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Form Approved OMB
No. 0938-0391

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 04/23/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview, and policy review, the facility failed to treat residents with dignity while providing feeding assistance. This affected two (#66 and #134) of three residents reviewed for dignity. The facility census was 141. Findings include:1. Review of the medical record for Resident #66 revealed an admissions date of 01/05/26 with diagnoses including cerebral ischemia, vascular dementia, dementia, transient cerebral ischemic, cerebral infraction, altered mental status, and need assistance with personal care. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #66 was cognitively impaired and required substantial or maximal assistance with eating. Review of the current care plan for Resident #66 revealed he had the potential for altered nutritional status. Interventions included providing assistance with meals as needed. Observation of the lunch service on 04/22/26 at approximately 12:45 P.M. revealed Certified Nursing Assistant (CNA) #244 was sitting at a dining table with Resident #66 and assisting with his meal. CNA #244 left the table to help another resident with personal care. Continued observation revealed at 1:00 P.M., CNA #244 returned to the table to assist Resident #66 and remained standing next to him while assisting him with eating the rest of his meal. Interview on 04/22/26 at 1:05 P.M. with CNA #244 verified she was standing up while assisting Resident #66 and that she should have been seated with the resident. 2. Review of the medical record revealed Resident #134 admitted to the facility on [DATE] with diagnoses including vascular dementia, Type II diabetes, altered mental status, adjustment disorder with depressed mood, muscle weakness, cognitive communication deficit, and dysphagia. Review of the MDS assessment dated [DATE] revealed Resident #134 was cognitively impaired and required supervision while eating. Review of the current care plan revealed Resident #143 had a Activities of Daily Living (ADLs) self-care performance deficit related to cognitive deficit, disease process, and functional deficit. Interventions included eating supervision or touching assist, helper cues, and/or touches/steadies resident. Observation on 04/19/26 at 12:46 P.M. revealed Medical Records Coordinator (MRC) #355 was standing next to Resident #134 while feeding him his meal.Interview on 04/19/26 at 12:50 P.M. with MRC #355 verified she stood over Resident #134 while assisting him with eating instead of being seated with the resident. Interview on 04/19/26 at 12:53 P.M. with Licensed Practical Nurse (LPN) #325 revealed Resident #134 had a recent decline where he would sit and stare instead of eating at meals times. LPN #325 stated staff had been feeding him at the start of meals to gain his interest and then Resident #134 would normally start to feed himself. Review of the undated facility policy titled, Resident Rights, revealed residents would be treated with respect and dignity. This deficiency represents non-compliance investigated under Complaint Numbers 2669811 and 2642807.

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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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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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, review of resident funds accounts, closed medical record review and policy review, the facility failed to ensure timely distribution of personal funds account balances after discharge. This affected one (#146) of three residents reviewed for personal funds accounts. The facility census was 141. Findings include: Review of the closed medical record for Resident #146 revealed an admission date of 7/24/23 and a discharge date of 08/27/25. Diagnoses included, but not limited to, Alzheimer's disease with late onset. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] for Resident #146 revealed a brief interview of mental status (BIMS) score of three, indicating severely impaired cognition. Review of the plan of care for Resident #146, dated 08/01/23 and revised on 07/01/25, revealed the resident had a communication problem related to disease condition including Alzheimer's disease, dementia with behavioral disturbances and psychotic disorder with delusions. Interventions include allowing for adequate response time, repeat as necessary, request feedback and clarification to ensure understanding and ask simple brief questions. Review of the resident fund management services ledger for Resident #146 revealed an account balance of $179.33 at the time of discharge on [DATE]. Further review revealed the account was closed on 10/03/25 (37 days after discharge) with check number 3056 being issued for 179.33 to Resident #146. Interview on 04/23/26 at 3:17 P.M. with Regional Business Office Manager (RBOM) #550 verified the account for Resident #146 was not closed and the refund issued within the required 30 days after discharge. Review of the facility policy titled, Resident Rights, undated, revealed the facility would return the resident's funds within 30 days. This deficiency represents non-compliance investigated under Complaint Number 2642807.

