STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365681	A. Building B. Wing	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Lane Healthcare Center	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on observation, resident interview, medical record review, staff interview, and review of facility policy, the facility failed to ensure skin treatments were completed per physician order. This affected one (#48) of three residents reviewed for wound treatments. The facility census was 71.Findings include:Review of the medical record for Resident #48 revealed an admission of 02/12/25. Diagnoses included morbid obesity, psoriasis vulgaris, seborrheic dermatitis, and Type I diabetes mellitus.Review of the quarterly Minimum Data Set (MDS) assessment, dated 07/09/25, revealed Resident #48 had intact cognition. Resident #48 required moderate assistance with Activities of Daily Living (ADLs). Review of the care plan dated 03/03/23 revealed Resident #48 was at risk for chronic cellulitis. Interventions included to cleanse areas daily with soap and water and dry thoroughly. Further review of the care plan revealed Resident #48 had actual ADL self-care performance deficits and was at risk for incontinence secondary to impaired mobility, generalized weakness, and fatigue. Interventions included monitoring skin during care. Additionally, Resident #48 was at risk for potential skin breakdown related to morbid obesity, lymphedema, and cellulitis. Resident #48 had a diagnosis of psoriasis vulgaris and seborrheic dermatitis. Interventions included documenting any refusals of treatment and completing treatments as ordered.Review of the physician orders revealed an order 02/29/25 for ketoconazole external cream 2%, apply to body topically every four days for psoriasis, apply small amount during shower. Further review revealed an order dated 03/03/25 for miconazole external powder 2% (anti-fungal), apply to folds and groin topically every day and evening shift for excoriation. Lastly, Resident #48 had an order dated 07/09/25 for triamcinolone acetonide external cream 0.1%, apply topically to affected areas every day and evening shift for plaque psoriasis.Review of the Treatment Administration Record (TAR) from 09/01/25 through 09/08/25 revealed Resident #48's ketoconazole external cream, miconazole external powder, and triamcinolone acetonide external cream were documented as administered as ordered. Interview on 09/08/25 at 2:29 P.M. with Resident #48 revealed she completed her own skin treatments, including ketoconazole external cream, miconazole external powder, and triamcinolone acetonide external cream. Resident #48 stated she had been out of the treatments for three days and had told nursing staff. Interview on 09/08/25 at 3:27 P.M. with Licensed Practical Nurse/Unit Manager (LPN/UM) #528 confirmed Resident #48 applied ketoconazole external cream, miconazole external powder, and triamcinolone acetonide external cream herself, and the treatments were left in the room. LPN/UM #528 verified that Resident #48 did not have an order to self-administer her treatments or keep treatments at bedside. LPN/UM #528 confirmed the treatments were signed off as completed on the TAR; however, LPN/UM #528 stated the treatments had not been available for a long time and were not available in the medication cart. Review of the facility policy titled, Medication Administration-General Guidelines, dated 03/20/18 revealed medications were administered in accordance with written orders of the attending physician.This deficiency represents non-compliance investigated under Complaint Number 1357196.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, staff interview, medical record review and review of the facility policy, the facility failed ensure medications were properly stored. This affected one (#48) of three residents reviewed for medication storage. The facility census was 71.Findings include:Review of the medical record for Resident #48 revealed an admission date of 02/12/25. Diagnoses included morbid obesity, chronic respiratory failure with hypoxia, and Type I diabetes mellitus. Review of the quarterly Minimum Data Set (MDS) assessment, dated 07/09/25, revealed Resident #48 had intact cognition. Resident #48 required moderate assistance with Activities of Daily Living (ADLs). Review of the care plan dated 03/03/23 revealed Resident #48 had chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), and a history of chronic respiratory failure with hypoxia. Interventions included monitoring for difficulty with breathing and give aerosol medication as ordered.Review of the physician orders revealed Resident #48 had an order dated 02/17/24 for fluticasone propionate nasal suspension 50 micrograms (mcg) per actuation (act), two sprays in both nostrils one time a day for allergies. Further review revealed Resident #48 did not have an order to self-administer medications or for medications to be left at bedside.Review of the Medication Administration Record (MAR) for 09/10/25 revealed Resident #48 received fluticasone propionate during morning medication administration.Interview on 09/08/25 at 2:29 P.M. with Resident #48 revealed nurses often left her medication on the bedside table. Observation on 09/10/25 at 8:58 A.M. of Resident #48's bedside table revealed a bottle of fluticasone propionate nasal suspension 50 mg/act with the prescription box next to the bottle. Further observation revealed the resident's name was on the box. Resident #48 was not in the room at the time of the observation. Interview on 09/10/25 at 8:59 A.M. with Licensed Practical Nurse (LPN) #704 revealed she administered Resident #48's morning medications. LPN #704 confirmed the fluticasone propionate was left on the bedside table, and further confirmed Resident #48 did not have a physician's order to self- administer medication or for medications to be left at bedside.Review of the facility policy titled, Medication Administration-General Guidelines, dated 03/20/18, revealed residents were allowed to self-administer medications when specifically authorized by the attending physician and in accordance with procedures for self-administration of medication. This deficiency represents non-compliance investigated under Master Complaint Number 1357285 (OH00167097) and Complaint Number 1357196 (OH00166824).

