

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365658	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/28/2026
NAME OF PROVIDER OR SUPPLIER Cardinal Woods Skilled Nursing & Rehab Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observations, interviews, and policy review, the facility failed to implement a comprehensive, individualized, and effective nutrition program to prevent and address significant resident weight loss. Actual harm occurred on 03/20/26 when the facility identified Resident #75 experienced an unplanned significant weight loss of 22.6 percent (%) in approximately one month, and failed to implement appropriate interventions, provide continued monitoring of the resident's weight, or notify the physician of concerns. Subsequently, Resident #75 experienced a second unplanned weight loss of 6.82% approximately two months later. In total, Resident #75 experienced a significant weight loss of 27.8% in approximately three months. This affected one (#75) of three residents reviewed for nutrition. The facility census was 89. Findings include: Review of medical record revealed Resident #75 was admitted to the facility on [DATE]. Medical diagnoses included major depressive disorder, lymphedema, peripheral vascular disease, unspecified psychosis, bipolar disorder, morbid obesity, heart failure, dysphagia, dysfunction of bladder, anxiety disorder, and schizophrenia. Review of Resident #75's advanced directives dated 09/26/16, revealed the resident was documented as having a full code status (to receive all possibly life-saving measures in the event of a cardiac or respiratory arrest). Review of Resident #75's plan of care, revised 03/26/26, revealed the resident had the potential for altered nutrition and hydration due to heart failure with the need for diuretics, bipolar disorder, anxiety, lymphedema, edema, morbid obesity, nausea and vomiting, history of weight and laboratory (lab) refusals. Interventions included to elevate the head of bed when eating or drinking to reduce risk of aspiration, monitor for signs of edema, monitor/document and report to the physician refusals to eat, obtain weight per orders, encourage resident to be weighed, record meal intake every meal, and staff to assist with tray set up and provide further assistance as needed. Further review revealed no new interventions to address significant weight loss or decline in food intake. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #75 had a Brief Interview of Mental Status (BIMS) score of five, indicating severe cognitive impairment. Resident #75 required staff assistance with eating and the resident did not receive hospice services. Review of Resident #75's physician's order dated 04/20/21 revealed an order was initiated for a Hoyer lift for transfers with two staff members. An order dated 05/15/22 revealed Resident #75 was on a regular diet, regular texture and thin liquid consistency. Further review revealed an order dated 03/01/26 for monthly weights. Review of Resident #75's weights, located in the electronic medical record (EMR), revealed the resident weighed 278.9 pounds (lbs.) on 01/05/25. Further review revealed no evidence a weight was obtained again until 02/09/26, when the resident weighed 288.0 lbs. On 03/20/26, Resident #75 weighed 223.0 lbs., indicating a 22.6% weight loss in approximately one month. No additional weights were obtained until 05/25/26, when Resident #75 weighed 207.8 lbs., for an additional 6.82% weight loss and a total of 27.85% weight loss in approximately three months. Review (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 0692 Level of Harm - Actual harm Residents Affected - Few	assessed Resident #75 on 04/02/26 and had not visited the resident since or provided additional documentation/recommendations regarding the significant weight loss. RD #604 verified no physical assessment was completed to rule out malnutrition despite Resident #75 refusing weights and experiencing significant weight loss. A follow-up interview on 05/21/26 at 12:24 P.M. with RN #240 revealed Resident #75 refused to be weighed on a mechanical lift but a bed scale could be used if a resident was fearful of a mechanical lift scale. RN #240 stated she was not concerned about Resident #75 refusing weights or experiencing a significant weight loss. Interview on 05/21/26 at 12:34 P.M. with the Director of Nursing (DON) revealed Resident #75 refused to be weighed and the facility did not have a bed scale available to monitor Resident #75's weights, even though the resident was fearful of the mechanical lift transfer. The DON confirmed Resident #75 had not been weighed for monitoring for over one year (from 01/05/25 to 02/09/26) or after a significant weight loss had been identified on 03/20/26. The DON confirmed therapy was not consulted for possible interventions after the facility discovered Resident #75 experienced a significant weight loss. Interview on 05/26/26 at 10:00 A.M. with Resident #75's friend revealed he was concerned with the resident's food intake because he observed her meal tray sitting in front of her while she lay sleeping during his visits. He stated Resident #75 did not usually sleep this much and she used to eat good. Interview on 05/26/26 at 11:49 A.M. with CNA #262 revealed Resident #75 was terrified of the mechanical lift and refused to get weighed almost every week. CNA #262 stated, We usually skip her weight and mark refused because we do not have another way to weigh her. CNA #262 stated Resident #75 would not wake up to eat therefore