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	04/15/2024

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34291 Based on record review, staff and resident interviews, and review of facility policy, the facility failed to ensure care conferences were completed. This affected three (#01, #15, and #91) residents of seven residents reviewed for care planning conferences. The census was 134. Findings include: 1) Review of the medical record for Resident #01 revealed an admitted [DATE]. Diagnoses included cardiorespiratory conditions, atrioventricular block first-degree, heart failure, peripheral vascular disease (PVD), renal insufficiency with dependency on dialysis, and non-Alzheimer's Dementia. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #01 was cognitively intact. Review of the care conferences from 07/01/23 through 04/12/24 for Resident #01, revealed the resident had one care conference on 02/07/24 and the resident was noted to be out to dialysis during the care conference. Interview with Resident #01 on 04/10/24 at 7:56 A.M. revealed she was not having care conferences every three months. Interview with the Licensed Social Worker (LSW) #123 on 04/11/24 at 8:18 A.M. revealed there were set dates for care conferences, and they were on Tuesdays and Thursdays. LSW #123 stated these days were the same days Resident #01 was out to her dialysis appointments. LSW #123 stated the facility had care conference on these days whether the residents could attend or not. LSW #123 stated the care conferences were supposed to be every three months and confirmed Resident #01 did not have a care conference every three months. 2) Review of the medical record for Resident #15 revealed the resident was admitted on [DATE]. Diagnoses included coronary artery disease, heart failure, peripheral vascular disease (PVD), renal insufficiency, diabetes, Alzheimer's disease, and dementia. Review of the MDS assessment dated [DATE], revealed Resident #15 was moderately cognitively impaired. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365722	A. Building B. Wing	04/15/2024

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of care conferences from 07/17/23 through 04/08/24 for Resident #15, revealed the resident's last care conference was dated 07/17/23. Interview with the Resident #15 on 04/09/24 at 11:51 A.M. revealed he had not received any care conferences. Interview with LSW #123 on 04/10/24 at 2:01 P.M. confirmed Resident #15's last care conference was dated 07/17/23 and stated care conferences should be held every three months. 43062 3) Review of the medical record for Resident #91 revealed the resident was admitted to the facility on [DATE]. Diagnoses included dementia, conversion disorder, epilepsy, borderline personality disorder, major depressive disorder, asthma, diabetes mellitus, anxiety disorder, post-traumatic stress disorder (PTSD), congestive heart failure (CHF), and gastro-esophageal reflux disease (GERD). Further review of Resident #91's record revealed no documented information related to a care conference being completed. Review of the MDS assessment dated [DATE], for Resident #91 revealed the resident had impaired cognition. Interview with LSW #123 on 04/10/24 at 4:31 P.M. revealed Resident #91 should have a had care conference scheduled in December 2023. LSW #123 confirmed the facility failed to provide a care conference for the Resident #91. Review of the facility policy titled Process for Care Plan Meetings, undated, revealed the facility's MDS coordinator and the facility's Social Worker would meet to determine when to schedule a Resident's care conference. Social Services would be responsible to ensure the care plan meeting invitation was completed and sent to the resident and the responsible part. A copy of the letter was to be placed in the resident's chart and the facility would keep a copy of the invitation families/and resident for the scheduled care conference the Resident's record. A care plan note must be created at the time of the meeting which includes the attendees and placed in the resident's electronic medical record (EMR) under progress notes.

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	04/15/2024

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 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44412 Based on record review, staff interviews, and observations, the facility failed to ensure ancillary services were provided to residents with hearing and visual impairments. This affected one (#116) resident out of two residents reviewed for hearing and vision. The facility census was 134. Findings include: Review of the medical record for Resident #116 revealed an admitted [DATE] with a readmission of 03/21/24. Diagnoses included parkinsonism, dementia, generalized anxiety disorder, and hypertension. Review of the personal items inventory log dated 11/10/23 for Resident #116 revealed the resident was admitted to the facility with hearing aids and two boxes of batteries. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #116 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of six. This resident was assessed to require supervision with eating, toileting, dressing, and transfers, and partial assistance with bathing. Review of section B for hearing, speech, vision of the Admission MDS dated [DATE] revealed Resident #116 had hearing aids. Review of the care plan dated 03/28/24 revealed Resident #116 had a communication problem related to sensorineural bilateral hearing loss. Interventions included offer interpretation services, staff to provide reading materials, movies, newspapers, and music in preferred language, staff to provide verbal education regarding equipment, treatments, and medications as needed and staff to refer resident to audiology for hearing consult as needed. Observations during the annual survey revealed Resident #116 was not wearing hearing aids and did not have them present in his room. Interview on 04/11/24 at 2:01 P.M. with the Administrator reported she was unaware Resident #116 had hearing aids. Interview on 04/12/24 at 10:07 A.M. with the Administrator revealed Resident #116 had bilateral hearing aids noted on his inventory log. Interview on 04/12/24 at 10:34 A.M. with Social Services Director (SSD) #123 revealed she was unaware Resident #116 had hearing aids upon admission. SSD #123 confirmed no ancillary referral services had been completed for Resident #16.

