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	12/29/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on resident interview, staff interview, review of facility self-reported incident (SRI), review of electronic medical record (EMR), and review of facility policy, the facility failed to ensure residents were free from verbal abuse. This affected one resident (#30) of three residents reviewed for abuse. The facility census was 70.' Findings Include: Review of the EMR for Resident #30 revealed an admission date of 08/05/24, with diagnoses including type two diabetes, hypothyroidism, anxiety disorder, atrial fibrillation, and hypertension. Review of the most recent Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating Resident #30 was cognitively intact. Resident #30 was dependent upon staff for toileting, showering/bathing, dressing, and transfers. Review of the facility SRI revealed that on 09/13/25 Resident #30 reported Certified Nursing Assistant (CNA) #401 was verbally abusive to her while assisting her with toileting. CNA #401 told Resident #30 to, Hurry up and pee because she had other people to take care of. Further review of the SRI revealed after investigation, the facility substantiated the verbal abuse from CNA #401 to Resident #30. CNA #401 was suspended on 09/13/25 and was terminated on 09/16/25 after the investigation was completed. Interview on 12/29/25 at 11:32 A.M. with Resident #30 revealed on 09/13/25, while assisting her with toileting, CNA #401 told Resident #30 to, hurry up and finish on the bedpan, so I can get you cleaned up. I have more people to take care of. Resident #30 stated she felt this comment was verbally abusive and caused her mental anguish. Interview on 12/29/25 at 12:10 P.M. with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) #108 verified the facility substantiated the verbal abuse allegations made by Resident #30 about CNA #401 on 09/13/25. The DON stated CNA #401 was immediately suspended and subsequently terminated upon completion of the investigation. Review of the undated facility policy titled, Abuse, Neglect, Exploitation & Misappropriation of Resident Property, revealed abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain, or mental anguish. Abuse also includes deprivation by an individual, including a caretaker of goods or services that are necessary to attain or maintain mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse and mental abuse, including abuse facilitated or enabled through the use of technology, such as through the use of photographs or recording device to demean or humiliate a resident. The deficient practice was corrected on 10/01/25 when the facility implemented the following corrective actions: On 09/13/25 CNA #401, the alleged perpetrator, was suspended pending the facility investigation results. On 09/15/25 Resident #30 was interviewed regarding this incident. On 09/15/25 all residents in the facility were interviewed to determine if they had experienced abuse of any kind. On 09/15/25 all staff received education from the DON and ADON #108 on abuse policies. On 09/16/25, upon completion of the facility investigation, CNA #401 was terminated from the facility. On 09/17/25 five residents were monitored and interviewed for abuse of any kind with none being identified. On 09/24/25 five residents were monitored and interviewed for abuse of any kind with none being identified. On 10/01/25 this incident was reviewed by the Quality Assurance (QA) Committee. Interviews on 12/29/25 with CNA's #158, #162, #176, and #198, Licensed Practical Nurses (LPNs) #127 and #157, and Registered Nurses (RNs) #131 and #400, revealed staff were able to identify types of abuse and procedures for abuse allegations. They all reported they received training on abuse policies and procedures. On 12/29/25 Resident #30 and two additional residents (#32 and #35) were sampled and reviewed for abuse. No other concerns were identified. On 12/29/25, review of the facility's SRI's revealed there were no further concerns identified regarding abuse. This deficiency represents non-compliance investigated under Complaint Number 2620684.