

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366460	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/25/2024
NAME OF PROVIDER OR SUPPLIER Canfield Acres LLC DbA Windsor House at Canfield		STREET ADDRESS, CITY, STATE, ZIP CODE 6445 State Route 446 Canfield, OH 44406	
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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43061 Based on record review, interview, and facility policy review the facility failed to ensure Resident #61's hospice care plan and actual skin impairment care plan were in place and updated. This affected one resident (#61) out of three residents reviewed for care plans. The facility census was 60. Findings include: Review of the closed medical record revealed Resident #61 was admitted to the facility on [DATE] and expired on [DATE]. Diagnoses included but was not limited to dementia unspecified, severe, without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, kidney disease, urine retention, colon cancer, malnutrition. Resident #61 was admitted to hospice on [DATE]. Review of the Minimum Data Set (MDS) assessment, dated [DATE], revealed Resident #61 was cognitively intact. The assessment noted he was at risk for pressure ulcers and had no pressure ulcers. Review of the care plan dated [DATE] revealed the care plan was not updated to include hospice admission on [DATE], three new areas of skin damage and groin swelling on [DATE]. Interview on [DATE] at 12:33 P.M. with Corporate Quality Assurance Registered Nurse (RN) #217 verified Resident #61 did not have a hospice care plan. Interview on [DATE] at 9:26 A.M. with Corporate Quality Assurance RN #217 verified Resident #61 did not have an updated care plan to reflect actual skin impairments to include two new areas of skin impairment (not staged by the facility) to the mid vertebrae, left heel deep tissue injury (DTI) (A purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue due to pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue), moisture associated damage (MASD) to bilateral buttocks, and groin swelling. Interview on [DATE] at 11:34 A.M. with MDS Licensed Practical Nurse (LPN) #218 verified Resident #61 did not have a hospice care plan and did not have an updated care plan to reflect actual skin impairments to include two new areas of skin impairment to the mid vertebrae, left heel DTI, MASD to bilateral buttocks, and groin swelling. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on [DATE] at 11:40 A.M. with MDS Float RN #219 verified Resident #61 did not have a hospice care plan, have an updated care plan to reflect actual skin impairments to include two new areas of skin impairment to the mid vertebrae, left heel DTI, MASD to bilateral buttocks, and groin swelling. Review of the facility policy titled Care Plans, revised ,d+[DATE], revealed to assure that all disciplines coordinate the care of each resident and develop a resident centered care plan that is consistent with resident rights. This deficiency represents non-compliance investigated under Master Complaint Number OH00154700.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45441 Based on record review, interview, and facility policy review the facility failed to appropriately monitor Resident #61 after a significant change in condition related to signs of urinary tract infection (UTI). This affected one resident (#61) of three residents reviewed for a change of condition. The facility census was 60. Findings include: Review of the closed medical record for Resident #61 revealed an admitted [DATE] and an expiration date of 04/26/24. Diagnoses included dementia, kidney disease, urinary retention, colon cancer, and malnutrition. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #61 was moderately cognitively impaired. He required setup and cleanup help for eating and oral hygiene, supervision for toileting and personal hygiene, and partial to moderate assistance for bathing. He had an indwelling urinary catheter and was frequently incontinent of bowel. Review of the care plan dated 08/22/23 revealed Resident #61 was at risk for recurrent UTI's due to an indwelling urinary catheter. Interventions included encouraging adequate fluid intake, monitoring, documenting, and reporting signs and symptoms of a UTI, and obtaining and monitoring lab work as needed. Review of the nursing progress note dated 03/27/24 at 2:10 P.M. revealed Resident #61 had poor fluid intake and complaints of not feeling well. His indwelling urinary catheter was noted to be draining well with dark yellow urine. Vital signs were obtained, and the physician was notified. An order for Zofran (antiemetic) 4 milligrams (mg) every eight hours as needed (prn) for nausea and vomiting as obtained. Review of the medical record revealed there was no documented evidence Resident #61 was monitored for fluid intake, urinary output and color of urine, vital signs, and complaints of not feeling well from 03/27/24 at 2:10 P.M. after the physician was notified that the resident had poor fluid intake, dark yellow urine, and complaints of not feeling well until 04/01/24 at 4:10 P.M. when the physician was notified of Resident #61's increase in confusion and concern for potential UTI. Review of the nursing note dated 04/01/24 at 4:10 P.M. revealed the physician was notified of Resident #61's increase in confusion and concern for potential UTI. An order was given to obtain a urinalysis culture and sensitivity. Review of the medical record revealed no documentation of when the urine sample was obtained and sent to the lab. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record revealed there was no documented evidence Resident #61 was monitored for fluid intake, urinary output and color of urine, vital signs, and complaints of not feeling well from 04/01/24 at 4:10 P.M. after the physician was notified that the resident had increased confusion and concerns for a UTI until 04/05/24 at 12:26 P.M. when the physician gave an order for an antibiotic. Review of the nursing note dated 04/05/24 at 12:26 P.M. revealed the physician was notified of the urine culture sensitivity results and ordered Cipro 250mg by mouth (PO) twice per day (BID) for five days for a UTI. Review of the April 2024 medication administration record (MAR) revealed Resident #61's Cipro was administered as ordered by the physician. Interview on 06/18/24 at 9:33 A.M. with Registered Nurse (RN) #201 confirmed there was no documented evidence Resident #61 was monitored thoroughly between 03/27/24 when he reported not feeling well with poor fluid intake and 04/05/24 when he was ordered to an antibiotic for UTI. Review of the facility policy titled Change of Condition, dated February 2024, revealed a change of condition was identified as any sudden or marked change of output of urine, diarrhea or behavior. When a change of condition was identified, symptoms, assessment, physician orders, treatments and notifications would be documented as well as follow-up nursing assessments and monitoring until the condition had stabilized. This deficiency represents noncompliance investigated under Master Complaint Number OH00154700.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43061 Based on medical record review, interviews, review of hospice notes, and review of the facility policy the facility failed to provide coordination of care between hospice and facility staff for Resident #61 related to pressure ulcer prevention. This affected one resident (#61) out of two residents reviewed for pressure ulcer prevention. The facility census was 60. Findings include: Review of the closed medical record revealed Resident #61 was admitted to the facility on [DATE] and expired on [DATE]. Diagnoses included but were not limited to dementia unspecified, severe, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, kidney disease, urine retention, colon cancer, malnutrition. Resident #61 was admitted to the hospice on [DATE]. Review of the Minimum Data Set (MDS) assessment, dated [DATE], revealed Resident #61 was cognitively intact. The assessment noted he was at risk for pressure ulcer development and had no pressure ulcers. Review of Resident #61's physician orders dated [DATE] revealed Skin Check by nurse weekly on Fridays, night shift. Cleanse bilateral upper inner thighs with soap and water, rinse, dry and apply Baza antifungal cream every shift. Cleanse groin with soap and water, pat dry, apply antifungal cream to affected area every shift for fungal infection. Cleanse sacrum with soap and water, pat dry, apply ET mix (four parts Aquaphor, one part stoma powder), every shift for preventive skin maintenance. Offload heels in bed for preventative skin care. Review of the progress noted dated [DATE] at 3:31 P.M., authored by Clinical Director Registered Nurse (RN) #200 revealed she received a call from Resident #61's family who stated he was notified by a hospice nurse that the resident had new skin issues. Clinical Director RN #200 and Director of Nursing (DON) immediately assessed the resident. Findings included two new skin issues noted to mid-upper back on bony prominence of vertebra and one skin area to left heel. Resident #61's daughter was present and notified at that time. Review of the incident report dated [DATE] at 3:40 P.M. revealed new skin areas noted per hospice nurse. The hospice nurse notified Resident #61's family who then called the facility to inquire about the new areas. Two new areas were noted to the bony prominence of mid vertebrae. The areas were red, non-blanchable with darker areas noted in the middle of each area. The first area measured 1.5 centimeter (cm) by (x) 2.0 cm. The second area on mid vertebrae measured 1.0 cm x 2.5 cm, and the entire area with redness measured 6.0 cm x 2.5 cm. The left heel was a deep tissue injury (DTI) (A purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue due to pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.) which measured 1.5 cm x 0.5 cm and redness around the DTI measuring 4.0 cm x 3.0 cm. (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #61's treatment administration records (TAR) dated [DATE] revealed Skin Check by nurse weekly as per evaluation every Friday, night shift. Cleanse bilateral upper inner thighs with soap and water, rinse, dry and apply Baza antifungal cream every shift. Cleanse groin with soap and water, pat dry, apply antifungal cream to affected area every shift for fungal infection. Cleanse sacrum with soap and water, pat dry, apply ET mix, every shift for preventative skin maintenance. Offload heels in bed for