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	04/15/2024

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 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** 34291 Based on record review, staff interviews and review of facility policy, the facility failed to ensure falls were reviewed and discussed by the Interdisciplinary Team (IDT) and a root cause analysis was determined. This affected two (#20 and #01) residents out of eight residents reviewed for falls. The filty census was 134. Findings include: 1) Review of the medical record for Resident #20 revealed an admitted [DATE]. Diagnoses included non-traumatic brain disorder, renal insufficiency, diabetes, dementia, and psychotic disorder. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #20 was cognitively intact. The resident required supervision for activities of daily living (ADLs). Review of the care plan dated 10/18/23 revealed Resident #20 was at risk for falls related to disease process. Review of a progress note dated 12/12/23 revealed Resident #20 was found on the floor next to his bed. The resident sustained a small skin tear to the left elbow, and to the back of the head. He had no bleeding, no pain, no change in mental status and no anticoagulation. Neuro checks were started per the facility's protocol. Further review of the medical record revealed no documented evidence of an IDT meeting being held to review and discuss the resident's fall on 12/12/23 and to determine a root cause analysis. Review of a progress note for Resident #20 dated 02/19/24 at 7:29 A.M. revealed at approximately 6:10 A.M. , the resident's roommate alerted the nurse Resident #20 had fallen. The resident was observed on the floor in the entrance to the bathroom and was lying on the left side in a fetal position. The resident indicated he hit his head and was sent out to the hospital for treatment, and there were no injuries. Further review of the medical record revealed no documented evidence of an IDT meeting being held to review and discuss the resident's fall on 02/19/24 and to determine a root cause analysis. Interview with Licensed Practical Nurse (LPN) #51 on 04/11/23 at 10:12 A.M. confirmed there were no IDT meetings held to review and discuss Resident #20's falls on 12/12/23 and 02/19/24 to determine a cause analysis. 2) Medical review for Resident #01 revealed an admitted [DATE]. Medical diagnoses included cardiorespiratory conditions, atrioventricular block first degree, heart failure, peripheral vascular disease, renal insufficiency, and non-Alzheimer's Dementia. Review of quarterly MDS dated [DATE] revealed Resident #01 was cognitively intact. Review of the care plan revised 01/18/24 revealed Resident #01 was at risk for falls related to disease process. (continued on next page)

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	04/15/2024

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a progress note dated 01/20/24 revealed Resident #01 fell while ambulating in the hall using her walker. The resident stated she lost her balance and fell and hit her head on the floor. The physician was notified with no new orders and neuro checks were initiated, which were negative. Further review of the medical record revealed no documented evidence of an IDT meeting being held to review and discuss the resident's fall on 01/20/24 and to determine a root cause analysis. Interview with LPN #51 on 04/11/23 at 10:12 A.M. confirmed there was not an IDT meeting held to review and discuss Residents #01's fall on 01/20/24 to determine a root cause analysis. Review of the undated facility policy titled Fall Prevention and Management revealed the IDT should review all information for all falls at the next daily clinical meeting. The IDT should discuss the fall, potential causes of the fall, interventions put into place and if they were effective. A deep root cause investigation should be discussed. A progress note of the discussion should be placed in the resident's chart. The team should have a way to inform all care given of any new interventions placed in the care plan. This deficiency represents non-compliance investigated under Complaint Number OH00152479.

