

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 01/09/2025
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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973</p> <p>THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY.</p> <p>Based on interview, observation, record review, review of social media post, review of Self-Reported Incident (SRI) #254779 and review of the facility abuse policy revealed the facility failed to ensure Resident #67 was free from abuse. This affected one resident (#67) out of two residents reviewed for abuse. The facility census was 80.</p> <p>Findings include:</p> <p>Review of medical record for Resident #67 revealed an admitted [DATE] and diagnoses included Alzheimer's disease, hypertension, major depression disorder, heart failure, and anxiety disorder.</p> <p>Review of SRI #254779 with a date of discovery of 12/05/24 revealed the facility filed the SRI related to emotional and verbal abuse. On 12/05/24 at approximately 12:50 P.M. the Administrator was notified by Restorative Certified Nursing Assistant (CNA) #510 that she observed a social media video post involving Resident #67 and Activity Aide #600. The video revealed Resident #67 seated in her recliner and Activity Aide #600 asking the resident if she would be interested in him and whether she wanted him. During the video Resident #67 did not respond. The administrator interviewed Activity Aide #600 who admitted recording and putting the video on social media. The SRI revealed Resident #67 was interviewed and had no recollection or knowledge of being recorded and her demeanor was at baseline. The facility substantiated the SRI for emotional and verbal abuse.</p> <p>Review of witness statement dated 12/05/24 completed by the Administrator revealed she spoke with Activity Aide #600 about the video uploaded to social media and he stated he had taken the video either 12/01/24 or 12/03/24 in Resident #67's room. The Administrator asked Activity Aide #600 why he had taken the video, and he stated it was on impulse and that he thought it would be funny. The Administrator asked if there were any other social media posts, and he denied any other incidents involving Resident #67 or any other resident.</p> <p>Review of quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #67 had impaired cognition as her Brief Interview for Mental Status (BIMS) score was six. She had no behaviors identified.</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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 01/06/25 at 11:02 A.M. with Resident #67 revealed she was cognitively impaired and was unable to recall if anyone ever took her picture or video at the facility or any details regarding the incident. Resident #67 revealed she felt safe at the facility and denied any abuse.</p> <p>Interview on 01/07/25 at 9:56 A.M. with the Administrator revealed on 12/05/24 at approximately 12:50 P.M. Restorative CNA #510 reported that she had observed a video on social media involving Resident #67 and Activity Aide #600. She revealed she immediately filed the SRI and initiated an investigation. The Administrator revealed Activity Aide #600 was not on duty at the time of the initiation of the investigation. Activity Aide #600 admitted to taking and placing the video on social media and he was terminated from the facility. Police Officer #601, Medical Director/ Primary Care Physician #602 and Resident #67's responsible party were notified of the incident on 12/05/24. The Administrator verified the facility had substantiated the incident as emotional and verbal abuse.</p> <p>Observation on 01/07/25 at 10:00 A.M. of the video (no longer on social media) with the Administrator revealed there was no exact date as to when it was uploaded to social media. Observation revealed a split screen with Resident #67 sitting in a recliner and Activity Aide #600 on the other side of the screen. The social media printed the following on the bottom of the screen as it indicated Activity Aide #600 stated Greetings in salutations gross. Resident #67 stated, Huh and Activity Aide #600 stated Greeting in salutation gross would you be interested in a young fine [expletive] male like myself. Activity Aide #600 then proceeded to pull down his surgical mask and stated, Do you want me? Resident #67 did not respond. The video ended with Resident #67 appearing to have a puzzled look on her face. The Administrator verified the above as to what was on the video.</p> <p>Interview on 01/07/25 at 11:01 A.M. with Restorative CNA #510 revealed her daughter had shown her the social media post as she went to school with Activity Aide #600 and after she showed it to her, she reported the incident to the Administrator. She verified the same video that was observed was the same video she had observed on social media.</p> <p>Review of the personnel file for Activity Aide #600 revealed his date of hire was 10/14/22 and that he was educated and signed an acknowledgement on 10/14/22 regarding the facility social media policy as well as he was trained on abuse. Activity Aide #600 was most recently trained regarding abuse on 01/22/24.