her tray was left in the room if she was to wake up. Interview on 05/26/26 at 11:50 A.M. with CNA #256 revealed Resident #75 would not eat because she slept a lot. CNA #256 verified Resident #75 did not eat her eggs or pancakes on her breakfast tray this morning. Interview on 05/26/26 at 2:27 P.M. with Resident #75's legal guardian's paralegal, who attended the resident's care conferences, revealed the resident's significant weight loss was concerning, but the facility did not indicate they were concerned about it. Interview on 05/26/26 at 3:00 P.M. with Nurse Practitioner (NP) #605 revealed she assisted in the care of Resident #75. NP #605 stated she was aware the facility attempted to weigh Resident #75 using a mechanical lift, but the resident refused. NP #605 stated the facility did not notify her of the additional 15.2 lb. weight loss on 05/25/26 and confirmed no new orders were written to address Resident #75's refusals to monitor her weight. NP #605 stated she was unaware of the extended amount of time the facility had not obtained a weight on Resident #75. Interview on 05/26/26 at 3:05 P.M. with NP #606 revealed she usually cared for Resident #75 and was not notified of the additional 15.2 lb. weight loss on 05/25/26. NP #606 stated Resident #75 was at risk for weight loss because of not getting out of bed and had poor food intakes. NP #606 verified she was not reconsulted by the facility regarding the resident's refusals to be weighed and poor food intakes. While the resident had recent concerns for nausea, vomiting, and a urinary tract infection (UTI), which she was being treated for, NP #606 confirmed Resident #75 had no signs that the significant weight loss was unavoidable. A follow-up interview on 05/26/26 at 2:27 P.M. with RD #604 confirmed she was aware of Resident #75's significant weight loss and stated she was aware the resident refused weights due to the mechanical lift. RD #604 stated she was aware of Resident #75's nutrition risk factors that contributed to the resident's decline in food intake, which included her loss of appetite related to recent nausea and vomiting and depression. RD #604 confirmed that the resident's decline in food intake was a change in condition. RD #604 stated the last time she spoke with or observed Resident #75 was during the annual assessment in April 2026 and she could not remember what Resident #75 stated to her during the assessment. RD #604 verified she did not notify the physician of Resident #75's significant weight loss or decline in food intake. RD #604 stated the (continued on next page)		

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F 0692 Level of Harm - Actual harm Residents Affected - Few	expectation was that if a resident had a significant weight loss with poor food intake and they were unsure if the weight was faulty, the facility would obtain weekly weights. While RD #604 stated Resident #75 was obese, the goal would have been for the resident to maintain a stable weight with no unplanned significant weight loss. RD #604 also stated she was aware Resident #75 refused weights for over a year and no interventions were implemented to prevent a significant weight loss. A follow-up interview on 05/26/26 at 3:20 P.M. with the DON verified Resident #75 experienced a significant weight loss and the facility did not pursue alternative methods for monitoring the resident's weights or initiate referrals to providers to potentially address the resident's fear of mechanical lift transfers or decreased food intakes. The DON further confirmed the facility did not implement updated interventions or proactively address Resident #75's weight refusals and poor food intakes until the resident was identified with an additional weight loss of 15.2 lbs. on 05/25/26. The DON stated it was the expectation of the facility to notify the physician if a resident refused three consecutive meals and documentation in the progress notes suggested the NP was notified, even though NP #605 and NP #606 both denied having knowledge. The DON verified Resident #75 experienced significant weight loss, and no interventions or monitoring were implemented to prevent further weight loss. The DON stated the resident lost weight due to a lack of appetite and stated the resident did not like the mechanical lift. Interview on 05/27/26 at 8:30 A.M. with the Administrator revealed Resident #75 had been bedbound for eight years because she was fearful of the mechanical lift. The Administrator stated the facility could have provided a bed scale, but they would have needed to slightly lift Resident #75 off the bed to zero out the scale, therefore the facility did not pursue an alternative method to obtain weights for Resident #75. Review of facility document titled, Therapy Referral Communication Form, undated, revealed staff could request an evaluation and screen by therapy for a resident who seemed to be experiencing a functional situation change. Areas for evaluation on the document included weight loss and eating/swallowing concerns. Review of facility policy titled, Weight Assessment and Intervention, revised March 2022, revealed weights were recorded in each unit's weight record chart and in the individual medical record. The threshold for significant unplanned weight change was based on the following criteria: greater than 5% in one month and greater than 10% in six months. The individualized care plan would address the cause of weight loss, goals and benchmarks for improvement with timeframes and parameters for monitoring and reassessment.		

