STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365658	A. Building B. Wing	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cardinal Woods Skilled Nursing & Rehab Ctr	6831 Chapel Road Madison, OH 44057

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed medical record review, staff interview and review of facility policy, the facility failed to ensure fall interventions were implemented. This affected one (#98) of four residents reviewed for falls. The facility census was 89.Findings include:Review of the closed medical record for Resident #98 revealed an admission date of 09/02/25. Diagnoses included senile degeneration of the brain, repeated falls, and unspecified dementia. Resident #98 discharged from the facility on 12/02/26.Review of the the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #98 had severe cognitive impairment and had one fall without injury since the last assessment period. Review of a physician order dated 09/09/25 revealed Resident #98 was to have a floor mat to the side of the bed with placement verification every shift and as needed.Review of the care plan, initiated 09/10/25, revealed Resident #98 was at high risk for falls related to decreased awareness to own safety, unsteady gait and effects from osteoarthritis and dementia. Interventions included ensure bed was kept in the lowest position and floor mat to the side of the bed. Review of a Post Fall Evaluation dated 01/07/26 revealed Resident #98 experienced an unwitnessed fall at approximately 9:15 A.M. while attempting to get out of bed. The document revealed the resident's bed was left in the high position and no mats were on the floor. The evaluation further revealed the bed was at an improper height and the floor mat was not in place at the time of the fall.Review of the facility's fall investigation, dated 01/07/26, revealed contributing factors related to Resident #98's fall included the resident's bed being left in the high position and the floor mat not positioned on the floor at bedside. Further review revealed the resident was attempting to get out of bed when the fall occurred. The investigation included staff witness statements corroborating the resident was found with the bed elevated and floor mat not positioned at bedside.Interview on 05/20/26 at 9:38 A.M. with Licensed Practical Nurse (LPN) #268 confirmed when Resident #98 fell on [DATE], the bed had been left in the high position and the floor mat was not at the side of the bed. LPN #268 stated it was believed the wound nurse and wound team left the room without notifying staff the bed remained elevated and the floor mat was not positioned next to the bed. Interview on 05/20/26 at 1:00 P.M. with Certified Nursing Assistant (CNA) #242 revealed on the day Resident #98 fell, she was preparing to provide care when the wound care team entered the resident's room and requested to complete wound care prior to her providing care. CNA #242 stated the bed was elevated and she briefly left the room. Upon returning, she observed Resident #98 on the floor with the bed still elevated and the floor mat positioned next to the other bed in the room. She stated she notified LPN #268, who assessed the resident.Interview on 05/20/26 at 1:19 P.M. with CNA #275 revealed she became aware of Resident #98's fall after CNA #242 requested the nurse come to the resident's room. CNA #275 stated she completed a witness statement indicating wound care staff had left the bed elevated.Review of the facility policy titled, Falls-Protocol, revised March 2018, revealed that after assessment, the staff and physician would identify pertinent interventions to try to prevent subsequent falls and to address the risks of clinically significant consequences of falling. Additionally, the staff and physician would monitor and document the individual's response to interventions intended to reduce falling or the (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	consequences of falling.This deficiency represents noncompliance investigated under Complaint Number 2710514.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365658	A. Building B. Wing	05/28/2026

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview, review of maintenance records and review of facility policy, the facility failed to ensure foods were stored and served at appropriate temperatures to prevent foodborne illnesses. Additionally, the facility failed to ensure kitchen equipment was maintained in a clean and sanitary manner. This had the potential to affect all 89 residents in the facility who were identified to receive food from the kitchen. The facility census was 89.Findings include:1. Observation on 05/18/26 at 8:30 A.M. revealed the temperature in the facility's walk-in refrigerator was 49 degrees Fahrenheit (F). Concurrent interview with Food Service Manager (FSM) #601 verified the walk-in refrigerator temperature.Observation on 05/19/26 at 10:50 A.M. revealed the temperature in the facility's walk-in refrigerator was 49 degrees F. Concurrent interview with FSM #601 verified the walk-in refrigerator temperature.Review of facility policy titled, Food Storage, undated, revealed the food storage temperature for the refrigerator was between 37 degrees F to 40 degrees F.2. Observation on 05/20/26 at 1:21 P.M. with FSM #601of a lunch meal test tray revealed the meal was the last tray removed from the cart. Further observation of the food items, tested with a facility calibrated thermometer, revealed the hot foods maintained a safe temperature. However, the milk temperature was 48 degrees F. Concurrent interview with FSM #601 verified the temperature of the milk. FSM #601 stated dietary staff sent milk to the units around 11:30 A.M. on a beverage cart, before the lunch meal trays arrived. Review of facility policy titled, Food Safety and Sanitation, undated, revealed refrigerated food was to be stored at or below 41 degrees F.3. Observation on 05/18/26 at 8:37 A.M. of the kitchen ice machine revealed cracked plastic and a frayed seal on the ice machine door. The filter was observed to be full of dust, and the output vents had a coating of dust. Concurrent interview with FSM #601 verified the filter was dusty and the output fan had excess dust and stated the filter needed cleaned through the dish machine. Interview on 05/20/26 at 3:10 P.M. with Maintenance Supervisor (MS) #700 revealed it was maintenance's responsibility to clean the top part of the ice machine, such as the fan and filter, every six months.Review of facility document titled, Machine Activity Log, revealed the last documented ice machine cleaning was on 09/10/25, when the ice machine was sanitized and the descaling cycle was run. The facility performed a sanitization and descaling on 05/26/26, during the annual survey.This deficiency represents non-compliance investigated under Complaint Number 2710514.