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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365722	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wood Glen Alzheimer's Community	3800 Summit Glen Drive Dayton, OH 45449

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44070 Based on medical record review, staff interview, review of investigation documents, and review of self-reported incidents, the facility failed to report injuries of unknown origin in a timely manner. This affected two (#17 and #30) of two residents reviewed for injuries of unknown origin. The facility census was 141. Findings Include: 1. Review of the medical record for Resident #17 revealed an admitted [DATE]. Diagnoses included encephalopathy, dementia, violent behavior, generalized anxiety, heart failure, malnutrition, and cellulitis. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #17 was assessed as cognitively impaired. Review of Resident #17's progress note created 01/17/25, and back dated to 01/13/25 at 3:06 P.M., titled Post Fall Evaluation, revealed documentation that a fall occurred on 01/13/25. The Post Fall Evaluation revealed vital signs were refused by Resident #17 and no injuries were noted. Review of a progress note created 01/17/25, and back dated to 01/13/25 at 3:28 P.M., titled Nurses Note, revealed a head-to-toe assessment was completed and range of motion (ROM) for all extremities were within normal limits. There were no complaints of pain at that time and neurological checks were initiated. Review of a progress note titled Nurses Note, created and completed on 01/16/25 at 3:55 P.M., revealed Resident #17 complained of pain to the right lower extremity during care, the physician and family were notified, an x-ray was ordered and performed, and the pain medication acetaminophen was ordered and administered. Review of a Nurses Note dated 01/16/25 at 10:39 P.M. revealed Resident #17's x-ray results were obtained, and a proximal femoral fracture was reported. The physician was notified of the findings and orders were obtained to send the resident to hospital. Review of a fracture incident investigation dated 01/16/25 revealed Resident #17 had no pain and had full ROM after the fall on 01/13/25. There was no pain or discomfort reported until 01/16/25. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365722	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER Wood Glen Alzheimer's Community		STREET ADDRESS, CITY, STATE, ZIP CODE 3800 Summit Glen Drive Dayton, OH 45449	

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Director of Nursing (DON) #257 on 03/06/25 at 8:55 A.M. revealed no investigation was completed as an injury of unknown origin for possible causes of Resident #17's fractured femur when it was discovered on 01/16/25. DON #257 indicated Resident #17's fractured femur to the fall on 01/13/25. Interview with Licensed Practical Nurse (LPN) #203 on 03/06/25 at 9:47 A.M. revealed the cause of Resident #17's fractured femur on 01/16/25 was unknown due to no documented incidents prior to 01/16/25. Interview on 03/06/25 at 2:00 P.M. with Regional Risk Manager #399 acknowledged an investigation for an injury of unknown origin should have been completed and reported for Resident #17 related to the fracture found on 01/16/25. 2. Review of the medical record for Resident #30 revealed an admitted [DATE]. Diagnoses included peripheral neuropathy, vascular dementia, Alzheimer's disease, dementia, cerebral atherosclerosis, and anxiety. Review of the MDS assessment dated [DATE] revealed Resident #30 was assessed as cognitively impaired. Review Resident #30's progress notes dated between 02/20/25 to 02/26/25 revealed no mention of behavioral outbursts, the resident banging on the door, or swinging her walker. Further review of the progress notes revealed no documentation of an injury being identified, contacting the physician, or getting an order for an x-ray. Review of a progress note dated 02/27/25 at 11:09 P.M. revealed review of an x-ray found a fracture of the distal phalanx of the left fourth digit with a plan to continue to manage pain with medications. Review of a fracture incident investigation related to the fracture identified on 02/27/25 revealed a questionnaire that indicated Resident #30 reported she was in her doorway when another resident tried to go in her room, so she used her walker to block the door and smashed her hand between the walker and the door. Review of a statement from Regional Director of Operations (RDO) #400 to DON #257 dated 02/27/25 revealed she met with Resident #30 and the team ordered an x-ray of the resident's finger. The statement also revealed Resident #30's ring finger had bruising. Interview on 03/05/25 at approximately 3:10 P.M. with DON #257 revealed the investigation was completed by RDO #400 and she was not familiar with the details. DON #257 revealed she was not sure if another resident was involved or not. Interview on 03/05/25 at approximately 3:40 P.M. with RDO #400 revealed she was not involved with the investigation and was unsure who completed it. RDO #400 confirmed she was not aware of any other residents being involved and just talked with Resident #30 on the day the x-ray was ordered. DON #257 confirmed a self-reported incident was not reported. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/06/25 at 1:50 P.M. with Regional Risk Manager #399 acknowledged since Resident #30 was assessed with severely impaired cognition and had an unwitnessed injury as evidence by the fracture to the distal phalanx of the left fourth digit discovered on 02/27/25. Regional Risk Manager #399 confirmed the facility did not report the injury as a self-reported incident. Review of facility self-reported incidents between 01/01/25 and 03/05/25 revealed no reports were made to the state agency regarding Resident #30's injury on 02/27/25. Review of an undated facility policy titled, Abuse, Neglect, and Misappropriation, revealed the facility shall identify and report incidents timely and accurately. Each occurrence of a resident incident, bruise and injury of unknown origin shall be reported timely. A suspected abuse investigation (including injury of unknown origin) shall be initiated and reported to the Administrator or designee and the Executive Director shall report to the appropriate agencies. If the incident involves serious bodily injury the facility shall report within two hours (to the state agency). This deficiency represents non-compliance investigated under Complaint Number OH00162164.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44070 Based on medical record review, staff interview, review of investigation documents, and review of self-reported incidents, the facility failed to thoroughly investigate injuries of unknown origin in a timely manner. This affected two (#17 and #30) of two residents reviewed for injuries of unknown origin. The facility census was 141. Findings Include: 1. Review of the medical record for Resident #17 revealed an admitted [DATE]. Diagnoses included encephalopathy, dementia, violent behavior, generalized anxiety, heart failure, malnutrition, and cellulitis. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #17 was assessed as cognitively impaired. Review of Resident #17's progress note created 01/17/25, and back dated to 01/13/25 at 3:06 P.M., titled Post Fall Evaluation, revealed documentation that a fall occurred on 01/13/25. The Post Fall Evaluation revealed vital signs were refused by Resident #17 and no injuries were noted. Review of a progress note created 01/17/25, and back dated to 01/13/25 at 3:28 P.M., titled Nurses Note, revealed a head-to-toe assessment was completed and range of motion (ROM) for all extremities were within normal limits. There were no complaints of pain at that time and neurological checks were initiated. Review of a progress note titled Nurses Note, created and completed on 01/16/25 at 3:55 P.M., revealed Resident #17 complained of pain to the right lower extremity during care, the physician and family were notified, an x-ray was ordered and performed, and the pain medication acetaminophen was ordered and administered. Review of a Nurses Note dated 01/16/25 at 10:39 P.M. revealed Resident #17's x-ray results were obtained, and a proximal femoral fracture was reported. The physician was notified of the findings and orders were obtained to send the resident to hospital. Review of a fracture incident investigation dated 01/16/25 revealed Resident #17 had no pain and had full ROM after the fall on 01/13/25. There was no pain or discomfort reported until 01/16/25. Interview with Director of Nursing (DON) #257 on 03/06/25 at 8:55 A.M. revealed no investigation was completed as an injury of unknown origin for possible causes of Resident #17's fractured femur when it was discovered on 01/16/25. DON #257 indicated Resident #17's fractured femur to the fall on 01/13/25. Interview with Licensed Practical Nurse (LPN) #203 on 03/06/25 at 9:47 A.M. revealed the cause of Resident #17's fractured femur on 01/16/25 was unknown due to no documented incidents prior to 01/16/25. Interview on 03/06/25 at 2:00 P.M. with Regional Risk Manager #399 acknowledged an investigation for an injury of unknown origin should have been completed and reported for Resident #17 related to the fracture found on 01/16/25. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the medical record for Resident #30 revealed an admitted [DATE]. Diagnoses included peripheral neuropathy, vascular dementia, Alzheimer's disease, dementia, cerebral atherosclerosis, and anxiety. Review of the MDS assessment dated [DATE] revealed Resident #30 was assessed as cognitively impaired. Review Resident #30's progress notes dated between 02/20/25 to 02/26/25 revealed no mention of behavioral outbursts, the resident banging on the door, or swinging her walker. Further review of the progress notes revealed no documentation of an injury being identified, contacting the physician, or getting an order for an x-ray. Review of a progress note dated 02/27/25 at 11:09 P.M. revealed review of an x-ray found a fracture of the distal phalanx of the left fourth digit with a plan to continue to manage pain with medications. Review of a fracture incident investigation related to the fracture identified on 02/27/25 revealed a questionnaire that indicated Resident #30 reported she was in her doorway when another resident tried to go in her room, so she used her walker to block the door and smashed her hand between the walker and the door. Review of a statement from Regional Director of Operations (RDO) #400 to DON #257 dated 02/27/25 revealed she met with Resident #30 and the team ordered an x-ray of the resident's finger. The statement also revealed Resident #30's ring finger had bruising. Interview on 03/05/25 at approximately 3:10 P.M. with DON #257 revealed the investigation was completed by RDO #400 and she was not familiar with the details. DON #257 revealed she was not sure if another resident was involved or not. Interview on 03/05/25 at approximately 3:40 P.M. with RDO #400 revealed she was not involved with the investigation and was unsure who completed it. RDO #400 confirmed she was not aware of any other residents being involved and just talked with Resident #30 on the day the x-ray was ordered. DON #257 confirmed a self-reported incident