</p> <p>Review of facility policy labeled, Social Media Policy dated January 2021 revealed staff members were not to post on social media sites photographs or videos of residents without permission from those individuals and the administrator.</p> <p>Review of facility policy labeled, Resident Abuse Prevention dated October 2022 revealed the facility was to protect all residents from mistreatment, neglect, and abuse including verbal, mental, physical and emotional abuse. The policy defined mental abuse as humiliation, and harassment as well as nursing staff taking or using photographs or recordings in any manner that would demean or humiliate a resident. The policy defined verbal abuse as any use of oral, written or gesture language that willfully included disparaging and derogatory terms to the resident regardless of ability to comprehend.</p> <p>The deficient practice was corrected on 12/07/24 when the facility implemented the following corrective actions:</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/05/24 the facility filed SRI #254779 regarding the incident of emotional/ verbal abuse involving Activity Aide #600 and Resident #67.</p> <p>On 12/05/24 Activity Aide #600 was terminated.</p> <p>On 12/05/24 the facility initiated and completed a thorough investigation including gathering of witness statements from staff and residents who were cognitively able.</p> <p>On 12/05/24 Police Officer #601 was notified of the incident.</p> <p>On 12/05/24 Medical Director/ Primary Care Physician #602 was notified of the incident and evaluated Resident #67 on 12/09/24 with no ill effects detected as she appeared at her baseline.</p> <p>On 12/05/24 and 12/06/24 Licensed Practical Nurse (LPN)/ Supervisor #587 met with Resident #67 and on assessment she appeared per her baseline as well as having no recollection of the incident.</p> <p>On 12/05/24 Resident #67's responsible party was notified of the incident.</p> <p>On 12/05/24 all staff received education on abuse, resident rights and the facility policy regarding social media.</p> <p>From 12/07/24 to 12/28/24 the facility completed cell phone audits ensuring staff were not utilizing their cell phone while on duty. Random audits to ensure staff were not utilizing their cell phone while on duty would be ongoing.</p> <p>To ensure ongoing compliance the Quality Assurance and Performance Improvement (QAPI) committee would monitor the data related to the issue at the next meeting an ongoing as necessary.</p> <p>This deficiency represents non-compliance investigated under Control Number OH00160787.</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>49774</p> <p>Based on record review, policy review, and interview the facility failed to send written notice to Residents #18 and #81 or the resident's representatives after the resident transferred from the facility was and admitted to the hospital. This affected two of two residents whose records were reviewed for discharge to hospital.</p> <p>Finding include:</p> <p>1. Review of the Nursing Note dated 11/01/24 timed 2:45 A.M. revealed Registered Nurse (RN) #501 overheard Resident #18 yell help us. The nurse ran down to the room and observed Resident #18 laying on the floor on her stomach with her head resting on the wheel and bar of the roommate's bed with head bleeding. Resident #18 was unable to tell the nurse what happened; when asked she said, I don't know. Resident #18 was observed with large open wound on the left side of her head, a reddened left shoulder, a large skin tear to the left hand, and skin tear to the left leg. Resident #18's wounds were cleansed, and bandages applied, and vital signs were taken. Emergency Medical Services was called, and Resident #18 was transported to the hospital where she was admitted . Resident #18's physician and her representative were notified.</p> <p>Review of the Nursing Note dated 11/0/2024 timed 4:35 P.M. revealed Resident #18 returned to the facility from the hospital via ambulance.</p> <p>Further review of Resident #18's records revealed no evidence of a written notice of discharge or transfer being sent to the resident or resident representative.</p> <p>Interview on 01/09/24 at 11:27 A.M. with Business Office Manager (BOM) #506 verified no written notification of discharge or transfer was sent to Resident #18 and/or the resident representative. Additionally, BOM #506 stated that since the beginning of November 2024, no written notification of discharge or transfers had been completed and sent to resident representatives because the former employee responsible for giving the notices left the facility and no one sent the notifications to resident representatives since November and most of December 2024.