

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  375400	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/09/2025
NAME OF PROVIDER OR SUPPLIER  Windsor Hills Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  2416 North Ann Arbor Oklahoma City, OK 73127	

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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>20960</p> <p>Based on observation, record review, and interview the facility failed to ensure care plans were developed and revised for smoking and the use of electronic vaping devices for 1 (#1) of 4 sampled residents reviewed for smoking and electronic vaping use.</p> <p>The DON identified one resident who vaped, three unsupervised smokers and nine supervised smokers.</p> <p>Findings:</p> <p>On 05/06/25 at 10:20 a.m., Resident #1's room was observed with a cup filled with brown liquid substance from chewing tobacco on the sink counter. Next to the bed was a plastic container on the over bed table that contained four various colored vaping devices. An oxygen concentrator was observed against the wall.</p> <p>A policy, Resident Smoking, revised 01/08/25, read in part, It is the policy of this facility to provide a safe and healthy environment for residents, visitors, and employees, including safety as related to smoking. Electronic cigarettes (e-cigarettes/vape/vapor pen) can catch on fire and/or explode if not handled and stored safely. Safety measures for the use of electronic cigarettes by residents will include but are not limited to: .Use of E cigarettes in designated smoking areas. A safe smoking assessment will be completed on all residents using e-cigarettes. Don't use the device around flammable gases or liquids, such as oxygen, propane, or gasoline. All safe smoking measures will be documented on each resident's care plan and communicated to all staff, visitors, and volunteers who will be responsible residents while smoking. Supervision will be provided as indicated on each resident's care plan.</p> <p>Resident #1's care plan, revised on 06/27/23, read in part, I am a independent tobacco user. I use tobacco products or smoke. Goal I wish to continue to maintain my independence in the usage of tobacco products. Interventions I am a tobacco user and have been educated on the health risk of dipping or chewing tobacco but I choose to use. I have been informed about nurses will perform periodic evaluations on me about my safety to continue to use tobacco independently I have been educated on smoke times, tobacco products use, and dangers of smoking (cigarette burns or health). I still choose to use tobacco products.</p> <p>The care plan did not address Resident #1's use of vape's.</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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident #1's care plan, revised on 02/20/25, read in part, OXYGEN: I require oxygen at by nasal cannula to maintain adequate oxygen and to breathe easier r/t my COPD/SOB Diagnosis. I refuse breathing treatments at times. Intervention Provide oxygen via nasal cannula at L/min as ordered by my doctor.</p> <p>The care plan was not updated to address Resident #1's use of a vape while in their room.</p> <p>Resident #1's Smoking Assessment, dated 03/19/24, showed they did not smoke.</p> <p>Resident #1's annual Minimum Data Set assessment, with an assessment reference date of 08/16/24, showed they were a current tobacco user and had a brief interview for mental status score of 15, which showed no cognitive impairments for daily decision making.</p> <p>Resident #1's quarterly Minimum Data Set assessment with and assessment reference date of 02/14/25, showed they had no cognitive impairments with a brief interview for mental status score of 15. Resident #1 was dependent on staff for all activities of daily living skills.</p> <p>Resident #1's Smoking Assessment, dated 04/17/25, showed they used a vape.</p> <p>On 05/07/25 at 11:04 a.m., the housekeeping supervisor stated Resident #1 vaped and never smoked. They stated Resident #1 never gets up to come out of their room and vaped in their room.</p> <p>On 05/07/25 at 11:20 a.m., CMA #2 stated Resident #1 vaped and did not get up and go out.</p> <p>On 05/07/25 at 11:33 a.m., CNA #1 stated staff charged the vape's everyday for Resident #1. CNA #1 stated everyone knew Resident #1 vaped in their room.</p> <p>On 05/07/25 at 12:41 p.m., LPN #1 stated Resident #1 was independent except for getting up and dressed. LPN #1 stated Resident #1 smoked using a vape, chewed tobacco and stayed in their room. LPN #1 stated Resident #1 always knew to take off their oxygen when vaping.</p> <p>On 05/07/25 at 1:00 p.m., CMA #1 stated Resident #1 smoked by using a vape. CMA #1 stated Resident #1 would vape in their room, used oxygen, but never kept it on when vaping.</p> <p>On 05/07/25 at 2:10 p.m., Resident #1 stated they vaped and chewed tobacco. Resident #1 stated they knew to remove the oxygen when they vaped in the room.</p> <p>On 05/08/25 at 1:01 p.m., the DON was asked to show how the care plan addressed Resident #1's vape use. The DON reviewed the care plan and stated the care plan did not address Resident #1's vape use.</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>20960</p> <p>On 05/09/25 at 10:15 a.m., a past non-compliance Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to have a system in place to ensure residents were monitored for safe smoking and the use of electronic vaping devices.