was not reported. Interview on 03/06/25 at 1:50 P.M. with Regional Risk Manager #399 acknowledged since Resident #30 was assessed with severely impaired cognition and had an unwitnessed injury as evidence by the fracture to the distal phalanx of the left fourth digit discovered on 02/27/25. Regional Risk Manager #399 confirmed the facility did not report the injury as a self-reported incident. Review of facility self-reported incidents between 01/01/25 and 03/05/25 revealed no reports were made to the state agency regarding Resident #30's injury on 02/27/25. Review of an undated facility policy titled, Abuse, Neglect, and Misappropriation, revealed the facility shall identify and report incidents timely and accurately. Each occurrence of a resident incident, bruise and injury of unknown origin shall be reported timely. A suspected abuse investigation (including injury of unknown origin) shall be initiated and reported to the Administrator or designee and the Executive Director shall report to the appropriate agencies. If the incident involves serious bodily injury the facility shall report within two hours (to the state agency). This deficiency represents non-compliance investigated under Complaint Number OH00162164.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44070 Based on medical record review, incident investigation documents, staff interview, and policy review, the facility failed to ensure medical records were complete and accurate. This affected two (#17 and #30) of three residents reviewed for medical record content. The facility census was 141. Findings Include: 1. Review of the medical record for Resident #17 revealed an admitted [DATE]. Diagnoses included encephalopathy, dementia, violent behavior, generalized anxiety, heart failure, malnutrition, and cellulitis. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #17 was cognitively impaired. Review of Resident #17's progress note created 01/17/25, and back dated to 01/13/25 at 3:06 P.M., titled, Post Fall Evaluation, revealed a fall occurred on 01/13/25. Review of a progress note created 01/17/25, and back dated to 01/13/25 at 3:28 P.M., titled Nurses Note, revealed a head-to-toe assessment was completed and range of motion (ROM) for all extremities were within normal limits. There was no complaints of pain and neurological checks were initiated at that time. Review of Resident #17's electronic medical record revealed no documentation of neurological checks completed related to the incident. Review of a fracture investigation file revealed a paper document titled, Neurological Assessment, dated 01/13/25 through 01/18/25. The document was signed and initialed by Licensed Practical Nurse (LPN) #203, LPN #325, and Director of Nursing (DON) #257 and was fully completed. Interview with on 03/06/25 at 9:47 A.M. with LPN #203 revealed she never completed any documentation for Resident #17's incident on 01/13/25, 01/14/25, 01/15/25, or 01/16/25. LPN #203 confirmed the signature and initials on Resident #17's document titled, Neurological Assessment, were not hers and further stated she had never seen that document before and had no knowledge of Resident #17 having had a fall on 01/13/25. Interview with on 03/06/25 at 11:42 A.M. with LPN #325 revealed she also had no knowledge of the document titled, Neurological Assessment, for Resident #17. LPN #325 revealed she was unaware of Resident #17 having had any incident on 01/13/25. 2. Review of the medical record for Resident #30 revealed an admitted [DATE]. Diagnoses included peripheral neuropathy, vascular dementia, Alzheimer's disease, dementia, cerebral atherosclerosis, and anxiety. Review of the MDS assessment dated [DATE] revealed Resident #30 was cognitively impaired. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #30's progress notes dated 02/20/25 to 02/26/25 revealed no documentation of behavioral outbursts, the resident banging on the door, or swinging her walker. The progress notes also did not include any documentation or mention of an injury being identified, contacting the physician, or getting an order for an x-ray. Review of Resident #17's progress note dated 02/27/25 at 11:09 P.M. revealed staff reviewed an x-ray and found a fracture of the distal phalanx of the left fourth digit with a plan to continue to manage pain with medications. Review of Resident #17's fracture incident investigation revealed a questionnaire that indicated the resident reported she was in her doorway when another resident tried to go in her room, so she used her walker to block the door, and smashed her hand between the walker and the door. Interview on 03/05/25 at approximately 3:40 P.M. with Regional Director of Operations (RDO) #400 revealed she was not involved with Resident #17's investigation and did not know specific details of how the injury occurred. RDO #400 confirmed the resident's medical record did not contain any details about behavioral incidents or injuries and also did not include any information about staff identifying a change in condition. RDO #400 confirmed the only notations in the resident's medical record included the x-ray results. Review of the undated facility policy titled, Clinical Documentation Standards, revealed the facility shall maintain the integrity and quality of medical records. A complete record contains accurate and functional representation of the actual experience of the resident and must contain enough information to show the status of the resident was known. Staff shall follow basic standards of documentation including timely and accurate. This deficiency represents an incidental finding discovered during investigation under Complaint Number OH00162164.