</p> <p>Review of the facility policy titled, Transfer and Discharge Rights Chapter IV-B which was revised October 2022 stated The facility must notify the resident and the resident's representative the reason for transfer or discharge and the reason for the move in writing; notice of transfer or discharge is given to the resident and their representative as soon as possible in the following situations: urgent medical need or the resident and/or the resident has not resided in the facility for thirty days</p> <p>2. Review of the Nursing Note dated 11/25/24 timed 1:00 A.M. revealed Licensed Practical Nurse (LPN) #513 contacted the local fire department who assisted with transferring Resident #81 from bed to a cot and transported Resident #81 to the hospital at 1:55 A.M. per resident request after a complaint of abdominal pain. Resident #81 was admitted to the hospital. Resident #18's physician and representative were notified.</p> <p>(continued on next page)</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Further record review revealed Resident #81 did not return to the facility and no evidence of a written notice of discharge or transfer being sent to the resident or resident representative.</p> <p>Interview on 01/09/24 at 11:27 A.M. with Business Office Manager (BOM) #506 verified no written notification of discharge or transfer was sent to Resident #81, and/or the resident representative. Additionally, BOM #506 stated that since the beginning of November 2024, no written notification of discharge or transfers had been completed and sent to resident representatives because the former employee responsible for giving the notices left the facility and no one sent the notifications to resident representatives since November and most of December 2024.</p> <p>Review of the facility policy titled, Transfer and Discharge Rights Chapter IV-B which was revised October 2022 stated The facility must notify the resident and the resident's representative the reason for transfer or discharge and the reason for the move in writing; notice of transfer or discharge is given to the resident and their representative as soon as possible in the following situations: urgent medical need or the resident and/or the resident has not resided in the facility for thirty days.</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide activities to meet all resident's needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48565</p> <p>Based on observation, interview and policy review the facility failed to provide meaningful activities as scheduled. This affected one resident (#70) of two residents (#70 and #78) who were reviewed for activities. The facility census was 80.</p> <p>Findings include:</p> <p>A review of medical records for Resident #70 revealed an admitted [DATE]. Significant diagnoses included Alzheimer's disease, schizophrenia, anxiety, Parkinson's disease, and congestive heart failure. Significant orders included activity as tolerated, Memantine 10 milligrams (mg) every 12 hours for Alzheimer's disease, Divalproex 500 mg take two tablets at bedtime for Alzheimer's disease, chlorpromazine 50 mg one tablet at bedtime for anxiety, Donepezil 10 mg at bedtime for Alzheimer's disease, and Lamictal 100 mg one tablet daily for schizophrenia.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of seven indicating severe cognitive impairment.</p> <p>Review of the care plan dated 11/27/24 revealed Resident #70 had impaired cognitive function/dementia or impaired thought processes related to Alzheimer's disease. Interventions included to encourage participation in small group activities that promoted choice, self-expression and/or responsibility and engage the resident in simple, structured activities that avoided overly demanding tasks.</p> <p>There was no activity assessment noted in the medical record for Resident #70.</p> <p>Observation on 01/06/25 at 10:00 A.M. revealed Resident #70 was laying in bed.</p> <p>Observation on 01/07/25 at 9:20 A.M. revealed Resident #70 sitting in front of the television in the common area on north hall.</p> <p>A review of the Activity Calendar for 01/07/25 revealed at 10:00 A.M. the game Yahtzee was to be played.</p> <p>An observation on 01/07/25 at 10:25 A.M. revealed Activity Assistant (AA) #522 and AA #543 sitting in the main dining room where the Yahtzee activity was to take place. AA #522 was coloring and AA #543 was drinking coffee. Yahtzee was not being played. There was one in the main dining room reading the newspaper. An interview with AAs #522 and #543 at the time of the observation revealed no residents wanted to play Yahtzee. AA #522 and #543 verified there was not an alternate activity happening.</p> <p>On 01/07/25 at 10:30 A.M. The Director of Nursing (DON) verified AA #522 was coloring and AA #543 was drinking coffee. The DON also verified there was no activity going on as scheduled.</p> <p>On 01/07/25 at 10:37 A.M. an interview with Activity Director (AD) #569 revealed when residents did not want to participate in an activity, the activity should be adjusted to resident wants and preferences. AD #569 also stated one on one activities could be done if residents did not want to participate in the scheduled activity.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 01/07/25 at 2:00 P.M. revealed Resident #70 laying in bed.</p> <p>On 01/08/25 at 12:52 P.M. an interview with AD #569 and Corporate Licensed Nursing Home Administrator #597 verified the lack of an activity assessment for Resident #70 within the medical record.