

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

Printed: 07/18/2026
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 01/08/2026
NAME OF PROVIDER OR SUPPLIER Canfield Acres LLC Dbw 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, record review and review of facility policy, the facility did not ensure Resident #32 was treated with respect and dignity when in need of assistance by staff. This affected one resident (#32) of one resident reviewed for assistance with activity of daily living. The facility census was 68. Findings include: Review of the medical record for Resident #32 revealed an admission date of 03/05/25 with diagnoses including contracture of an unspecified joint, muscle wasting and atrophy, lack of coordination, hypertension, difficulty in walking, and muscle weakness. Review of the physician's orders for Resident #32 identified orders for a mechanical lift for all transfers with an effective date of 03/05/25. Review of the self-care plan of care, initiated 03/13/25, indicated Resident #32 was at-risk for a self-care deficit. Interventions included, but were not limited to, remind resident to use call light and ask for assistance before self-transferring (03/13/25), up to wheelchair as tolerated (03/13/25), and use assistive devices as indicated (03/13/25). Review of the activities of daily living (ADL) care plan, initiated 03/21/25, indicated Resident #32 had an ADL self-care performance deficit related to limited mobility, limited range of motion, and musculoskeletal impairment. Interventions included, but were not limited to, encourage the resident to use the call bell to call for assistance (03/21/25). Review of the three day functional assessment, dated 11/04/25, indicated Resident #32 was dependent on staff for chair/bed-to-chair transfers. Review of the quarterly Minimum Data Set (MDS) assessment, dated 11/06/25, indicated Resident #32 had severe cognitive impairment and was dependent on staff for chair/bed-to-chair transfers. On 01/06/26 at 3:08 P.M., an observation of Resident #32's room revealed the call light was on and Resident #32 was laying in bed calling out hello and does anybody work here repeatedly. At the time of observation, Registered Nurse (RN) #306 was observed standing at the nurse's station which was directly next to Resident #32's room. On 01/06/26 at 3:16 P.M., an interview with RN #306 confirmed they were aware Resident #32 had put her call light on. RN #306 stated staff had already been in Resident #32's room five times and the resident knew they would be coming. On 01/06/26 at 3:23 P.M., an observation of Resident #32's room revealed RN #306 entered Resident #32's room, asked the resident if she wanted to get up, Resident #32 said yes, RN #306 turned the call light off and told Resident #32 someone would be right in to get her up, then RN #306 exited the room and returned to the nurse's station without alerting any other staff. On 01/06/26 at 3:24 P.M., an interview with RN #306 verified Resident #32's call light was on because she wanted to get out of bed. RN #306 stated when Resident #32 wanted to get out of bed, she would put her call light on and then continually call out hello until someone came to get her out of bed. On 01/06/26 observation at 3:50 P.M. through 4:08 P.M. revealed Resident #32 was observed to still be in her bed at 3:50 P.M. and no staff were in the room. At 4:00 P.M., Resident #32 turned her call light on and began calling out hello and anybody. At 4:08 P.M., Certified Nursing Assistants (CNAs) #338 and #348 began the process of transferring Resident #32 out of bed utilizing a mechanical lift device, exactly one hour after Resident #32 was first observed asking for assistance transferring out of bed. CNA #338 and #348 confirmed the time of transfer at the time of the observation. On 01/06/26 at 5:16 P.M., an interview with Regional Quality Assurance (QA) Nurse #396 stated it was the facility's expectation that the call light stayed on until the care was (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provided and if it was shut off, then the resident's need would be immediately communicated to additional staff who could provide assistance. Review of the facility's policy titled Use of Call Light, dated 07/2017, indicated the purpose was to respond promptly to resident's calls for assistance. The policy indicated all call lights would be answered promptly in a calm and courteous manner and the call light would be turned off as soon as staff entered the room. Staff were not to make residents feel as if they were too busy to provide assistance.		

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. Based on record review, interview and review of the facility policy, the facility failed to ensure authorizations for resident funds were witnessed as required. This affected one resident (#37) of five residents reviewed for resident funds. Facility census was 68. Review of Resident #37's medical record revealed an admission date of 02/16/24 and diagnoses including anemia, vitamin D deficiency, subclinical iodine-deficiency hypothyroidism, severe protein-calorie malnutrition and malignant neoplasm of rectum. Resident #37 was her own responsible party and per the quarterly Minimum Data Set (MDS) 3.0 assessment on 12/29/25, Resident #37 was cognitively intact. Review of a choice of resident funds disposition form, signed electronically by Resident #37's brother on 02/19/24, revealed an area on the form for a witness signature which was left blank. Interview on 01/06/26 at 2:29 P.M. with Business Office Manager (BOM) #383 revealed the resident funds authorizations were electronically signed and she was not sure how the witnessing of the authorization worked with the electronic signatures. BOM #383 stated admission Director (AD) #394 completed the funds authorization form as part of a resident's new admission paperwork. Interview on 01/06/26 at 2:46 P.M. with AD #394 and Regional Quality Assurance (RQA)/Registered Nurse (RN) #396 revealed during the admission paperwork process, AD #394 would sit down with the resident/family and do the resident funds authorization form over her computer. When asked about how authorization forms were witnessed, AD #394 stated if two family members were present this was doable but if only one family member was present, then that was the only signature completed. During the interview, AD #394 and RQA/RN #396 confirmed Resident #37's resident funds authorization form was not witnessed and should have been. Review of the facility policy, Management of Personal Funds, reviewed July 2024 revealed written authorization is obtained from the resident or the resident's representative and the authorization requires a witness signature the witness cannot be an employee of the facility or the organization.		

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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. 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 staring 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 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 (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.		