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	02/27/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, facility documentation, and review of facility policy, the facility failed to ensure allegations of resident neglect were reported to the state agency. This affected two (#2, #3) of three residents reviewed for staff treatment and care. The facility census was 72. Findings include: 1. Review of the medical record for Resident #2 revealed an admission date of 10/28/25. Diagnoses included, type II diabetes mellitus, epilepsy, dementia, major depression, cerebral infarction, parosmia, and hypertension. Review of the most current Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #2 had severe cognitive impairment, exhibited no behaviors, was dependent for all activities of daily living including toileting, was frequently incontinent, and was at risk for pressure ulcer with no current skin breakdown. Review of the resident's progress notes from October 2025 through February 2026 lacked evidence regarding any alleged incidents.2. Review of the medical record for Resident #3 revealed an admission date of 09/01/25. Diagnoses included Alzheimer's disease, dementia, epilepsy, major depressive disorder, anemia, and anxiety disorder. Review of the MDS assessment dated [DATE] revealed Resident #3 had severe cognitive impairment, behaviors directed at others, was dependent on staff for completion of activities of daily living, was incontinent of bladder, was continent of bowel, and was at risk for pressure ulcer development with no skin breakdown. Review of the resident's progress notes from October 2025 through February 2026 lacked evidence regarding any alleged incidents.On 02/27/26 at 9:27 A.M. interview with Human Resources Director (HRD) #200 revealed on 12/03/25 Activity Assistant (AA) #300 provided a written statement regarding Certified Nurse Aide (CNA) #400 and CNA #401. The statement indicated CNA #400 and CNA #401 had denied certain residents residing on the dementia unit opportunities to toilet and treated the residents in a disrespectful manner. HRD #200 stated the allegations were not reported to the state agency and a written investigation was not completed. Furthermore, CNA #400 and #401 were not removed from the facility due to the allegations but were placed on a different unit to provide care to those residents.Review of AA #300 written statement dated 12/03/25 revealed her first couple of weeks working in the unit, AA #300 witnessed the nurses aide CNA #400 raise her voice at a resident multiple occasions. One time CNA #400 raised her voice and told Resident #3 she was not allowed to speak to people a certain way and was told she needed to apologize. Later CNA #400 was heard yelling at Resident #3 that she needed to be quiet. Resident #3 was in her room. AA #300 was down the hall in the main area. On another occasion, about a week prior to providing the written statement, Resident #3 asked to use the restroom. Resident #3 had gone maybe 45 minutes prior to asking and CNA #400 asked Resident #3, Are you going to go this time? in a demeaning tone. Resident #3 continued asking if she could use the restroom and was told, hold on by CNA #400. After five to ten minutes of asking, the lunch cart arrived and CNA #400 told Resident #3 it was lunch time now and that she could not take her to the bathroom. Resident #3 was clearly upset. CNA #400 told the resident it was okay, because (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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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she was wearing a brief, in front of many people. On multiple occasions CNA 400 has scolded Resident #3. Most recently being yesterday December 2nd in the afternoon. CNA #400 and #401 recounted what seemed to consider a humorous anecdote about Resident #3 being upset about something pertaining to her dog (the resident has a stuffed dog she considers real) and CNA #401 took the dog and threw it in front of Resident #3, causing distress. The joke was they told Resident #3 the dog grew wings in that moment. AA #300 stated Resident #3 is regularly targeted and subjected to bullying and neglectful treatment. Further review of the written of AA #300's written statement revealed a few weeks ago AA#300 was at the table with a few residents, including Resident #2. Resident #2 announced she needed to use the restroom. CNA #401 was assisting another resident. So CNA #400 told her they would help her soon. Over the next hour, Resident #2 continued asking to use the restroom repeatedly. CNA #400, who was on her phone, kept telling her she had to wait. Resident #2 kept telling AA #300 over and over I'm going to poop my pants, I need to go to the bathroom now.On 12/07/25 CNA #400 wrote a statement regarding the allegation on 12/03/25 stating she has never denied any resident's request on brining them to the bathroom when they ask. If they happen to ask during a mealtime and the other aide on the floor is in a resident's room, she apologizes and lets the resident know she cannot leave the dining room unattended and tells them as soon as the other aide comes back she will take the resident to the