STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366456	A. Building B. Wing	03/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Medical Center Inc	1454 East Maple Street North Canton, OH 44720

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed record review, facility policy review, and interview the facility failed to effectively and timely communicate and provide information as requested to State and local public health authorities to mitigate the potential spread of legionella. This had the potential to affect 3 of 3 residents residing in the facility. Findings include:Review of an undated facility policy titled Water Management Policy revealed when a suspected or confirmed outbreak occurred, the Water Management Team would initiate a thorough investigation to identify the source, assess the extent of exposure, and implement control measures. Information regarding the suspected or confirmed outbreak would be communicated as soon as possible directly to the resident(s) or their responsible parties by the Infection Preventionist or their designee. Staff would be notified and updated regarding suspected or conformed outbreaks through the Kronos System. The Water Management Team would immediately notify public health authorities regarding a confirmed outbreak. The policy did not include a plan for when a public health authority notified the facility of a possible healthcare exposure of Legionella, plan for timely, collaborative and ongoing communication between the facility and public health authorities or the timely development of a Legionella sampling plan based on local public health authority recommendations. Review of the closed medical record for Resident #20 revealed the resident was at a local hospital from [DATE] through 11/13/25, was first admitted to the certified nursing facility on 11/13/25 and discharged on 11/17/25 to a local hospital for a non-respiratory related injury. The resident did not reside at the facility at the time of the survey. Review of Resident #20's hospital lab results dated 11/21/25 revealed a legionella urine antigen test was completed (during the resident's hospitalization) and the result was positive.Further review of the resident's medical record revealed no additional information related to Resident #20's Legionnaires disease diagnosis.Review of a timeline provided by Environmental Specialist #200 (a representative for the State agency) revealed on 12/15/25, the Bureau of Infectious Disease (BID) notified the Bureau of Environmental Health and Radiation Protection (BEHRP) of a possible healthcare exposure of Legionella (associated with the positive test result for Resident #20). BEHRP contacted the local county health department notifying them of the exposure and requested materials from the facility.-On 12/16/25 the local health department contacted the facility and requested materials.-On 12/17/25 the facility provided their temperature log, the past routine Legionella sampling, and a water management plan. -On 12/19/25 the State agency requested the facility to collect a representative sample set of their water system for the investigation.-On 01/05/26 the facility stated they were in the process of collecting samples to send to a lab. The State agency requested the [water] sampling plan the facility was using.-On 01/21/26, the State agency called the facility and was able to make contact. The facility verbally stated they were working with maintenance to obtain the sample plan developed and supplies ordered.-On 01/26/26, the State agency tried calling the facility again. Their contact replied via email and stated the Administrator was supposed to be sending the sample plan.-On 01/29/26, the State agency requested an update from the facility on when the sample plan was to be expected. No response was received.-On 02/03/26, the State agency requested the facility Administrator's contact information to be contacted directly.-On 02/04/26, the State agency contacted the facility's (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administrator regarding the sample plan. No response was received.-On 02/10/26, the State agency leadership emailed the Administrator regarding the sample plan. No response was received.An interview on 02/24/26 at 12:15 P.M. with Environmental Specialist (ES) #200 revealed the facility had a resident admitted to the facility from 11/13/25 through 11/17/25 who later became symptomatic and tested positive for Legionnaire's disease on 11/21/25 (during hospitalization). A limited investigation was opened on 12/15/25 to develop a sampling plan and obtain sampling from the facility to ensure their water sources did not contain the Legionella bacteria. ES #200 revealed the facility had not yet sent in a plan and had stopped communication. An interview on 02/26/26 at 9:00 A.M. with a Bureau of Infectious Disease (BID) representative, (BID #109) revealed Resident #20 was at a local hospital from [DATE] through 11/13/25, she was then admitted to the facility on [DATE] and hospitalized again on 11/17/25. Resident #20 became symptomatic (of Legionnaire's disease) on 11/20/25 while at a local hospital. On 11/21/25 testing completed at the hospital was positive for Legionnaires' disease (a urine antigen test) which noted the presence of legionella bacteria. BID #109 revealed any (resident) admission in a healthcare setting 14 days prior to the onset of symptoms was considered to be a potential source of contact. She verified the facility fell within this time period and the BEHRP was notified. A follow-up interview on 02/26/26 at 10:36 A.M. with Environmental Specialist #200 revealed for a limited investigation, the priority was for the facility to develop a sampling plan. She stated while they did not have a specific timeline by which the sampling plan must be submitted, [actual] sampling should not begin until after this has occurred. She stated for this reason, they recommend the facility provide the sampling plan in a timely manner (for example, within around 10 days of initial notification). Environmental Specialist #200 stated they would be looking for a response within days to a couple weeks, not months and that it was also important to note that this investigative sampling was in response to a [positive] case which was not the same as a facility's routine sampling, as it was aimed to be more comprehensive and representative of the water system.An interview on 02/26/26 at 10:45 A.M. with the facility Administrator verified he had not submitted a sampling plan to the State agency/public health authority. He reported he was unaware there was a timeline to submit the plan and verified the State agency did contact him in December 2025 asking him for a sampling plan due to Resident #20 having a potential exposure to Legionella while residing at the facility.An interview on 03/02/26 at 9:14 A.M. with Director of Environmental Health #300 from the local health department, revealed the facility stopped communicating with them regarding developing a Legionella sampling plan on 01/06/26. This deficiency represents noncompliance investigated under Complaint Number 2748589.