

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365458	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/06/2025
NAME OF PROVIDER OR SUPPLIER Wood Haven Health Care Senior Living & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 1965 E Gypsy Lane Rd Bowling Green, OH 43402	

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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31638</p> <p>Based on record review, resident interview, staff interview and review of facility policy the facility failed to ensure residents were free from abuse. This affected one resident (#10) of two residents reviewed for abuse. The facility census was 71.</p> <p>Findings include:</p> <p>Review of Resident #10's medical record revealed an admitted [DATE]. Diagnoses included schizophrenia, psychosis, and congestive heart failure.</p> <p>Review of Resident #10's annual MDS dated [DATE] revealed he had an intact cognition. No behaviors were documented.</p> <p>Review of Resident #10's most recent care plan revealed he had a history of trauma that carried negative effects. Interventions included to encourage the resident to express feelings, concerns, and thoughts in a safe space and identify items that lessen the effect of trauma and provide comfort.</p> <p>Review of Resident #10's medical record revealed a nurse's note dated 12/08/24 informing Licensed Practical Nurse (LPN) # 230 Resident #10 was in an activity with another male resident who came up to him with a clenched fist. Resident #10 was upset and stated he had not done anything to the other resident.</p> <p>Interview with Activity Director on 01/06/24 at 8:20 A.M. revealed there was an incident on 12/08/24 between Residents #10 and #11. The residents were arguing and separated. The Activity Director revealed Activity Aide #105 wrote a letter regarding the incident and gave it to the Director of Nursing (DON).</p> <p>Interview with Resident #10 on 01/06/24 at 8:48 A.M. revealed Resident #11 swung his fists at him multiple times but never made contact. Resident #10 stated he was unable to attend activities due to Resident #11's behavior towards him. Resident #10 stated he had reported the situation to everyone but no one would do anything regarding the threats.</p> <p>Interview with the DON and Administrator on 01/07/25 at 3:13 P.M. revealed neither had notified of the incident between Residents #10 and #11 on 12/08/24 nor had the DON received a letter regarding the incident.</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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Self-Reported Incidents revealed no information was reported to the State of Ohio regarding the abuse.</p> <p>Review of the facility policy titled Abuse, Neglect, and Exploitation dated 07/20/22 revealed mental abuse includes, but not limited to humiliation, harassment, threats of punishment or deprivation.</p> <p>This violation represents non-compliance investigated under Complaint Number OH00160615.</p>		

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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>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31638</p> <p>Based on staff interviews, resident interviews, record review, and facility policy review revealed facility staff failed to report an allegation of abuse. This affected two residents (#10 and #11) of two residents reviewed for abuse. The facility census was 71.</p> <p>Findings include:</p> <p>Review of Resident #11's medical record revealed an admitted [DATE]. Diagnoses included intellectual disabilities, encephalopathy, and altered mental status.</p> <p>Review of Resident #11's quarterly Minimum Data Set (MDS) revealed the resident had a moderate decline in cognition. The resident had no behaviors documented.</p> <p>Review of Resident #11's behavior note dated 12/08/24 revealed the resident was in the activity room and displayed inappropriate actions and required redirection from staff back to his room. The actions were not specified.</p> <p>Review of Resident #11's physician note dated 12/10/24 revealed the resident had developed more aggressive behaviors since being off Abilify (antipsychotic).</p> <p>Review of Resident #11's behavior note dated 12/13/24 revealed the resident was removed from music entertainment for disruptive behavior.</p> <p>Review of Resident #11's psychiatric note dated 12/16/24 revealed the resident was seen at the request of staff for a follow-up on medication management due to disruptive behavior in group settings which included hitting others with his wheelchair.</p> <p>An additional note dated 12/18/24 revealed Resident #11 was removed from morning coffee bar for disruptive behavior.</p> <p>Review of Resident #10's medical record revealed an admitted [DATE]. Diagnoses included schizophrenia, psychosis, and congestive heart failure.</p> <p>Review of Resident #10's annual MDS dated [DATE] revealed he had an intact cognition. No behaviors were documented.</p> <p>Review of Resident #10's most recent care plan revealed he had a history of trauma that carried negative effects. Interventions included to encourage the resident to express feelings, concerns, and thoughts in a safe space and identify items that lessen the effect of trauma and provide comfort.</p> <p>Review of Resident #10's medical record revealed a nurse's note dated 12/08/24 informing Licensed Practical Nurse (LPN) # 230 Resident #10 was in an activity with another male resident who came up to him with a clenched fist. Resident #10 was upset and stated he had not done anything to the other resident.</p> <p>(continued on next page)</p>		