bathroom. CNA #400 stated she has never told a resident to just go in your brief. As to the allegation of CNA #400 just sitting at the table, its because you can see everything especially the television area where there is also a door. CNA #400 stated they do have a resident that can not have anything by mouth and on occasion one of the residents likes to share snacks with this said resident.On 02/27/26 at 11:40 A.M. interview with the Director of Nursing (DON), Assistant Director of Nursing (ADON), and Human Resources Director #200 verified when Activity Assistant submitted written allegations no investigation was documented and the state agency was not notified of the allegations.Review of facility Abuse, Neglect, Exploitation and Misappropriation of Resident Property policy dated 2016. All incident and allegations of Abuse, Neglect, Exploitation, Mistreatment of a resident, or misappropriation of resident property and all injuries of unknown source must be immediately reported to the administrator or designee. The Administrator of his/her designee will notify the state survey agency of all alleged violations involving of Abuse, Neglect, Exploitation, Mistreatment of a resident, or misappropriation of resident property and all injuries of unknown source as soon as possible, but no later than twenty-four (24) hours from the time of the incident/allegation was made known to the staff member.This deficiency represents non-compliance investigated under Complaint Number 2715158.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, review of facility documentation, and review of facility policy, the facility failed to ensure allegations of resident neglect were promptly acted upon to prevent further neglect, and thoroughly investigated. This affected two (#2 and #3) of three residents reviewed for staff treatment and care. The facility census was 72. Findings include: 1. Review of the medical record for Resident #2 revealed an admission date of 10/28/25. Diagnoses included, type II diabetes mellitus, epilepsy, dementia, major depression, cerebral infarction, parosmia, and hypertension. Review of the most current Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #2 had severe cognitive impairment, exhibited no behaviors, was dependent for all activities of daily living including toileting, was frequently incontinent, and was at risk for pressure ulcer with no current skin breakdown. Review of the resident's progress notes from October 2025 through February 2026 lacked evidence regarding any alleged incidents.2. Review of the medical record for Resident #3 revealed an admission date of 09/01/25. Diagnoses included Alzheimer's disease, dementia, epilepsy, major depressive disorder, anemia, and anxiety disorder. Review of the MDS assessment dated [DATE] revealed Resident #3 had severe cognitive impairment, behaviors directed at others, was dependent on staff for completion of activities of daily living, was incontinent of bladder, was continent of bowel, and was at risk for pressure ulcer development with no skin breakdown. Review of the resident's progress notes from October 2025 through February 2026 lacked evidence regarding any alleged incidents.On 02/27/26 at 9:27 A.M. interview with Human Resources Director (HRD) #200 revealed on 12/03/25 Activity Assistant (AA) #300 provided a written statement regarding Certified Nurse Aide (CNA) #400 and CNA #401. The statement indicated CNA #400 and CNA #401 had denied certain residents residing on the dementia unit opportunities to toilet and treated the residents in a disrespectful manner. HRD #200 stated the allegations were not reported to the state agency and a written investigation was not completed. Furthermore, CNA #400 and #401 were not removed from the facility due to the allegations but were placed on a different unit to provide care to those residents.Review of AA #300 written statement dated 12/03/25 revealed her first couple of weeks working in the unit, AA #300 witnessed the nurses aide CNA #400 raise her voice at a resident multiple occasions. One time CNA #400 raised her voice and told Resident #3 she was not allowed to speak to people a certain way and was told she needed to apologize. Later CNA #400 was heard yelling at Resident #3 that she needed to be quiet. Resident #3 was in her room. AA #300 was down the hall in the main area. On another occasion, about a week prior to providing the written statement, Resident #3 asked to use the restroom. Resident #3 had gone maybe 45 minutes prior to asking and CNA #400 asked Resident #3, Are you going to go this time? in a demeaning tone. Resident #3 continued asking if she could use the restroom and was told, hold on by CNA #400. After five to ten minutes of asking, the lunch cart arrived and CNA #400 told Resident #3 it was lunch time now and that she could not take her to the bathroom. Resident #3 was clearly upset. CNA #400 told the resident it was okay, because she was wearing a brief, in front of many people. On multiple occasions CNA 400 has scolded Resident #3. Most recently being yesterday December 2nd in the afternoon. CNA #400 and #401 recounted what seemed to consider a humorous anecdote about Resident #3 being upset about