manual revealed the resident's primary caregiver was responsible for ensuring that anyone who was unfamiliar with, unwilling, or unable to adhere to the safety and operating instructions, was not permitted to operate or move the chair. After a resident was transferred into the chair, assess the amount of tilt required. It was recommended that when a resident had been moved to their destination, the chair was placed where the resident cannot reach handrails or other objects, fixed or movable. This was to prevent the resident from pulling the chair over or pulling themselves off the seating surface and to prevent the resident from pulling movable objects onto the chair and themselves. It was recommended the chair be used in a supervised area to prevent untrained residents, caregivers, or third parties from unauthorized operation, movement, or unsafe actions such as sitting or leaning on the reclined back, elevated footrest, or the armrests. These actions, if not prevented, put the chair at risk of tipping or damage to the chair. The special casters found on the Broda chair have total lock brakes which prevent the wheels from turning and swiveling. The brakes must always be applied when the chair was not in use, the resident was being transferred (moved) into or out of the chair, and when the chair was not being moved by a caregiver.</p> <p>Review of facility fall management policy, revised 07/31/14, revealed qualified staff assess all residents for fall risk through the nursing assessment form upon admission, quarterly, and with a significant change. The fall risk assessment assists in identifying the appropriate preventative interventions, and that they are recorded on the resident's care plan. If a fall occurs qualified staff immediately investigate the reason and determine the intervention to prevent future falls.</p> <p>Review of the undated fall investigation policy revealed intervention and prevention to include staff training on fall prevention strategies and proper use of assistive devices.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00160133.</p>		