STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365681	A. BUILDING _____ B. WING _____	03/14/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WINDSOR LANE HEALTHCARE CENTER	355 WINDSOR LANE GIBSONBURG, OH 43431

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 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record reviews, resident interview, staff interview, and policy reviewe, the faciltiy failed failed to follow their policy for allegations of verbal abuse. This affected two (Residents #24 and #19) of four residents reviewed for abuse. The facility census was 68. Findings include: Review of Resident #24's medical record revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of Resident #24's Minimum Data Set (MDS) assessment, dated 01/31/2020, revealed the resident was cognitively intact. Resident #24 displayed no behaviors during the review period. Resident #24 required limited assistance with bed mobility. Resident #24 required supervision with transfers, walking, and locomotion. Resident #24 required extensive assistance with dressing, toilet use, and personal hygiene. Resident #24 required physical help from staff in part of the bathing activity. Review of Resident #19's medical record revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of Resident #19's MDS assessment dated [DATE] revealed he was cognitively intact. Resident #19 displayed no behaviors during the review period. Resident #19 required supervision with bed mobility, transfer, walking, locomotion and personal hygiene. Resident #19 required extensive assistance with dressing and toilet use. Review of Resident #19's care plan revised 02/21/19 revealed supports and interventions for risk for decline in ability to walk, risk for falls, nutritional risk, obesity, risk for adverse consequences from taking [MEDICATION NAME] for anxiety and delusional disorders, dependent on staff for activities, self-care deficit and potential to be verbally aggressive. Review of Resident #19's progress notes revealed on 03/05/2020, Resident #19 had increased behaviors. He was screaming and throwing things off his night stand. A staff person from the MDS office came and talked with the resident and calmed the resident down. Review of Resident #19's behavior tracking on the Treatment Administration Record (TAR) revealed Resident #19 was documented as having a behavior on the evening shift on 03/05/20. It was noted interventions included redirection, and deep breathing. The specific behavior was not documented. Review of Resident #24's progress notes revealed on 03/06/2020 at 3:02 A.M., Resident #24 made comments to staff regarding fear of another resident. Staff provided reassurance. A message was left for social services and administration. Resident #24 was in his room resting in bed. On 03/11/2020 Resident #19 had an outburst of aggression toward another resident. Resident#19 believed the other resident had cameras in the facility and was watching this resident provide care on himself. Resident #19 went down the hall to other resident's room where the resident was sitting outside of his room in the hallway. Resident #19 was yelling at the resident and walking towards the other resident. A State tested Nursing Assistant (STNA) got in front of the other resident and Resident #19 continued yelling at the other resident swinging his arms. Resident #19 hit the STNA on the right shoulder. A nurse came out of office across the hall from other resident's room and was able to take Resident #19 down to his own room when he began hitting his door and walls with his fist. The Nurse Practitioner and received new order to send resident to the hospital for evaluation and treatment. 911 was called for transport and Resident #19 was transported to the hospital at 2:20 P.M. Interview on 03/14/2020 at 11:15 A.M. with Resident #24 revealed he was afraid of Resident #19, who lived on the same hall as him. Resident #24 reported he has witnessed Resident #19 be verbally abusive to staff and other residents. Resident #24 reported Resident #19 would hit anyone but would yell and accuse people of putting cameras in his bathroom and taking pictures of him and stuff like that. Resident #24 reported last week on 03/05/20 Resident #19 became verbally abusive to him. Resident #24 reported Resident #19 was yelling at him, waving his arms and accusing him of putting cameras up in his room and bathroom. Resident #24 stated Resident #19 then made the comment to him that this was going to end only one way, which was one of them going to jail and the other going to the morgue. Resident #24 reported at that point he became scared of Resident #19 because he wasn't sure what he would actually do. Resident #24 reported never seeing Resident #19 get physical but he felt threatened. Resident #24 reported the incident to the aide and said he was worried. She said she would keep an eye on him. Resident #24 stated he also reported it to the nurse and the social worker came and talked to him about it. Resident #24 stated he knows Resident #19 was sent to the hospital earlier this week for having behaviors but he came back the same day. Resident #24 reported he didn't think anything was done for what happened to him. Resident #24 reported he stopped eating his breakfast in the dining room because he wanted to stay away from Resident #19. Review of the facility's Self-Reported Incidents (SRI) revealed no corresponding SRI for Resident #24's report of fearing another resident. No Social Services follow up was found. Interview on 03/14/20 at 12:45 P.M. with the Director of Nursing (DON) revealed knowledge of Resident #19 lashing out and having outbursts due to his psychological issues. The DON verified an SRI was not completed, an investigation was not started, and they