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	04/15/2024

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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34291 Based on record review, staff and resident interviews, and review of facility policy, the facility failed to follow-up on a cellular (cell) phone being reported missing. This affected one (#15) resident of six residents reviewed for missing personal property. The facility census was 134. Findings include: Review of the medical record for Resident #15 revealed the resident was admitted on [DATE]. Diagnoses included coronary artery disease, heart failure, peripheral vascular disease (PVD), renal insufficiency, diabetes, Alzheimer's disease, and dementia. Review of quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #15 was moderately cognitively impaired. Review of the care conference notes for Resident #15 dated 07/17/23 held with the Veteran's Administration (VA) representative revealed Resident #15 had lost his cell phone in transition to the hospital from another facility. The VA representative indicated she would replace the cell phone for the resident. Review of the progress notes from 07/17/23 through 04/11/24 for Resident #15 revealed no documentation related to Resident #15's cell phone being lost or communication with the VA representative for follow-up. Interview with Resident #15 on 04/09/24 at 11:28 A.M. revealed his cell phone was missing when he transferred to the hospital from another facility, and he was told it would be replaced and it had not been replaced yet. Interview with the Licensed Social Worker (LSW) #123 on 04/10/24 at 2:01 P.M. revealed she knew about the missing cell phone for Resident #15, but waited to see if it was going to be replaced by the VA representative and it never got replaced. LSW #123 verified she had not reached out to the VA representative to follow-up on the missing cell phone. Review of the policy entitled Social Services dated 07/17/20 revealed the primary objective of the Social Services Department was to establish a working system designed to meet the social and psychological needs of the residents and their families. This includes intervention while the individual resides here and communication with outside agencies, upon discharge. Promoting psychosocial well-being within the nursing facility is a primary concern. This deficiency represents non-compliance investigated under Complaint Number OH00152479.

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	04/15/2024

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39967 Based on record review, staff interviews, review of facility policy, review of pharmacy documents, and review of online resources from Medscape, the facility failed to ensure residents' antipsychotic medications were given with adequate indications for use. This affected three (#61, #71 and #104) residents out of five residents reviewed for unnecessary medications. The facility census was 134. Findings include: 1) Review of the medical record for Resident #104's revealed the resident was admitted to the facility on [DATE] with diagnoses including unspecified dementia unspecified severity with other behavioral disturbance, generalized anxiety disorder, major depressive disorder, insomnia, alcohol dependence with alcohol induced persisting dementia, weakness, and muscle weakness. Review of the physician's order for Resident #104 dated 02/21/24, revealed the resident was ordered quetiapine fumarate (Seroquel) (anti-psychotic) 50 milligrams (mgs) by mouth at bedtime for agitation and Alzheimer's Disease. Review of the admission Minimum Data Set (MDS) assessment for Resident #104 dated 03/12/24 revealed the resident had severe cognitive impairment. Resident #104 was assessed as receiving anti-psychotic and anti-depressant medication during the MDS review period. Review of the anti-psychotic medication care plan for Resident #104 dated 03/13/24, revealed the resident would be provided anti-psychotic medications per the physician's orders. Interview with the Director of Nursing (DON) on 04/10/24 at 4:27 P.M. verified Resident #104 was ordered Seroquel 50 mg by mouth at bedtime for agitation and Alzheimer's Disease. Review of the facility's pharmacy documents from the Seroquel manufacturer's prescribing information dated 11/29/21 revealed Serious Warning and Precautions: increased mortality in elderly patients with dementia. Review of online resources from Medscape.com (https://reference.medscape.com/drug/seroquel-xr-quetiapine-342984#5) revealed Seroquel was not approved for dementia-related psychosis and elderly patients with dementia-related psychosis who are treated with antipsychotic drugs are at increased risk of death. 2) Review of the medical record for Resident #61 revealed the resident was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy, squamous cell carcinoma of skin of right lower eye lip including canthus, unspecified dementia unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, unspecified asthma, type two diabetes mellitus without complications, chronic kidney disease stage four, hypertension, syncope and collapse, depression, personal history of malignant neoplasm of breast, and sleep disorder. (continued on next page)

