

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  366281	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/21/2025
NAME OF PROVIDER OR SUPPLIER  Windsor House at Champion		STREET ADDRESS, CITY, STATE, ZIP CODE  200 East Glendola Avenue Champion, OH 44483	

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 0689  Level of Harm - Actual harm  Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.  (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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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on closed medical record review, facility policy review and interview, the facility failed to ensure Resident #88 was provided with necessary and adequate care and services to prevent accidents with injury during staff assisted care. This affected one resident (#88) of three residents who were investigated for accidents. The facility census was 87. Actual Harm occurred on 08/30/25 when Resident #88, who had severe cognitive impairment and was dependent on staff for activities of daily living sustained a fractured distal medial femoral metadiaphysis when staff failed to ensure the resident's foot was not caught under her wheelchair while being transported by staff. Actual harm also occurred on 10/03/25 when staff members failed to secure Resident #88 in the Hoyer (mechanical) lift during a transfer, which resulted in a fractured right upper extremity/elbow. Findings include: Review of the closed medical record revealed Resident #88 was admitted to the facility on [DATE] with diagnoses of unspecified dementia, early onset Alzheimer's disease, major depressive disorder, anxiety disorder, osteoarthritis and muscle wasting. Resident #88 was discharged to another skilled nursing facility on 10/06/25. Review of Resident #88's care plan dated 12/21/23 revealed the resident had difficulty with communication related to moderate hearing impairment and impaired cognition and was sometimes understood and rarely/never understood others. Interventions included facing the resident while talking and giving the resident time to respond with each interaction. The care plan also revealed Resident #88 was at risk of falls and required a Hoyer lift for all transfers. The care plan also noted the resident used a wheelchair daily. The use of elevating leg rests was added to the wheelchair on 09/03/25. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of three out of 15, indicating Resident #88 had severe cognitive impairment. The assessment revealed Resident #88 was dependent on staff for all activities of daily living (ADL) and mobility. Review of Resident #88's fall risk assessment dated [DATE] revealed the resident was at high risk for falls with a score of 13. Review of a nursing progress note dated 08/31/25 at 07:09 A.M. authored by Licensed Practical Nurse (LPN) #527 revealed she was notified the resident's left knee was swollen and when staff attempted to move her leg, she yelled out in pain. LPN# 527 then obtained an order for an x-ray of the left knee. Review of the result of Resident #88's left knee x-ray from 08/31/25 revealed a displaced oblique periprosthetic fracture of the distal medial femoral metadiaphysis and a recommendation for an orthopedic consultation. The facility investigation dated 08/31/25 revealed a knee injury occurred on 08/30/25. Resident #88 was complaining of knee pain on the evening of 08/30/25 after her foot went under her wheelchair while she was being pushed back to her room after dinner. The resident was medicated with Tylenol by LPN #507 but complained of knee pain when her knee was touched or her leg was moved. On 08/31/25, LPN # 597 obtained an x-ray of the resident's left knee which revealed a fracture of the distal medial femoral metadiaphysis. The resident was then transferred to the emergency room and returned wearing a leg immobilizer and a recommendation for an orthopedic consultation. Interview with Certified Nursing Assistant (CNA) #568 on 10/16/25 at 4:12 P.M. revealed Resident #88 didn't have leg rests on her wheelchair on 08/30/25 and while pushing her back to her room from dinner her feet were dangling, her toes grazed the floor, and her left foot skidded under the wheelchair. CNA #568 also stated she tried to recline Resident #88's chair when the resident complained of pain in her left leg/knee. CNA #88 stated it was common knowledge among the CNAs that Resident #88 would not lift her feet while being transported and would often need reminded to do so. She was unaware of what Resident #88's care plan said with regard to transporting her in the wheelchair or whether or not she was supposed to have leg rests. Interview the CNA #564 on 10/16/25 at 5:02 P.M. revealed Resident #88 had a short chair, her feet always drug on the ground, and she needed to be leaned back while she was moving. CNA #564 also stated Resident #88's feet were always on the ground and indicated the resident needed to have leg rests (on the wheelchair) but didn't have them. CNA #564 also stated this was common knowledge among the CNAs. CNA #564 stated when she came in to work on 08/30/25, Resident #88 was in a lot of pain when the resident was assisted to bed and the nurse on duty gave her Tylenol (analgesic). CNA #564 stated the next morning, the resident was still in a lot of pain every time she moved her left leg. CNA #564 further stated Resident #88 would often drop her feet and stop the wheelchair from moving while being transported. CNA #564 stated she told everyone this resident needed leg rests, but she didn't have them</p>		