</p> <p>Resident #1 was a known vape device user, in their room with continuous oxygen use. Resident #1 did not have a care plan that addressed the vape device, and the use of the device in their room. Staff confirmed the knowledge of the use of the vaping devices in the room and they charged them. On 05/02/25, Resident #1 while in their room with oxygen on lit a cigarette causing flash burns to his face.</p> <p>Based on observation, record review, and interview, the facility failed to have a system in place to ensure residents were supervised and monitored for safe smoking and the use of electronic vaping devices for 1 (#1) of 4 sampled residents reviewed for smoking and electronic vaping use. Resident #1 lit a cigarette in their room, while oxygen was in use, causing a flash burn to their nostrils and left cheek.</p> <p>The DON identified one resident who vaped, three unsupervised smokers and nine supervised smokers reside in the facility.</p> <p>Findings:</p> <p>On 05/06/25 at 10:20 a.m., Resident #1's room was observed with a cup filled with brown liquid substance from chewing tobacco on the sink counter. Next to the bed was a plastic container on the over bed table that contained a can of chewing tobacco and four various colored vaping devices. An oxygen concentrator was observed against the wall.</p> <p>05/07/25 at 2:05 p.m., Resident #1 was observed in his hospital bed with their left cheek red, with a large blister on the lower left cheek. Resident #1's nose was observed with peeling skin, brownish in color.</p> <p>A facility policy Resident Smoking, revised 01/08/25, read in part, It is the policy of this facility to provide a safe and healthy environment for residents, visitors, and employees, including safety as related to smoking. Smoking is prohibited in all areas except the designated smoking areas. Electronic cigarettes (e-cigarettes/vape/vapor pen) can catch on fire and/or explode if not handled and stored safely. Safety measures for the use of electronic cigarettes by residents will include but are not limited to: .Use of E cigarettes in designated smoking areas. A safe smoking assessment will be completed on all residents using e-cigarettes. Don't use the device around flammable gases or liquids, such as oxygen, propane, or gasoline.</p> <p>An undated smoking list, provided by the DON on 05/06/25 at 1:30 p.m., did not list Resident #1 as a smoker or a vape user.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Resident #1's care plan, revised on 06/27/23, read in part, I am a independent tobacco user. I use tobacco products or smoke.Goal I wish to continue to maintain my independence in the usage of tobacco products. Interventions I am a tobacco user and have been educated on the health risk of dipping or chewing tobacco but I choose to use. I have been informed about nurses will perform periodic evaluations on me about my safety to continue to use tobacco independently I have been educated on smoke times, tobacco products use, and dangers of smoking (cigarette burns or health). I still choose to use tobacco products.</p> <p>The care plan did not address Resident #1's use of vape's.</p> <p>Resident #1's care plan, revised on 02/20/25, read in part, OXYGEN: I require oxygen at by nasal cannula to maintain adequate oxygen and to breathe easier r/t my COPD/SOB Diagnosis. I refuse breathing treatments at times.Intervention Provide oxygen via nasal cannula at L/min as ordered by my doctor.</p> <p>Resident #1's Smoking Assessment, dated 03/19/24, showed they did not smoke.</p> <p>Resident #1's annual Minimum Data Set assessment, with an assessment reference date of 08/16/24, showed they were a current tobacco user and had a brief interview for mental status score of 15, which showed no cognitive impairments for daily decision making.</p> <p>Resident #1's order summary, dated 05/06/25, read in part, keep oxygen saturations above 90% by adjusting oxygen every shift for SOB related to SHORTNESS OF BREATH. The order was first written 08/17/24.</p> <p>Resident #1's quarterly Minimum Data Set assessment, with an assessment reference date of 02/14/25, showed they had no cognitive impairments with a brief interview for mental status score of 15. Resident #1 was dependent on staff for all activities of daily living skills.</p> <p>Resident #1's Smoking Assessment, dated 04/17/25, showed they used a vape.</p> <p>Resident #1's Incident Report, dated 05/02/25, read in part, Nursing Description: Resident called out for help from his bed. Nurse aide went into Resident room and notified nurse and upon entering Residents room, Nurse observe cheeks, nose, around nose, facial hair charred some parts blistered. Upper part of Oxygen tubing burnt.Resident Description: Resident verbalized My face got caught on fire I can't explain how. Resident reports facial burn and discomfort.Description: Head to toe assessment done. Focus assessment on face. Vitals are BP 127/68. HR 88 02 93 on room air. Temp 97.8. Resident sent to ER for evaluation. DON ADON and Administrator notified. Resident is his own responsible party.