did not report the allegation of verbal abuse in relation to the incident between Residents #19 and #24 Interview on 03/14/20 at 1:28 P.M. with Licensed Social Worker (LSW) #127 verified she received a message from the night nurse regarding Resident #24's concerns on 03/05/220. LSW #127 reported the message stated Resident #24 was very paranoid about Resident #19 and the nurse wanted LSW #127 to talk with him. LSW #127 reported she talked with Resident #24 the next day and he told her he was afraid of Resident #19 because he was yelling, and it frightened him. LSW #127 stated she didn't believe Resident #19's yelling was directed at Resident #24 since Resident #19 has been known to accuse people of putting cameras in his room. LSW #127 reported she did not document the interaction with Resident #24 because Resident #19 yells out and she didn't think it rose to the level of abuse. LSW #127 did verify she began to add a verbal aggression support to Resident #19's care plan. Interview on 03/14/20 at 1:58 P.M. with Dietary Director (DD) #167 revealed Resident #24 did stop coming down to breakfast in the dining room. DD #167 reported Resident #24 switched to shakes for his meals so he stopped coming to the dining room on 03/11/20. The alleged incident with Resident #19 and Resident #24 took place on 03/05/20. It was not believed Resident #24's change in breakfast locations was related to Resident #19. Interview on 03/14/20 at 2:23 P.M. with Resident #19 verified he had verbal conflicts with some of the residents who lived on his hall. Resident #19 stated there was a group of them who fuss about him all the time and put cameras in his bathroom and bedroom so they can catch him doing things he shouldn't be doing. Resident #19 stated he doesn't do anything illegal, but he knows they were trying to catch him and get him kicked out. Resident #19 stated he got very angry about that. He said the facility even sent him to the hospital this week and he came right back. Resident #19 said he wasn't suicidal, and he came right back. Resident #19 stated he keeps trying to back away from those guys, but things just get worse. Resident #19 reported the staff at the facility were supportive and tried to help him stay cooled off. Interview on 03/14/20 at 3:06 P.M. with STNA #128 verified Resident #24 reported being fearful of Resident #19 because he was yelling and accusing him of things. STNA #128 reported she was not witness to the confrontation that took place between the two but she saw the after affects to Resident #24. He was withdrawn and not himself the next day. STNA #128 reported she talked to him about it and learned he was fearful because he felt threatened by Resident #19. STNA #128 stated she knows the incident was reported because the social worker came and talked with him. STNA #128 reported Resident #24 was cooperative with care, was able to make his needs known, and had no behavior concerns. Review of facility policy titled Abuse, Neglect, Exploitation, and Misappropriation of Resident Property, dated 2016, revealed the facility was to investigate all alleged violations involving abuse, neglect, exploitation, mistreatment of [REDACTED]. Facility staff were to immediately report all such allegations to the Administrator and the Ohio Department of Health (ODH). Once

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) the Administrator and ODH were notified an investigation of the allegation violation would be conducted. This deficiency substantiated Complaint Number OH 859.
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** Based on medical record reviews, resident interview, staff interview and policy review, the facility failed to ensure allegations of verbal abuse were reported to the state agency. This affected two (Residents #24 and #19) of four residents reviewed for abuse. The facility census was 68. Findings include: Review of Resident #24's medical record revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of Resident #24's Minimum Data Set (MDS) assessment, dated 01/31/2020, revealed the resident was cognitively intact. Resident #24 displayed no behaviors during the review period. Resident #24 required limited assistance with bed mobility. Resident #24 required supervision with transfers, walking, and locomotion. Resident #24 required extensive assistance with dressing, toilet use, and personal hygiene. Resident #24 required physical help from staff in part of the bathing activity. Review of Resident #19's medical record revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of Resident #19's MDS assessment dated [DATE] revealed he was cognitively intact. Resident #19 displayed no behaviors during the review period. Resident #19 required supervision with bed mobility, transfer, walking, locomotion and personal hygiene. Resident #19 required extensive assistance with dressing and toilet use. Review of Resident #19's care plan revised 02/21/19 revealed supports and interventions for risk for decline in ability to walk, risk for falls, nutritional risk, obesity, risk for adverse consequences from taking [MEDICATION NAME] for anxiety and delusional disorders, dependent on staff for activities, self-care deficit and potential to be verbally aggressive. Review of Resident #19's progress notes revealed on 03/05/2020, Resident #19 had increased behaviors. He was screaming and throwing things off his night stand. A staff person from the MDS office came and talked with the resident and calmed the resident down. Review of Resident #19's behavior tracking on the Treatment Administration Record (TAR) revealed Resident #19 was documented as having a behavior on the evening shift on 03/05/20. It was noted interventions included redirection, and deep breathing. The specific behavior was not documented. 