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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>Interview with Activity Director on 01/06/24 at 8:20 A.M. revealed there was an incident on 12/08/24 between Residents #10 and #11. The residents were arguing and separated. The Activity Director revealed Activity Aide #105 wrote a letter regarding the incident and gave it to the Director of Nursing (DON).</p> <p>Interview with Resident #10 on 01/06/24 at 8:48 A.M. revealed Resident #11 swung his fists at him multiple times but never made contact. Resident #10 stated he was unable to attend activities due to Resident #11's behavior towards him. Resident #10 stated he had reported the situation to everyone but no one would do anything regarding the threats.</p> <p>Interview with the DON and Administrator on 01/07/25 at 3:13 P.M. revealed neither had notified of the incident between Residents #10 and #11 on 12/08/24 nor had the DON received a letter regarding the incident.</p> <p>Attempted interview with Activity Aide #105 revealed she was unavailable.</p> <p>Review of the Self-Reported Incidents revealed no information was reported to the State of Ohio regarding the abuse.</p> <p>Review of the facility policy titled Abuse, Neglect, and Exploitation dated 07/20/22 revealed mental abuse includes, but not limited to humiliation, harassment, threats of punishment or deprivation.</p> <p>This violation represents non-compliance investigated under Complaint Number OH00160615.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31638</p> <p>Based on staff interview, nurse practitioner interview, family interview, and review of facility policy revealed the facility failed to follow documented medication orders in resident records. This affected one (#84) resident of three residents reviewed for medication orders. The facility census was 71.</p> <p>Findings included:</p> <p>Review of Former Resident (FR) #84's medical record revealed an admitted [DATE]. Diagnoses included thyroid cancer, urinary tract infection, and cystitis.</p> <p>Review of FR #84's five-day Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had an intact cognition.</p> <p>Review of FR #84's care plan revealed the resident had a temporary placement in the facility and planned on returning home after the completion of therapies.</p> <p>Review of FR #84's nursing note dated 11/22/24 revealed the resident was admitted from a local hospital and was alert, oriented and able to make needs known.</p> <p>Review of FR #84's Medication Administration Record (MAR) dated 11/22/24 revealed the resident refused Gavreto. On 11/23/24 Gavreto was administered. On 11/24/24 Gavreto was not administered due to parameters by Registered Nurse (RN) #141. On 11/25/24 the MAR was documented 9 which represented see nurses notes and on 11/26/24 the drug was marked as refused.</p> <p>Review of FR #84's nurses note dated 11/24/24 revealed two capsules of Gavreto 100 milligrams each for medullary thyroid carcinoma was held per FR #84's daughter. The daughter stated the oncologist ordered to hold the Gavreto until Resident #84 completed the intravenous antibiotic ordered for the urinary tract infection.</p> <p>Telephone interview with the hospital Certified Nurse Practitioner (CNP) #400 on 01/02/25 at 10:07 A.M. revealed FR #84's chemotherapy medication was on hold and that information was written on the hospital discharge summary. CNP #400 stated Gavreto was on the medication list but since it was only on hold it was not removed from the residents medication list. Adding, if there was any questions, the staff should have notified the oncologist.</p> <p>Interview with RN #141 on 01/06/25 at 10:14 A.M. verified she charted on 11/24/24 that the medication (Gavreto) was out of parameters but failed to chart the reason in the nurses notes. RN #141 stated Resident #84's daughter and the resident informed the staff that the physician had discontinued the chemotherapy medication while receiving the antibiotic therapy, but were unaware of why. The nurse revealed she failed to contact the oncologist office to verify the medication order.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Telephone interview with Unit Manager #149 on 01/06/25 revealed she attempted to contact FR #84's oncologist to verify the chemotherapy medication, but the office failed to return the phone call. In the meantime, a verbal order was given to staff to hold the medication. Unit Manager #149 verified she failed to document the order to hold the medication and staff attempted to administer the medication to the resident daily. Unit Manager #149 verified FR #84 did receive Gavreto on 11/22/24 and the medication should have been held.</p> <p>Review of the facility policy titled Medication Administration dated 05/2024 revealed medications are administered by licensed nurses, or other staff who are legally authorized to do so in the state, as ordered by the physician and in accordance with professional standards of practice. Report and document any adverse side effects or refusals.</p> <p>This violation represents non-compliance investigated under Complaint Number OH00160942.</p>		