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	365722	A. Building B. Wing	04/23/2026

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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 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 medical record review, observations, staff interviews and review of the facility policy, the facility failed to ensure fall interventions were implemented. This affected two (#13 and #83) of eight residents reviewed for falls. The facility census was 141. Findings include:1. Review of the medical record for Resident #13 revealed an admission date of 03/04/25 with diagnoses including, but not limited to, Alzheimer's disease with late onset. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #13 was severely cognitively intact. Resident #13 required maximum assistance from staff for bed mobility and transfers and had two or more falls without serious injury. Review of the current plan of care revealed Resident #13 was at risk for falls related to weakness, unsteady ambulation, and pain. Interventions included assessment for fall risk on admission, readmission and quarterly, encourage hipsters (shock-absorbing foam or plastic pads designed to protect the hips from fractures during side-impact falls) as resident allowed and may remove for hygiene purposes, encourage resident to be in common area while awake, ensure resident's room was free of potential visible hazards, bed locks engaged, neurological (neuro) checks if falls were unwitnessed, and perimeter mattress to bed. Observation on 04/22/26 at 4:44 P.M. revealed Resident #13 was not wearing hipsters. Concurrent interview with Licensed Practical Nurse (LPN) #292 verified Resident #13 was not wearing hipsters and should have them on as a fall intervention when she was out of bed and ambulating. Interview on 04/22/26 at 4:46 P.M. with Certified Nursing Assistant (CNA) #274 revealed Resident #13 had the hipsters on earlier today, but they were soiled and sent to the laundry. CNA #13 confirmed Resident #13 did not have hipsters on because they did not have any available to apply. Observation on 04/22/26 at 4:50 P.M. revealed Registered Nurse (RN) #401 checked the supply room and returned to advised CNA #274 that the facility did not have any additional hipsters in the stock room. 2. Review of the medical record for Resident #83 revealed an admission date of 02/27/25 with diagnoses including, but not limited to, Parkinson's disease, hypertension, peripheral vascular disease and diabetes mellitus. Review of the quarterly MDS assessment dated [DATE] revealed Resident #83 was severely cognitively impaired. Resident #83 required maximum assistance from staff with bed mobility and transfers. Review of the current plan of care for Resident #83 revealed the resident was at risk for falls related to disease process, gait and balance problems, and history of falls. Interventions included assessing risk for falls on admission, quarterly and as needed, ensure bed locks were engaged, hipsters, perimeter mattress, and neuro checks if fall was unwitnessed. Review of a post fall follow up progress assessment dated [DATE] revealed Resident #83 had a fall, and it was not known what was happening at the time of the fall. Hipsters were added as an intervention. Observation on 04/22/26 at 4:20 P.M. of Resident #83 revealed the resident did not appear to have hipsters on. Interview on 04/22/26 at 4:24 P.M. with CNA #252 verified Resident #83 did not have hipsters on. Interview on 04/22/26 at 4:31 P.M. with LPN #292 confirmed hipsters were a fall intervention for Resident #83 and further verified the resident did not have them on. Review of the facility policy titled Fall Prevention and Management, undated revealed if a resident was identified to be at risk for falls, a care plan should be initiated that included a plan to potentially diminish the risk for falls. The care plan should be reviewed and updated as needed with each change of condition. This deficiency represents non-compliance investigated under Complaint Numbers 2967069 and 2642807.