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A nurse came out of office across the hall from other resident's room and was able to take Resident #19 down to his own room when he began hitting his door and walls with his fist. The Nurse Practitioner and received new order to send resident to the hospital for evaluation and treatment. 911 was called for transport and Resident #19 was transported to the hospital at 2:20 P.M. Interview on 03/14/2020 at 11:15 A.M. with Resident #24 revealed he was afraid of Resident #19, who lived on the same hall as him. Resident #24 reported he has witnessed Resident #19 be verbally abusive to staff and other residents. Resident #24 reported Resident #19 would hit anyone but would yell and accuse people of putting cameras in his bathroom and taking pictures of him and stuff like that. Resident #24 reported last week on 03/05/20 Resident #19 became verbally abusive to him. Resident #24 reported Resident #19 was yelling at him, waving his arms and accusing him of putting cameras up in his room and bathroom. Resident #24 stated Resident #19 then made the comment to him that this was going to end only one way, which was one of them going to jail and the other going to the morgue. Resident #24 reported at that point he became scared of Resident #19 because he wasn't sure what he would actually do. Resident #24 reported never seeing Resident #19 get physical but he felt threatened. Resident #24 reported the incident to the aide and said he was worried. She said she would keep an eye on him. Resident #24 stated he also reported it to the nurse and the social worker came and talked to him about it. Resident #24 stated he knows Resident #19 was sent to the hospital earlier this week for having behaviors but he came back the same day. Resident #24 reported he didn't think anything was done for what happened to him. Resident #24 reported he stopped eating his breakfast in the dining room because he wanted to stay away from Resident #19. Review of the facility's Self-Reported Incidents (SRI) revealed no corresponding SRI for Resident #24's report of fearing another resident. No Social Services follow up was found. Interview on 03/14/20 at 12:45 P.M. with the Director of Nursing (DON) revealed knowledge of Resident #19 lashing out and having outbursts due to his psychological issues. The DON verified an SRI was not completed, an investigation was not started, and they did not report the allegation of verbal abuse in relation to the incident between Residents #19 and #24 Interview on 03/14/20 at 1:28 P.M. with Licensed Social Worker (LSW) #127 verified she received a message from the night nurse regarding Resident #24's concerns on 03/05/220. LSW #127 reported the message stated Resident #24 was very paranoid about Resident #19 and the nurse wanted LSW #127 to talk with him. 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Facility staff were to immediately report all such allegations to the Administrator and the Ohio Department of Health (ODH). Once the Administrator and ODH were notified an investigation of the allegation violation would be conducted. This deficiency substantiated Complaint Number OH 859.
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record reviews, resident interview, staff interview, and review of a facility policy, the facility failed to ensure allegations of verbal abuse were thoroughly investigated. This affected two (Residents #24 and #19) of four residents reviewed for abuse. The facility census was 68. Findings include: Review of Resident #24's medical record revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of Resident #24's Minimum Data Set (MDS) assessment, dated 01/31/2020, revealed the resident was cognitively intact. Resident #24 displayed no behaviors during the review period. Resident #24 required limited assistance with bed mobility. Resident #24 required supervision with transfers, walking, and locomotion. Resident #24 required extensive assistance with dressing, toilet use, and personal hygiene. Resident #24 required physical help from staff in part of the bathing activity. Review of Resident #19's medical record revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of Resident #19's MDS assessment dated [DATE] revealed

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F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) he was cognitively intact. Resident #19 displayed no behaviors during the review period. Resident #19 required supervision with bed mobility, transfer, walking, locomotion and personal hygiene. Resident #19 required extensive assistance with dressing and toilet use. Review of Resident #19's care plan revised 02/21/19 revealed supports and interventions for risk for decline in ability to walk, risk for falls, nutritional risk, obesity, risk for adverse consequences from taking [MEDICATION NAME] for anxiety and delusional disorders, dependent on staff for activities, self-care deficit and potential to be verbally aggressive. Review of Resident #19's progress notes revealed on 03/05/2020, Resident #19 had increased behaviors. He was screaming and throwing things off his night stand. 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Resident #19 went down the hall to other resident's room where the resident was sitting outside of his room in the hallway. Resident #19 was yelling at the resident and walking towards the other resident. A State tested Nursing Assistant (STNA) got in front of the other resident and Resident #19 continued yelling at the other resident swinging his arms. Resident #19 hit the STNA on the right shoulder. A nurse came out of office across the hall from other resident's room and was able to take Resident #19 down to his own room when he began hitting his door and walls with his fist. The Nurse Practitioner and received new order to send resident to the hospital for evaluation and treatment. 