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on resident interview, staff interview, medical record review, and review of facility policy, the facility failed to ensure accurate Treatment Administration Records (TARs). This affected one (#48) of three residents reviewed for accurate medical records. The facility census was 71.Findings include:Review of the medical record for Resident #48 revealed an admission of 02/12/25. Diagnoses included morbid obesity, psoriasis vulgaris, seborrheic dermatitis, and Type I diabetes mellitus.Review of the quarterly Minimum Data Set (MDS) assessment, dated 07/09/25, revealed Resident #48 had intact cognition. Resident #48 required moderate assistance with Activities of Daily Living (ADLs). Review of the care plan dated 03/03/23 revealed Resident #48 was at risk for chronic cellulitis. Interventions included to cleanse areas daily with soap and water and dry thoroughly. Further review of the care plan revealed Resident #48 had actual ADL self-care performance deficits and was at risk for incontinence secondary to impaired mobility, generalized weakness, and fatigue. Interventions included monitoring skin during care. Additionally, Resident #48 was at risk for potential skin breakdown related to morbid obesity, lymphedema, and cellulitis. Resident #48 had a diagnosis of psoriasis vulgaris and seborrheic dermatitis. Interventions included documenting any refusals of treatment and completing treatments as ordered.Review of the physician orders revealed an order dated 02/29/25 for ketoconazole external cream 2%, apply to body topically every four days for psoriasis, apply small amount during shower. Further review revealed an order dated 03/03/25 for miconazole external powder 2% (anti-fungal), apply to folds and groin topically every day and evening shift for excoriation. Lastly, Resident #48 had an order dated 07/09/25 for triamcinolone acetonide external cream 0.1%, apply topically to affected areas every day and evening shift for plaque psoriasis.Review of the Treatment Administration Record (TAR) from 09/01/25 through 09/08/25 revealed Resident #48's ketoconazole external cream, miconazole external powder, and triamcinolone acetonide external cream were documented as administered as ordered. Interview on 09/08/25 at 2:29 P.M. with Resident #48 revealed she completed her own skin treatments, including ketoconazole external cream, miconazole external powder, and triamcinolone acetonide external cream. Interview on 09/08/25 at 3:27 P.M. with Licensed Practical Nurse/Unit Manager (LPN/UM) #528 confirmed Resident #48 applied ketoconazole external cream, miconazole external powder, and triamcinolone acetonide external cream herself, and the treatments were left in the room. LPN/UM #528 verified that nursing staff did not know if the resident applied the treatments or not and did not have an order to self-administer her treatments or keep treatments at bedside. LPN/UM #528 confirmed the treatments were signed off by nursing staff as completed on the TAR, including today; however, LPN/UM #528 stated the treatments were not available in the medication cart. Review of the facility policy titled, Medication Administration - General Guidelines, revised 03/20/18, revealed topical medications used in treatments were listed on the TAR. Further review revealed the individual who administered the medication dose recorded the administration directly after the medication was given. This deficiency represents noncompliance investigated under Master Complaint Number 1357285 (OH00167097).