STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365458	A. Building B. Wing	12/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wood Haven Health Care Senior Living & Rehab	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)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on medical record review and staff interview, the facility failed to ensure accurate assessments were completed. This affected one (#65) of three residents reviewed for assessments. The facility census was 76. Findings include:Review of the medical record for Resident #65 revealed an admission date of 02/20/25 with diagnoses including, but not limited to, psychotic disorder with delusions, Parkinson's disease, anxiety, depression, dementia, and neurocognitive disorder with Lewy bodies.Review of the Nursing admission Assessment completed on 02/20/25 revealed the resident had natural teeth, with missing teeth and no dentures.Review of the Oral Status and Dental assessment completed on 02/21/25 revealed the resident had natural teeth, with missing teeth and no dentures.Review of the Oral Status and Dental assessment completed on 05/22/25 revealed the resident had natural teeth, with missing teeth and no dentures.Review of the Minimum Data Set (MDS) assessment, dated 11/04/25, revealed the resident had severe cognitive impairment. The assessment indicated Resident #65 had no broken or loosely fitting full or partial dentures. The resident had no mouth or facial pain, discomfort, or difficulty chewing.Interview on 12/08/25 at 11:24 A. M. with Certified Nursing Assistant (CNA) #308 revealed that Resident #65 had partial dentures.Interview on 12/08/25 at 1:35 P.M. with Unit Manager (UM) #290 verified the dental assessments completed for Resident #65 stated the resident had natural teeth and did not have dentures. This deficiency represents non-compliance investigated under Master Complaint Number 2669641.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Review of the medical record for Resident #19 revealed an admission date of 07/12/25 with diagnoses including, but not limited, to seborrheic dermatitis, pressure ulcer of sacral region stage three (full thickness to fat), pressure ulcer of right buttock stage three, pressure ulcer of left buttock stage three, and paraplegia.Review of the Minimum Data Set (MDS) assessment, dated 12/02/25, revealed the resident was cognitively intact. Resident #19 had two stage three pressure ulcers that were present on admission.Review of the care plan dated 07/16/25 revealed the resident had two stage three pressure ulcers upon admission and dermatitis/fungal infection related to disease processes- paraplegic, non-compliant with care and getting up out of bed. Interventions included administer treatments as ordered, low air loss (LAL) alternating pressure mattress, and weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, and type of tissue and exudate.Review of the weekly skin assessment dated [DATE] revealed the stage three pressure to the right buttock measured 5.0 centimeters (cm) in width by (x) 2.1 cm in length x 0.1 cm in width. Wounds number two and three were measured together, with the measurements being a combined 8.0 cm width x 8.1 cm in length x 0.1 cm in depth. Wounds number three and four were measured together, with a combined measurement of 8.9 cm in width x 4.9 cm in length x 0.1 cm in depth. The stage three pressure ulcer to the left buttock was resolved. There was a moderate amount of serosanguinous drainage to all areas. Treatment included Silvadene to all areas and cover with abdominal (ABD) pads. Wound beds were beefy red with much improvement noted. Review of the weekly skin assessment dated [DATE] revealed the stage three pressure to the right buttock measured 5.0 centimeters (cm) in width by (x) 2.1 cm in length x 0.1 cm in width. Wounds number two and three were measured together, with the measurements being a combined 8.0 cm width x 8.1 cm in length x 0.1 cm in depth. Wounds number three and four were measured together, with a combined measurement of 8.9 cm in width x 4.9 cm in length x 0.1 cm in depth. The stage three pressure ulcer to the left buttock was resolved. There was a moderate amount of serosanguinous drainage to all areas. Treatment included Silvadene to all areas and cover with abdominal (ABD) pads. Wound beds were beefy red with much improvement noted. Interview on 12/04/25 at 2:30 P.M. with Unit Manager (UM) #290 revealed she completed wound rounds with the NP weekly. UM #290 stated the NP usually came on Fridays to do wound rounds. UM #290 stated the NP always came on Mondays to do regular rounds and she would do wound rounds if she knew she would not be in on Friday. UM #290 stated she was always present in the room when the NP completed wound rounds and would write down the measurements. UM #290 verified the NP came in and completed rounds on 11/03/25 and when the weekly skin assessment came up in the electronic record on 11/06/25, she documented the same measurement as 11/03/25 during rounds. UM #290 verified on 11/06/25 she did not remeasure or assess the wounds. This deficiency represents non-compliance investigated under Complaint Number 2668796.