</p> <p>A review of the policy titled; Resident Activities Policy, Activities assessment dated [DATE] revealed the facility would provide an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interest and the physical, mental, and psychosocial well-being of each resident. The policy also indicated the purpose of resident activities was to encourage self-care, maintain an optimal level of psychosocial desires and movements. It also strived to encourage the resident to want to do activities within the limitations of the individual. Activities were appropriate to the needs and interests of each resident. The program was flexible and designed to accommodate the changing needs and interests of residents. The policy also indicated residents' individual activity plan of care should be reviewed by the activity coordinator at least quarterly and with a significant change.</p>

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<p>F 0868</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have the Quality Assessment and Assurance group have the required members and meet at least quarterly</p> <p>51073</p> <p>Based on record review and interview, the facility did not ensure Quality Assurance Performance Improvement (QAPI) meetings were held at least quarterly. This had the potential to affect all residents in the facility. The facility census was 80.</p> <p>Findings include:</p> <p>A review of the facility documents titled QA Signature Sheet revealed QAPI meetings were held on 04/12/23, 05/17/23, 06/07/23, 08/16/23, 10/11/23, 04/17/24, 05/08/24, 06/05/24, 07/10/24, 11/13/24, and 12/18/24. There was no evidence a QAPI meeting had been held during the first quarter of 2024.</p> <p>An interview was conducted on 01/09/25 at 2:48 P.M. with the Director of Nursing who verified there was no QAPI meeting held in the first quarter of 2024 and verified the QA Signature Sheets reflected accurate dates of the QAPI meetings.</p>

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973</p> <p>Based on interview, record review, review of Centers for Disease Control and Prevention (CDC) guidelines and review of facility policy, the facility to ensure residents were up to date with their influenza and pneumococcal vaccinations. This affected three residents (Resident #2, #64 and #67) out of five residents reviewed for vaccinations. The facility census was 80.</p> <p>Findings include:</p> <p>1. Review of medical record for Resident #67 revealed an admitted [DATE]. Diagnoses included Alzheimer's disease, hypertension, major depression disorder, heart failure, and anxiety disorder. Review of immunizations revealed the last influenza vaccine Resident #67 received was 10/13/23 and that she received the Pneumococcal polysaccharide (PPSV23) on 04/27/17.</p> <p>Review of the facility consent form labeled, Influenza Vaccine dated 11/27/24 revealed Quality Assurance (QA)/ Infection Control/ Licensed Practical Nurse (LPN) #575 received a verbal consent for Resident #67 to have the influenza vaccine from Resident #67's responsible party.</p> <p>Review of the facility consent form labeled, Pneumococcal Conjugate Vaccine- PCV20 revealed QA/ Infection Control/ LPN #575 received a verbal consent for Resident #67 to have the Pneumococcal conjugate vaccine (PCV20) from Resident #67's responsible party.</p> <p>Review of quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #67 had impaired cognition and had not received an influenza vaccine that year.</p> <p>Interview on 01/08/24 at 11:37 A.M. with QA/ Infection Control/ LPN #575, Director of Nursing and Corporate QA #603 revealed the facility should follow the recommendations as indicated on the Pneumococcal Vaccine Timing for Adults per the CDC guidelines.</p> <p>Interview on 01/08/25 on 11:58 A.M. with QA/ Infection Control/LPN #575 verified she had received a consent on 11/27/24 for Resident #67 to receive the influenza vaccine and the PCV20 but that Resident #67 had not received these vaccines. She stated, she was behind and was just trying to get caught up. She verified Resident #67 had received the PPSV23 on 04/27/17 and verified per CDC guidelines Resident #67 should have received the 15-valent pneumococcal conjugate vaccine (PCV15) or the PCV20 at least one year after the PPSV23.</p> <p>Review of facility policy labeled Influenza/ Pneumococcal Immunizations/ Vaccines dated September 2023 revealed it was the policy of the facility to follow CDC recommendations to offer each resident immunization against the influenza annually as well as lifetime immunizations against the pneumococcal disease unless medically contraindicated. The flu season immunization began in September and October of each year. The CDC recommended if a resident received the PPSV23 that they should then receive the PCV 20 at least one year later.</p> <p>Review of Pneumococcal Vaccine Timing for Adults per the CDC dated October 2024 revealed adults older than [AGE] years old was to complete the following pneumococcal schedules: if a resident already received the PPV23 then either they were to receive after one year the PCV15, PCV20, or PCV21.