

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 01/08/2026
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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on medical record review, interview, review of the facility's self-reported incidents (SRI) of abuse, and review of facility policy, the facility failed to report to the state agency a resident to resident verbal abuse incident. This affected two residents (#29 and #59) of two reviewed for abuse. The facility census was 68. Findings include: 1. Review of the medical record for Resident #29 revealed an admission date of 09/20/24 with diagnoses including history of stroke, expressive language disorder, metabolic encephalopathy, anxiety disorder, and vascular dementia. Review of the quarterly Minimum Data Set (MDS) assessment, dated 10/20/25, revealed Resident #29 was cognitively intact. Review of Resident #29's progress note dated 11/18/25 at 5:15 P.M. revealed another resident thought Resident #29 was his sister. Review of Resident #29's progress notes for December 2025 revealed there was no documentation of any incidents occurring between Resident #29 and Resident #59. On 01/05/26 at 3:06 P.M., an interview was attempted with Resident #29, however, Resident #29 was not interviewable due to starting off into the distance during the interview and stated I don't know when asked if anyone had tried to hurt her at the facility. 2. Review of the medical record for Resident #59 revealed an admission date of 10/08/25 with diagnoses including metabolic encephalopathy, muscle weakness, and mild cognitive impairment with unknown etiology. Review of the physician's orders for Resident #59 identified orders for Divalproex Sodium oral capsule delayed release 125 milligram (mg) to give one capsule by mouth two times daily for aggressive behavior with an effective date of 10/09/25. Review of the admission MDS assessment, dated 10/14/25, revealed Resident #59 had moderate cognitive impairment. Review of Resident #59's progress note dated 12/07/25 at 12:15 P.M. indicated Resident #59 was yelling at Resident #29, using expletive language, and Resident #59 threatened to hit Resident #29's head against the table. The note further indicated Resident #59 thought Resident #29 was his sister. Review of the behavior care plan initiated 12/07/25 indicated Resident #59 had the potential to be verbally aggressive toward staff and other residents related to dementia. Interventions included administer medications as ordered (12/07/25), analyze time of day, places, circumstances, triggers, and what de-escalates behaviors and document (12/07/25), assess and anticipate resident's needs (12/07/25), modify the environment by adjusting room temperature, reducing noise, dimming lights, placing familiar objects in room, or keeping door closed (12/07/25), monitor every shift and document observed behaviors and attempted interventions (12/07/25), and monitor, document, and report any signs or symptoms of resident posing a danger to self or others (12/07/25). On 01/06/26 at 11:20 A.M., an interview with Social Services Director (SSD) #366 confirmed Resident #59 had verbal behaviors toward Resident #29, whom Resident #59 thought was his sister. SSD #366 stated Resident #59 was unaware that Resident #29 was not his sister. On 01/07/26 at 10:00 A.M., an interview with Regional Quality Assurance (QA) Nurse #396 stated Resident #29 looked similar to Resident #59's sister. Regional QA Nurse #396 confirmed the incident on 12/07/25 had not been reported to the state agency as a self-reported incident (SRI) because Resident #59 did not realize Resident #29</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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>was not his sister due to his impaired cognition and the facility did not view the situation as verbal abuse at the time of the incident. On 01/07/26 at 10:26 A.M., an interview with Regional QA Nurse #396 confirmed Resident #59's progress note dated 12/07/25 at 12:15 P.M. indicated Resident #59 was yelling at Resident #29, using expletive language, and Resident #59 threatened to hit Resident #29's head against the table because he thought Resident #29 was his sister. On 01/08/25 at 11:20 A.M., an interview with Regional QA Nurse #396 stated at the time of the incident on 12/07/25, Resident #29 did not know Resident #59 was yelling at her. Regional QA Nurse #396 stated the facility did not feel verbal abuse had occurred because Resident #29 was unaware the verbal behaviors were directed toward her. Regional QA Nurse #396 confirmed the progress note from 12/07/25 indicated Resident #59's verbal behavior and verbal threat was directed toward Resident #29, confirmed staff knew who Resident #59 was speaking to, and confirmed staff were aware of Resident #59's history of thinking Resident #29 was his sister. Review of the facility's self-reported incidents of abuse to the state agency revealed there were no incidents reported on or around 12/07/25. Review of the facility's document titled Resident to Resident Abuse, dated 2002, indicated it was understood the facility had residents who were confused at times and that confusion occasionally led to aggressive incidents. The document indicated the facility would determine or eliminate abusive episodes, protect all residents from harm, and bring aggressive residents and occurrences under control. The document further indicated all abuse would be documented and investigated according to federal and state regulations and acute aggressive episodes would be managed by nursing for residents who were physically and verbally abusive. Review of the facility's policy titled Resident Abuse Prevention Practices, dated 10/2022, defined verbal abuse as any use of oral, written, or gestured language that willfully included disparaging or derogatory terms to the residents or their families or within hearing distance, regardless of their age, ability to comprehend, or disability. The policy indicated alleged and suspected violations of abuse would be reported immediately to the department of health via online submission of self-reported incident. This deficiency represents non-compliance investigated under Complaint Number 2679635.</p>		