</p> <p>Resident #1's hospital record, dated 05/02/25, read in part, Mechanism of injury: flame.Circumstances of injury: Patient was on oxygen and try [SIC] to smoke and sustained flash burn.Date of injury: May 2, 2025. Skin: Partial thickness burn to lower face including both nostrils.Assessment and Plan: [age and gender deleted] with history of asthma, COPD, 3 L oxygen, stroke with hemiparesis of the left side, anxiety disorder, depression who sustained flash burn to the nose and lower part of face.Partial thickness burn to face wash with water and soap daily, apply glucan Pro 3000 daily.Inhalation injury inhalation protocol including Heparin, Mucous, albuterol started.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Resident #1's care plan, revised on 05/06/25, read in part, 5/2/25 Burns to face from smoking incident. Interventions 5/2/25 Send to ER for assessment of burns to face.</p> <p>On 05/05/25, the facility initiated their quality assurance with all committee members to develop a performance improvement plan related to residents attempting to smoke in the room while having oxygen on. The plan included vaping devices.</p> <p>On 05/05/25, the facility implemented new smoking assessments, smoking agreements, and a questionnaire to monitor and track smokers understanding of the policy. Resident #1 would have their agreement completed once back from the hospital.</p> <p>On 05/05/25 all residents were reviewed for their smoking status and a new assessment was completed for all the smokers. Care plans were reviewed and updated as indicated by the assessments.</p> <p>On 05/05/25 in-services were completed with all staff regarding smoking, supervised smoking and the policy which included vaping devices.</p> <p>On 05/07/25 at 8:00 am., the facility completed all-staff training through a message regarding the same information as the face-to-face in-service on 05/05/25. All facility employees were verified as receiving the messaged in-service. A third in-service was scheduled for 05/09/25 for all staff over the same information.</p> <p>On 05/07/25 at 11:04 a.m., the housekeeping supervisor stated Resident #1 vaped and never smoked. They stated Resident #1 never came out of their room to smoke, and vaped in their room. The housekeeper stated Resident #1 used oxygen daily.</p> <p>On 05/07/25 at 11:20 a.m., CMA #2 stated Resident #1 vaped and did not get up and go out of their room. CMA #2 stated Resident #1 can dip tobacco and use a vape on their own and was very independent. CMA #2 stated Resident #1 used oxygen all the time.</p> <p>On 05/07/25 at 11:33 a.m., CNA #1 stated the facility smoking policy was residents needed to be outside. CNA #1 stated Resident #1 vaped and three or four vapes were kept in their room. CNA #1 stated Resident #1 never used materials that had to be lit by staff. CNA #1 stated staff charged the vapes' everyday for Resident #1. CNA #1 stated on Friday, Resident #1 called out their name. CNA #1 stated when they went in to check on Resident #1, they had burned their face. CNA #1 stated Resident #1's face was really red from lighting a cigarette with oxygen on. CNA #1 stated Resident #1 always vaped and they were not sure where the cigarette and lighter came from. CNA #1 stated Resident #1 was bed bound and only vaped prior to the incident. CNA #1 stated they have never found Resident #1 with oxygen on while vaping because they knew to take it off. CNA #1 stated everyone knew Resident #1 vaped in their room.</p> <p>On 05/07/25 at 12:41 p.m., LPN #1 stated Resident #1 was independent except for getting up and dressed. LPN #1 stated Resident #1 smoked using a vape, chewed tobacco and stayed in their room. LPN #1 stated Resident #1 used oxygen and always vaped in their room. LPN #1 stated Resident #1 always knew to take of their oxygen when vaping.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 05/07/25 at 1:00 p.m., CMA #1 stated Resident #1 smoked by using a vape. CMA #1 stated Resident #1 vaped in their room, used oxygen, but never kept it on when vaping. CMA #1 stated Resident #1 yelled out their names, and they smelled an odor of something that had been burnt. CMA #1 stated Resident #1 stayed in their room, vaped and they did not know where the cigarette and lighter came from. CMA #1 stated they charged the vapes' for Resident #1 and everyone knew he vaped in the room.</p> <p>On 05/07/25 at 2:10 p.m., Resident #1 stated they had not smoked in a very long time and they had a craving. Resident #1 stated they vaped and chewed tobacco. Resident #1 stated it was stupid of them to have a craving and smoke in the room and they regret they ever did. Resident #1 stated they had never done this before and never will again. Resident #1 stated he put the flames out with their hands and a blanket. Resident #1 stated they knew to remove the oxygen when they vaped in the room.</p> <p>On 05/08/25 at 1:01 p.m., the DON stated residents who vape must vape in the designated smoke area. The DON stated they were not aware of Resident #1 ever smoking cigarettes. The DON stated they were not aware of the vaping in the room. The DON stated they would not allow vaping in the building because the device could explode. The DON stated they were not sure where the cigarette and lighter came from, and prior to the incident there had been no smoking materials found in the room.</p> <p>On 05/08/25 at 1:55 p.m., the administrator stated they did not know any residents vaped in the facility. The administrator stated Resident #1 only dipped tobacco and stopped smoking long before admission the facility. The administrator stated vaping was not to be done in the room and Resident #1 stated their family provided the cigarette and lighter.</p>		