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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 #601 of 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.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on medical record review, staff interview and review of the facility policy, the facility failed to ensure comprehensive care plans were developed and updated to address resident care needs. This affected one (#75) of three residents reviewed for care planning. The facility census was 89. Findings include: Review of Resident #75's medical record revealed an admission date of 09/26/16. Diagnoses included major depressive disorder, lymphedema, peripheral vascular disease, psychosis, bipolar, morbid obesity, heart failure, atrial fibrillation, hyperlipidemia, anxiety disorder, essential primary hypertension and schizophrenia. Review of the Minimum Data Set (MDS) 3.0 assessment, dated 04/01/26, revealed Resident #75 was severely cognitively impaired. Review of a physician order dated 04/20/21 revealed an order was initiated for Hoyer lift for transfers with two staff members. Further review of an order dated 03/01/26 revealed Resident #75 was to have monthly weights every day shift starting on the first and ending on the sixth of every month. Review of the Medication Administration Record (MAR) for March 2026 revealed Resident #75 was ordered Lasix (furosemide) 40 milligrams (mg) by mouth two times daily every other day related to morbid obesity. The medication had a start date of 02/27/24 and a discontinued date of 03/25/26. Review of Resident #75's weights, located in the electronic medical record (EMR), revealed the facility obtained a weight on 01/05/25. Further review revealed no evidence a weight was obtained again until 02/09/26. Review of the nursing and dietary progress notes revealed Resident #75 refused weights on 01/12/26, 02/04/26, 04/10/26, 04/07/26, 04/10/26, 04/13/26, 04/14/26 and 05/12/26. Review of the current care plan, initiated 09/22/17, revealed an absence of a care area, goal, or interventions regarding Resident #75's diagnosis of (congestive) heart failure (CHF) or the administration of the diuretic medication Lasix under the focused area of cardiovascular status. The care plan lacked instructions for staff to monitor clinical indicators for CHF complications or the clinical risks related to the resident's refusals of weights. Interview on 05/21/26 at 11:12 A.M. with Registered Nurse (RN) #240 revealed Resident #75 was not consistently weighed because she was terrified of the mechanical lift. Interview on 05/26/26 at 11:49 A.M. with CNA #262 revealed Resident #75 was terrified of the mechanical lift and refused to get weighed almost every week. Additional review of the current care plan revealed the Interdisciplinary Team (IDT) did not update or develop a care plan to address Resident #75's refusals of weights by a mechanical lift, no documented strategies, education efforts, or alternative methods to accommodate the resident's weight refusals due to the resident's fear of using a mechanical lift. Interview on 05/21/26 at 3:30 P.M. with MDS Coordinator (MDSC) #244 confirmed Resident #75 had a diagnosis of CHF and had received Lasix therapy but the care plan was not updated to address the resident's care needs. MDSC #244 also verified the care plan was not updated to address Resident #75's refusals of weights, due to fears of using a mechanical lift, to monitor her nutritional status. Interview on 05/21/26 at 4:10 P.M. with the Director of Nursing (DON) revealed Resident #75 had the right to refuse weights, so nursing staff would document the refusals in the progress notes. The DON verified a specific care plan was not created for the refusal to use the mechanical lift for weight status because the facility felt it was the resident's right to refuse. Review of facility's policy titled, Care Plans, Comprehensive Person-Centered, revised March 2022, revealed a comprehensive, person-centered care plan that included measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs was implemented and developed for each resident. The care plan interventions were derived from a thorough analysis of the information gathered as part of the comprehensive assessment. Interventions would address the underlying source of the problem, not just the symptoms or triggers.		

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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 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 consequences of falling. This deficiency represents noncompliance investigated under Complaint Number 2710514.		