STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366456	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Medical Center Inc	1454 East Maple Street North Canton, OH 44720

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on record review, interview, and review of facility policies, the facility failed to provide written transfer and bed hold notices to Residents #1 and #114 at the time of transfer to the hospital. This affected two residents (#1 and #114) of two reviewed for hospitalization. Findings include: 1. Review of the medical record for Resident #1 revealed an admission date of 04/03/25 with diagnosis including, sepsis, diabetes type 2, hypertension, UTI, pneumonia, kidney stones, low potassium, and anemia. Resident #1 was discharged to the hospital 05/03/25. Review of progress note dated 05/03/25 at 1:15 P.M. revealed abnormal lab results were reported to the Certified Nurse Practitioner (CNP) and the response was to send Resident #1 to the hospital for further evaluation. Review of the physician's orders for Resident #1 revealed an order to send the resident to the emergency room for evaluation and treatment (ordered 05/03/25 at 2:15 P.M.). Review of Resident #1's medical record revealed no evidence Resident #1 received written notice of details of the transfer or bed hold notice. On 5/06/25 at 09:47 A.M. an interview with Social Services Designee (SSD) #586, who is also the admission Coordinator, revealed she was unaware of what the facility process was for issuing transfer and bed hold notifications or if it was being done. The nurses do a transfer summary in point click care (PCC) that is sent as part of the hospital communication. On 05/06/25 at 03:31 P.M. an interview with the SSD #586 revealed that the facility policy was for the nurses to fill out a transfer to hospital form in the electronic medical record. Notifications of transfer were made over the phone, and the family/responsible party was asked if they want to hold the bed and charges to hold beds were given at that time. She confirmed nothing was given in writing at the time of Resident #1's transfer. Review of the facility policy titled Bed Holds and Returns, dated 05/03/24, revealed that for a transfer that facility would give the resident written notice explaining duration of bed hold, payment required and details of transfer. 2. Review of the medical record for Resident #114 revealed an admission date of 05/01/25 with diagnosis including, polyneuropathy, depression, anemia, elevated WBCs, hyperlipidemia, essential (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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hypertension, muscle weakness. Review of a progress note dated 05/04/25 at 12:39 P.M. revealed chest x-ray results showed left lower lung infiltrates and the CNP was notified and new orders were received for Doxycycline and probiotic. Upon notification of new orders, the family requested the resident be transferred to the hospital. Review of the physician's orders for Resident #114 revealed an order dated 05/03/25 at 12:45 P.M. to send the resident to the emergency room for evaluation and treatment. Review of Resident #114's medical record revealed no evidence Resident #1 received written notice of details of the transfer or bed hold notice. On 5/06/25 at 09:47 A.M. an interview with SSD #586, revealed she was unaware of what the facility process was for issuing transfer and bed hold notifications or if it was being done. The nurses do a transfer summary in point click care (PCC) that is sent as part of the hospital communication. On 05/06/25 at 03:31 P.M. an interview with the SSD #586 revealed that the facility policy was for the nurses to fill out a transfer to hospital form in the electronic medical record. Notifications of transfer were made over the phone, and the family/responsible party was asked if they want to hold the bed and charges to hold beds were given at that time. She confirmed nothing was given in writing at the time of Resident #114's transfer. Review of the facility policy titled Bed Holds and Returns, dated 05/03/24, revealed for a transfer the facility would give the resident written notice explaining duration of bed hold, payment required and details of transfer.

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on record review and interview, the facility failed to ensure resident assessments were completed accurately. This affected two (Residents #116 and #117) of 11 residents reviewed for accuracy of assessments. Findings include: 1. Review of the medical record for Resident #116 revealed an admission date of 03/10/25 with diagnoses including adult failure to thrive, congestive heart failure and hypertension. Resident #116 remained in the facility as of the survey on 05/08/25. Review of Resident #116's Minimum Data Set (MDS) 3.0 assessments the facility had completed revealed the facility had submitted a discharge return not anticipated assessment on 04/17/25. Interview on 05/08/25 at 2:18 P.M. with Registered Nurse (RN) #554 verified she had completed Resident #116's MDS assessment on 04/17/25 as discharge return not anticipated. She stated Resident #116's insurance had changed and she was paying privately for her room. She verified Resident #116 did not discharge from the facility or change beds to a licensed only bed. 2. Review of the medical record for Resident #117 revealed an admission date of 03/24/25 with diagnoses including hypertension and diabetes mellitus. Resident #117 remained in the facility as of the survey on 05/08/25. Review of Resident #117's MDS 3.0 assessments the facility had completed revealed the facility had submitted a discharge return not anticipated assessment on 04/12/25. Interview on 05/08/25 at 2:18 P.M. with RN #554 verified she had completed Resident #117's MDS assessment on 04/12/25 as discharge return not anticipated. She stated Resident #117's insurance had changed and she was paying privately for her room. She verified Resident #117 did not discharge from the facility or change beds to a licensed only bed.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on record review and interview, the facility failed to ensure medications were obtained timely from the pharmacy and were administered as ordered. This affected one (Resident #65) of eight residents reviewed for medications being administered as ordered. Findings include: Review of the medical record for Resident #65 revealed an admission date of 01/02/25 with diagnoses including congestive heart failure, chronic respiratory failure and glaucoma (eye condition with high pressure in the eye causing damage to the optic nerve). Review of the physician's orders for Resident #65 revealed she had an order for Latanoprost Ophthalmic Solution 0.005%, one drop in both eyes at bedtime for glaucoma, dated 01/04/25. Review of the Medication Administration Record (MAR) for Resident #65 revealed she did not receive her Latanoprost Ophthalmic Solution on 02/17/25, 03/18/25 and 04/25/25 as ordered. Review of the nursing progress notes for Resident #65 revealed on 02/17/25 at 7:41 P.M. Latanoprost Ophthalmic Solution was not available to administer. On 03/18/25 at 8:11 P.M. the nursing progress note stated the Latanoprost Ophthalmic Solution was not available and on order. On 04/25/25 at 7:56 P.M. it was noted the Latanoprost Ophthalmic Solution was unavailable and would be in the night's drop box from the pharmacy. Interview on 05/06/25 at 9:45 A.M. with Registered Nurse (RN) #506 verified Resident #65 did not receive her Latanoprost Ophthalmic Solution as ordered on the dates listed above due to the facility not having the medication. RN #506 stated most of the medications would come on a monthly cycle rotation, however, this medication did not arrive timely from the pharmacy. Review of the facility policy titled, Administering Medications, dated 04/17/24, revealed medications must be administered in accordance with the orders including any required time frame.