preventative skin care. Review of the hospice visit notes for [DATE] revealed no documentation regarding the skin issues noted. Review of the hospice visit notes for [DATE] reported an addendum noted to include the wound to the posterior coccyx as a stage I pressure ulcer (Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area.) onset date [DATE] measuring 2.50 cm x 2.00 cm x 0.10. No eschar, no slough, no granulation, no epithelial, and 100% clean non-granulating. No drainage, no pain associated with wound, and peri-wound intact. An addendum on [DATE] revealed a left plantar foot - heel pressure ulcer - unstageable deep tissue injury and measured 0.5 cm x 0.50 cm with eschar greater than 25%, no slough, no granulation, epithelial greater than 25%, no drainage, no pain, and per-wound intact. The note stated Resident #61's penis and scrotum swelling, d+[DATE]+ edema, to keep the area elevated on towel, and Resident #61 was prescribed Bactrim (antibiotic) for penis/scrotum edema. No documentation in the hospice notes from [DATE] to [DATE] to indicate that the facility nurse was updated on wounds. Review of Resident #61's current care plans (dated [DATE]) revealed he had potential for pressure ulcer development related to decreased mobility, and the resident had potential impairment to skin integrity related to occasional incontinence and need of assistance with activity of daily living (ADL). The care plan was not updated to include hospice care, skin impairment, and/or groin/scrotum swelling. Interview on [DATE] at 10:05 A.M. with Wound Licensed Practical Nurse (LPN) #206 revealed she does not recall being informed of any new areas to Resident #61. Wound LPN #206 reported Resident #61 had moisture associated skin damage (MASD) to bilateral buttocks which healed and was being treated prophylactically. Wound LPN #206 reported she saw Resident #61 on [DATE] and [DATE] with no new areas noted. Wound LPN #206 reported she saw Resident #61 on [DATE] and saw two dressings close together on the resident's mid back. She removed the dressings and assessed the area with no negative findings noted. Wound LPN #206 reported the hospice nurse was calling the area to the coccyx a Stage I pressure ulcer, but the area was actually MASD. Interview on [DATE] at 1016 A.M. with the Director of Nursing (DON) revealed the facility was never notified by the hospice nurse of Resident #61's skin issues. The DON reported the hospice nurse notified Resident #61's family on [DATE] of new skin issues, and the family called the facility. Resident #61 was immediately assessed by Clinical Director RN #200 and herself. See incident report findings to include two new areas to mid vertebrae and one new area to left heel. (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on [DATE] at 10:55 A.M. with Hospice RN #213 revealed Resident #61 was admitted to hospice on [DATE] with diagnosis of severe protein calorie malnutrition. Hospice RN #213 reported Resident #61 was seen three times a week by a hospice nurse and three times a week by a hospice aide. Hospice RN #213 reported after every visit, the hospice nurse would leave a care coordination note. Hospice RN #213 reported on [DATE] that Resident #61 was seen by hospice nurse with no skin issues noted. Hospice RN #213 reported it was not surprising in last two weeks of life that Resident #61 had skin breakdowns, it was expected, and the main goal was comfort care. Interview on [DATE] at 11:50 A.M. with Hospice Clinical Manager #214 revealed hospice aides would notify the hospice nurse of any new skin areas during bath. Hospice Clinical Manager #214 reported there would be no documentation of this, it would be reported verbally. The hospice nurse who completed the admission on [DATE] reported she spoke with the facility nurse regarding a skin issue. Hospice Clinical Manager #214 was unable to provide name of the facility nurse she spoke to. Interview on [DATE] at 12:33 P.M. with Corporate Quality Nurse (CQN) #217 verified Resident #61 did not have a hospice care plan. CQN #217 reported the hospice nurse never notified facility of any skin issues. Interview on [DATE] at 1:22 P.M. with Clinical Director RN #200 revealed the facility was never notified by the hospice nurse that Resident #61 had any skin issues. The DON reported that the hospice nurse notified Resident #61's family on [DATE] of new skin issues, and the family called the facility. Resident #61 was immediately assessed by Clinical Director RN #200 and the DON. See incident report findings to include two new areas to mid vertebrae and one new area to left heel. Interview on [DATE] at 9:26 A.M. with CQN #217 verified the care plan was not updated to reflect three new skin areas, MASD, and groin swelling. CQN #217 reported there was not adequate communication from the hospice nurse to the facility staff regarding any skin issues. CQN #217 reported the hospice nurse never notified facility of any skin issues. Review of the facility policy titled Hospice Policy, revised ,d+[DATE], revealed the facility will ensure a hospice agreement/contract is in place that outlines hospice services and responsibilities and the facilities collaboration of care. This deficiency represents non-compliance investigated under Master Complaint Number OH00154700.		