

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

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Form Approved OMB
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 10/11/2024
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 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** 46195 Based on record review, facility self-reported incident (SRI) review, interviews, and facility policy review, the facility failed to timely report an allegation of physical abuse to the state agency. This affected two residents (Resident #32 and Resident #65) out of three residents reviewed for abuse. The facility census was 63. Findings include: 1. Review of the medical record for Resident #32 revealed an admitted [DATE]. Diagnoses included chronic diastolic (congestive) heart failure, major depressive disorder, anxiety disorder, and exudative age-related macular degeneration of the right eye. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #32 was moderately impaired cognitively with no behaviors or signs or symptoms of delirium and required supervision or touch assistance from staff for sit to stand, transfers, and walking ten feet. Interview on 10/11/24 at 5:56 A.M. with Resident #32 revealed there had been an incident where another resident (Resident #33), who was mentally unstable, hit her with a phone on an unspecified day. Review of the Ohio Department Health's Gateway System of SRI tracking #252676 revealed on 10/05/24 (Saturday) at 3:30 P.M. Resident #32 reported Resident #33 was upset and hit her hand. The facility created an SRI report for physical abuse on 10/06/24 (Sunday)at 9:59 A.M. Review of the witness statement dated 10/06/24 and authored by Licensed Practical Nurse (LPN) #607 revealed on 10/05/24, as she was completing a treatment to Resident #33's leg, when the resident said, that girl next door hit me with my phone. She was swinging it around and it hit my hand. Review of the witness statement dated 10/06/24 authored by State tested Nursing Assistant (STNA) #651 revealed on 10/05/24, STNA #651 heard Resident #33 shouting. When she went down the hall, STNA #651 observed Resident #33 coming out of Resident #32's room. Resident #32 stated Resident #33 hit her on her hand with Resident #32's phone. (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 366460	If continuation sheet Page 1 of 2

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 10/11/24 at 10:11 A.M. with the Administrator confirmed the incident had occurred on Saturday (10/05/24) around 3:30 P.M. and he was not notified of the incident until Sunday morning (10/06/24) around 9:00 A.M. He also confirmed the SRI related to the physical abuse allegation on 10/05/24 was not submitted to the state agency within two hours of discovery as required because he was not notified of the incident until the next morning. 2. Review of the medical record for Former Resident #65 revealed an admitted [DATE] and discharge date of [DATE]. Diagnoses included multiple sclerosis, anxiety disorder, depression, unspecified psychosis not due to a substance or known physiological condition, delirium due to known physiological condition, and fibromyalgia. Review of the discharge return not anticipated MDS assessment dated [DATE] revealed Resident #65 was independent for daily decision making and had altered level of consciousness which fluctuated. Resident #65 exhibited no behaviors and required partial/moderate assistance from staff for personal hygiene. The resident was dependent on staff for toileting hygiene and transfers, did not walk, and used a motorized wheelchair. Review of the care plan dated 12/20/22 revealed Resident #65 was verbally aggressive and accusatory toward staff related to her ineffective coping skills. Review of the Ohio Department Health's Gateway System of SRI tracking #239096 revealed on 09/12/23 at 8:00 A.M. the facility was notified of a physical abuse allegation between Resident #65 and STNA #678. The facility created an SRI report for physical abuse on 09/12/23 at 2:37 P.M. Review of Corporate Quality Assurance Nurse #670 statement dated 09/12/23 revealed the Administrator informed her he received a voicemail that morning (09/12/23) from Resident #65, which was left the evening after business hours on 09/11/23, in which Resident #65 stated she wanted to talk to someone about an aide that was rough with her. Interview on 09/12/23 with Resident #65 by Corporate Quality Assurance Nurse #670 revealed last Thursday night (09/07/23) STNA #678 was rough while providing care, and the resident felt STNA #678 was intentionally being rough while providing care and was hurting her on purpose. Interview on 10/11/24 at 1:12 P.M. with the Administrator confirmed SRI #238096 was not submitted to the state agency in a timely manner and could not give a reason why it was not submitted to the state agency within two hours as required. Review of the facility policy titled Resident Abuse Prevention Practices, revised October 2022, revealed alleged and suspected, or observed abuse would be thoroughly investigated by the Administrator and the Director of Nursing or the designee and the alleged and suspected violations would be reported immediately to the Department of Health for on-line submission. This deficiency represents non-compliance investigated under Complaint Number OH00158588.		