911 was called for transport and Resident #19 was transported to the hospital at 2:20 P.M. Interview on 03/14/2020 at 11:15 A.M. with Resident #24 revealed he was afraid of Resident #19, who lived on the same hall as him. 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Resident #24 stated he also reported it to the nurse and the social worker came and talked to him about it. Resident #24 stated he knows Resident #19 was sent to the hospital earlier this week for having behaviors but he came back the same day. Resident #24 reported he didn't think anything was done for what happened to him. Resident #24 reported he stopped eating his breakfast in the dining room because he wanted to stay away from Resident #19. Review of the facility's Self-Reported Incidents (SRI) revealed no corresponding SRI for Resident #24's report of fearing another resident. No Social Services follow up was found. Interview on 03/14/20 at 12:45 P.M. with the Director of Nursing (DON) revealed knowledge of Resident #19 lashing out and having outbursts due to his psychological issues. 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Resident #19 stated he got very angry about that. He said the facility even sent him to the hospital this week and he came right back. Resident #19 said he wasn't suicidal, and he came right back. Resident #19 stated he keeps trying to back away from those guys, but things just get worse. Resident #19 reported the staff at the facility were supportive and tried to help him stay cooled off. Interview on 03/14/20 at 3:06 P.M. with STNA #128 verified Resident #24 reported being fearful of Resident #19 because he was yelling and accusing him of things. STNA #128 reported she was not witness to the confrontation that took place between the two but she saw the after affects to Resident #24. He was withdrawn and not himself the next day. STNA #128 reported she talked to him about it and learned he was fearful because he felt threatened by Resident #19. STNA #128 stated she knows the incident was reported because the social worker came and talked with him. STNA #128 reported Resident #24 was cooperative with care, was able to make his needs known, and had no behavior concerns. Review of facility policy titled Abuse, Neglect, Exploitation, and Misappropriation of Resident Property, dated 2016, revealed the facility was to investigate all alleged violations involving abuse, neglect, exploitation, mistreatment of [REDACTED]. Facility staff were to immediately report all such allegations to the Administrator and the Ohio Department of Health (ODH). Once the Administrator and ODH were notified an investigation of the allegation violation would be conducted. This deficiency substantiated Complaint Number OH 859.
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, resident interview, staff interview and policy review, the facility failed to ensure a resident received a showre as scheduled. This affected one (Resident #24) of three reviewed for bathing. The facility census was 68. Review of Resident #24's medical record revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of Resident #24's Minimum Data Set ((MDS) dated [DATE] revealed the resident was cognitively intact. Resident #24 displayed no behaviors during the review period. Resident #24 required limited assistance with bed mobility. Resident #24 required supervision with transfers, walking, and locomotion. Resident #24 required extensive assistance with dressing, toilet use, and personal hygiene. Resident #24 required physical help from staff in part of the bathing activity. Review of Resident #24's care plan, revised 03/02/2020, revealed supports and interventions risk for ineffective breathing patterns, history of surgical wound to groin area, activities, self-care deficit, risk for falls, use of [MEDICAL CONDITION] medications for anxiety, depression, and [MEDICAL CONDITION], obesity, risk for alteration in skin integrity, and risk for pain. Review of the Shower List revealed Resident #24 was scheduled to get showers on Sundays, Wednesdays, and Fridays. Review of Resident #24's State tested Nursing Assistant (STNA) tasks for the last 30 days revealed Resident #24 received bathing support on 02/14/20, 02/17/20, 02/19/20, 02/22/20, 02/23/20, 02/29/20, 03/01/20, 03/04/20, 03/12/20, and 03/13/20. Review of Resident #24's Refusal of Shower or Bed Bath forms revealed Resident #24 had one refusal on 03/06/20. Resident #24 went six days before he was offered bathing again. Interview on 03/14/20 at 11:15 A.M. with Resident #24 revealed he was scheduled for his showers on Sundays, Wednesdays and Fridays. He reported he was scheduled for a shower on 03/06/20 but he refused. Resident #24 explained it was the day after an incident which took place with Resident #19 and he just didn't feel like taking a shower. Resident #24 reported he signed the form saying that he refused. Resident #24 reported he was supposed to get a shower on 03/08/20 and 03/11/20. Resident #24 reported he asked at 7:00 P.M. on both days for his shower. He reported he ended up going to bed and never received his shower on those days. Resident #24 reported he didn't get a shower until 03/12/20. Interview on 03/14/20 at 12:45 A.M. with the Director of Nursing (DON) verified Resident #24 didn't receive his showers as scheduled. Review of the facility policy titled Bathing Frequency, undated, revealed the facility was to

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F 0677 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) establish frequency of bathing per resident choice. This deficiency substantiates Complaint Numbers OH 859 and OH 860.