something pertaining to her dog (the resident has a stuffed dog she considers real) and CNA #401 took the dog and threw it in front of Resident #3, causing distress. The joke was they told Resident #3 the dog grew wings in that moment. AA #300 stated Resident #3 is regularly targeted and subjected to bullying and neglectful treatment. Further review of the written of AA #300's written statement revealed a few weeks ago AA#300 was at the table with a few residents, including Resident #2. Resident #2 announced she needed to use (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the restroom. CNA #401 was assisting another resident. So CNA #400 told her they would help her soon. Over the next hour, Resident #2 continued asking to use the restroom repeatedly. CNA #400, who was on her phone, kept telling her she had to wait. Resident #2 kept telling AA #300 over and over I'm going to poop my pants, I need to go to the bathroom now.On 12/07/25 CNA #400 wrote a statement regarding the allegation on 12/03/25 stating she has never denied any resident's request on brining them to the bathroom when they ask. If they happen to ask during a mealtime and the other aide on the floor is in a resident's room, she apologizes and lets the resident know she cannot leave the dining room unattended and tells them as soon as the other aide comes back she will take the resident to the bathroom. CNA #400 stated she has never told a resident to just go in your brief. As to the allegation of CNA #400 just sitting at the table, its because you can see everything especially the television area where there is also a door. CNA #400 stated they do have a resident that can not have anything by mouth and on occasion one of the residents likes to share snacks with this said resident.Review of CNA #400's timecard noted time entries on 12/02/25 from 7:00 A.M. to 2:45 P.M, 12/03/25 from 7:00 A.M. to 3:00 P.M. , 12/04/25 from 7:00 A.M. to 3:00 P.M., and 12/05/25 7:00 A.M. to 5:30 P.M.Review of a progressive disciplinary action form dated 12/03/25 noted CNA #400 received a final warning. Details revealed the employee had been observed using her cell phone multiple times in resident care areas while on clock, violating facility policy. The discipline also referenced CNA #400 having an unprofessional demeanor toward staff and residents on multiple occasions and reports indicating inappropriate or disrespectful demeanor towards co-workers and/or residents including tone of voice, attitude, or behavior inconsistent with facilities standards for resident care along with failure to complete assigned duties and tasks for residents.Review of CNA #401 timecard noted time entries on 12/01/25 from 7:00 A.M. to 7:15 P.M., 12/02/25 from 7:15 A.M. to 3:15 P.M., 12/04/25 from 10:30 A.M. to 11:30 A.M , 12/06/25 from 7:00 A.M. to 7:15 P.M. Review of a progressive disciplinary action form dated 12/04/25 noted CNA #401 received a verbal warning. Details revealed CNA #401 was on cell phone while in resident care areas.On 02/27/26 at 11:40 A.M. interview with the Director of Nursing (DON), Assistant Director of Nursing (ADON), and Human Resources Director #200 verified when Activity Assistant submitted written allegations no investigation was documented and the state agency was not notified of the allegations.Review of facility Abuse, Neglect, Exploitation and Misappropriation of Resident Property policy dated 2016. All incident and allegations of Abuse, Neglect, Exploitation, Mistreatment of a resident, or misappropriation of resident property and all injuries of unknown source must be immediately reported to the administrator or designee. The Administrator of his/her designee will notify the state survey agency of all alleged violations involving of Abuse, Neglect, Exploitation, Mistreatment of a resident, or misappropriation of resident property and all injuries of unknown source as soon as possible, but no later than twenty-four (24) hours from the time of the incident/allegation was made known to the staff member. Once the administrator and state survey agency is notified, an investigation of the allegation violation will be conducted. If a staff member is accused or suspected of Abuse, Neglect, Exploitation, Mistreatment of a resident, or misappropriation of resident property. The facility should immediately remove the staff member from the facility and the schedule pending the outcome of the investigation. Documentation in then nurses notes should include results of the residents assessment, notification of the physician and resident representative, and any treatment provided. The investigation must be completed within five (5) working days. Investigation protocol included; Interview the resident, the accused, and all witnesses. Witnesses generally include anyone who witnessed or heard the incident; came in close contact with the resident and/or the alleged victim the day of the incident. Obtain a statement from the resident, if possible, (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the accused, and each witness. Review the residents records. Evidence of the investigation should be documented. This deficiency represents non-compliance investigated under Complaint Number 2715158.