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F 0692 Level of Harm - Minimal harm or potential for 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, observation, staff interview and review of the facility policy, the facility failed to ensure resident weights were obtained to monitor for weight loss. This affected one (#20) of seven residents reviewed for nutrition. The facility census was 141. Findings include: Medical record review for Resident #20 revealed an admission date of 01/20/26 with diagnoses including, but not limited to, fracture of unspecified part of right femur, acute posthemorrhagic anemia, and atrial fibrillation. Review of the significant change Minimum Data set (MDS) assessment dated [DATE] revealed Resident #20 was severely cognitively impaired. Resident #20 was coded for coughing and choking during meals or when swallowing medications and holding food in mouth or cheeks after meals. Resident #20 had no significant weight loss or gain and weighed 100 pounds. Review of the plan of care, dated 02/02/26 and without revision, revealed Resident #20 was at risk for dehydration related to cognitive or functional impairment, decreased kidney function, and protein calorie malnutrition. Interventions included administering medications as ordered, nutritional consult on admission, quarterly and as needed, obtain weights, and diet, oral care, and speech therapy as ordered or needed. Review of the recorded weights for Resident #20 revealed weights were obtained on 01/26/26, 02/05/26, 02/09/26, 02/10/26, and 02/16/26. The resident's documented weight on 01/26/26 was 100.8 pounds (lbs) and her weight on 02/16/26 was 99.8 lbs.Review of the admission nutritional assessment dated [DATE] revealed Resident #20 received a regular diet with an average intake of 50 percent (%). Assessment notes indicated intakes were likely not adequate to meet estimated energy needs and fortified pudding at lunch and house supplement two times a day would be added.Review of a progress note dated 02/24/26 revealed Resident #20 was transferred to the hospital for evaluation of a displaced fracture of the right femoral hip. Review of a progress note dated 03/04/26 revealed Resident #20 was readmitted to the facility. Review of the nursing admission note dated 03/04/26 at 7:46 P.M. revealed no documented admission weight for Resident #20. Review of the post hospital visit dated 03/05/26 and completed by the Nurse Practitioner (NP) revealed the resident was readmitted post-surgical repair of a fracture of the right femur following a fall at the facility. Further review revealed the resident's weight was automatically (auto) populated from the last documented weight in the electronic medical record (EMR) on 02/16/26, at which time the resident weighed 99.8 lbs.Review of the NP progress note dated 03/06/26 revealed a follow-up post hospitalization visit. The progress note stated no acute concerns were reported by staff. Oral intakes and vital signs remained stable. The resident's weight was auto populated from the weight obtained on 02/16/26 at 99.8 lbs.Review of the NP progress note dated 03/09/26 revealed a follow-up post hospitalization visit. The resident's weight was auto populated from the weight obtained on 02/16/26 at 99.8 lbs. Review of the NP progress note dated 03/11/26 revealed a follow-up post hospitalization visit. The progress note stated no acute concerns had been reported by staff. The resident's weight auto populated from the weight obtained on 02/16/26 at 99.8 lbs.Further review of Resident #20's weights revealed the next documented weight was on 04/02/26, at which time the resident weighed 93.8 lbs. On 04/07/26, Resident #20 weighed 93.0 lbs.Review of the NP progress note dated 04/08/26 revealed Resident #20 was seen for an acute visit for evaluation of constipation. Staff reported chronically poor intake, which remained unchanged. Physical appearance notable for temporal wasting, chronic poor oral intake and ongoing weight loss. Further review revealed the NP documented a diagnosis of cachexia and appreciation for dietary recommendations, assist with feeding, and monitor weekly weights. Additional review of Resident #20's documented weights revealed on 04/13/26, the resident weighed 93.4 lbs.Review of the dietary progress noted dated 04/14/26 at 2:38 P.M. revealed a weight change warning for Resident #20. Dietary preferences were updated per resident's family with salads being added two times a day and bananas three times a day. Review of the Nutrition at Risk (NAR) note dated 04/16/26 at 1:43 P.M. revealed Resident #20 had weight loss since 01/26/26, due to low (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	oral intake. Observation on 04/20/26 at 12:19 P.M. revealed Resident #20 was independently ambulating throughout the unit. Resident #20 appeared very thin. Interview on 04/22/26 at 3:29 P.M. with Corporate Registered Nurse (CRN) #319 revealed weights should be obtained upon readmission. CRN #319 verified the facility did not obtain a weight upon Resident #20's readmission to the facility on [DATE] to adequately monitor the resident for weight loss. Review of the facility policy titled, Resident Height and Weight, undated, revealed on admission, the resident would be weighed within 24 hours and documented in the electronic health record. This deficiency represents non-compliance investigated under Complaint Number 2738781.