</p> <p>(continued on next page)</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>51073</p> <p>2. Review of the medical record for Resident #64 revealed an admitted [DATE] with diagnoses including surgical aftercare for inguinal hernia with obstruction, pulmonary fibrosis, iron deficiency anemia, biliary acute pancreatitis, COVID-19, pneumonia, moderate protein-calorie malnutrition, acute systolic heart failure, osteoarthritis of knee, hyperlipidemia, dysphagia, dilated cardiomyopathy, nonrheumatic aortic valve stenosis, and left bundle-branch block. The immunization section of the record showed that the last influenza vaccination the resident received was on 09/16/20. There was no documentation to indicate Resident #64 had received a Pneumovax. Review of Pneumovax and Influenza vaccination consent forms revealed a consent formed was signed by Resident #64 who gave consent to receive the vaccination.</p> <p>Interview on 01/08/25 at 1:14 P.M. with QA/Infection Control/LPN #575 verified Resident #64 had provided consent for the influenza vaccination and Pneumovax, however, Resident #64 had not yet received the vaccinations because Resident #64 had COVID-19 during the time the vaccinations were offered and QA/Infection Control/LPN #575 had not held another vaccination clinic since that time.</p> <p>3. Review of the medical record for Resident #2 revealed an admitted [DATE] with diagnoses including Alzheimer's disease, major depressive disorder, intermittent explosive disorder, hypothyroidism, gastro-esophageal reflux disease, anemia, age-related osteoporosis, peripheral vascular disease, personal history of COVID-19, spondylosis, dysphagia, chronic kidney disease stage three, and generalized anxiety disorder. The immunization section of the record showed the last influenza vaccination occurred on 10/13/23. There was no documentation to indicate Resident #2 had received the influenza vaccine since 10/13/23.</p> <p>Interview on 01/08/25 at 1:14 P.M. with QA/Infection Control/LPN #575 revealed Resident #2's power of attorney had provided consent for the influenza vaccination for Resident #2 but it had not been given.</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>48565</p> <p>Based on observation, interview and policy review the facility failed to provide a clean shower room on the north hall unit. This had the potential to affect 40 residents identified as utilizing the shower room (Residents #1, #4, #5, #6, #8, #11, #13, #14, #15, #18, #20, #22, #23, #24, #27, #29, #30, #31, #32, #36, #40, #41, #42, #43, #44, #46, #47, #49, #51, #57, #59, #61, #62, #70, #72, #74, #77, #133, #183, and #184). The facility also failed to maintain clean Hoyer (mechanical) lifts on the north hall unit. This had the potential to affect 12 residents (Residents #4, #8, #11, #20, #29, #32, #36, #44, #47, #70, #77, and #183) identified as utilizing the Hoyer lift on the north hall. The facility census was 80.</p> <p>Findings include:</p> <p>Observation on 01/06/25 at 9:00 A.M. during an initial tour of the facility revealed a shower room on the north hall. The shower stall had a black substance around the base of the shower where the walls connected to the base. The stall also had a build up of a slimy gray substance in the front right corner of the stall. There was a paper clip within the slimy gray substance. The floors of the shower room had dust and debris on them including a build up in the corner behind the door. There was dust and a peanut noted around the garbage can on the floor. The mirror had a visible dust build up on top of it. An interview with Certified Nurse Assistant (CNA) #519 at the time of the observation verified the observations. Also, during the initial tour there were two Hoyer lifts noted with a built-up white substance at the base appearing to be powder or skin flakes.</p> <p>On 01/07/25 at 11:10 A.M. an interview and observation with the Licensed Nursing Home Administrator (LNHA) and Housekeeping Supervisor (HKS) #591 revealed the black substance around the base of the shower where the walls met the base. The slimy gray substance with the paper clip was still noted in the front right corner of the shower base. There was dust and a peanut noted around the garbage can on the floor. The mirror had a visible dust build up on top of it. The LNHA and HKS #591 verified the observations. HKS #591 stated the shower room was to be cleaned daily.</p> <p>On 01/07/25 at 1:30 P.M. an observation of the two Hoyer lifts on the north hall revealed they remained dirty with the white build-up noted on them. An interview with the Director of Nursing (DON) verified the observation. The DON stated Hoyer lifts were to be cleaned two times weekly on night shift.</p> <p>A review of the document title Housekeeping Routine that was undated revealed shower rooms were to be cleaned daily.</p> <p>A review of the undated policy titled; Cleaning Shower Procedure revealed an objective to maintain clean, hygienic, and attractive surroundings.</p> <p>A review of the policy titled; Cleaning of Resident Care Equipment dated October 2010 revealed noncritical devices that touched residents' intact skin were to be cleaned after each use.</p>		