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	04/15/2024

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the physician's order for Resident #61 dated 02/09/24, revealed the resident was ordered Trazodone (anti-depressant) 50 milligrams (mgs) by mouth at bedtime for mood and mental health. Review of admission MDS assessment for Resident #61 dated 02/12/24, revealed the resident had severe cognitive impairment. Resident #61 received anti-psychotic and anti-depressant medication during the MDS review period. Review of the anti-depressant care plan for Resident #61 dated 02/20/24, revealed the resident used anti-depressant medication related to depression. Interventions included provide anti-depressant medication per medical provider's orders. Interview with the DON on 04/10/24 at 4:29 P.M. verified Resident #61 was ordered Trazodone 50 mgs at bedtime for mood and mental health. 43062 3) Review of the medical record for Resident #71 revealed the resident was admitted to the facility on [DATE]. Diagnoses included Alzheimer's disease, dementia, chronic kidney disease, edema, anxiety disorder, dysphasia, major depressive disorder, and vitamin-d deficiency. Review of the most recent MDS assessment dated [DATE], revealed Resident #71 was cognitively impaired. Review of the physician's order dated 03/18/24 for Resident #71, revealed an order for quetiapine fumarate 12.5 mgs by mouth every morning and at bedtime for dementia behaviors. Review of the care plan for Resident #71 dated 08/01/22, revealed the resident received anti-psychotic medication related to behavior management. Interview with the DON on 04/15/24 at 8:05 A.M. confirmed Resident #71 was taking Seroquel 12.5 mgs every morning at bedtime for dementia behaviors. The DON confirmed she was aware of the medications black box warning for seniors with Dementia. Review of the facility's pharmacy documents from the Seroquel manufacturer's prescribing information dated 11/29/21 revealed Serious Warning and Precautions: increased mortality in elderly patients with dementia. Review of online resources from Medscape.com (https://reference.medscape.com/drug/seroquel-xr-quetiapine-342984#5) revealed Seroquel was not approved for dementia-related psychosis and elderly patients with dementia-related psychosis who are treated with antipsychotic drugs are at increased risk of death.

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	04/15/2024

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44412 Based on observations, record review, staff interviews, and review of facility policy, the facility failed to ensure medications were properly labeled with a date after being opened. This affected one (#58) resident of the four residents observed for medication administration. The facility also failed to ensure medications were discarded after their expiration date. This affected six (#10, #16, #21, #32, #124, and #236) residents of the 37 who received medication from the medication cart. The facility also failed to ensure medications were not left unattended at residents' bedside. This affected one (#1) resident of the one resident observed. The facility census was 134. Findings include: 1) Review of the medical record for Resident #58 revealed an admitted [DATE]. Diagnoses included Alzheimer's disease, type two diabetes mellitus (DM II), and chronic kidney disease stage three. Review of the physician's order dated 08/23/23 revealed Resident #58 was ordered to receive Insulin Glargine (long-acting insulin) subcutaneous solution 100 units/ milliliter (ml), inject 15 units subcutaneously in the morning for diabetes. Review of the physician's order dated 03/20/24 revealed Resident #58 was ordered to receive Humalog (short acting insulin) KwikPen subcutaneous solution injector 100 units/milliliter (ml), inject per sliding scale before meals and at bedtime. Observation of the Heatherwood medication cart on 04/11/24 at 3:50 P.M. with Registered Nurse (RN) #54 revealed Resident #58's Humalog KwikPen and the Insulin Glargine pen was opened and not dated. Interview with RN #54 at the same time verified Resident #58's insulin pens were opened but not labeled with an open date. 2) Observation of the Magnolia medication cart on 04/12/24 at 10:43 A.M. with RN #45 revealed a bottle of over the counter (OTC) Geri-knot (laxative) 8.6 milligrams (mg) with an expiration date of March 2024. Interview with RN #45 at the same time verified the bottle of Geri-knot 8.6 mg was expired. Review of the physician's orders for the residents on the Magnolia unit, revealed Residents #10, #16, #21, #32, #124, and #236 had orders to receive Geri knot 8.6 mg. 34291 3) Review of medical record for Resident #01 revealed an admitted [DATE]. Diagnoses included Dementia, cardiorespiratory conditions, atrioventricular block first degree, heart failure, peripheral vascular disease, and renal insufficiency. Review of quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #01 was cognitively intact. (continued on next page)

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	04/15/2024

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of Resident #01's room on 04/12/24 at 9:54 A.M. revealed two white pills inside a clear plastic container sitting on the resident's bedside table. Interview with the Licensed Practical Nurse (LPN) #23 on 04/12/24 at 9:58 A.M. confirmed the two white pills on Resident #01's bedside table. LPN #23 confirmed she left the medication cup with two potassium pills at Resident #1's beside. LPN #23 stated she was supposed to watch the resident take the medication. Review of the facility policy titled, Storage of Medications, dated 09/2018 revealed medications and biologicals were stored safely, securely, and properly following manufacturer's recommendations or those of the supplier. The medication supply was accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. The nurse would check the expiration date of each medication before administering it. All expired medications would be removed from the active supply and destroyed in accordance facility policy, regardless of amount remaining. The nurse shall place a date opened stick on the medication and record the date opened and the new date of expiration. The expiration date of the vial or container would be 30 days from opening unless the manufacturer recommended another date or regulations/guidelines require different dating.

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	04/15/2024

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 43062 Based on observations, staff interview, and review of facility policy, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety. This had the potential to affect 133 residents who received meals from the facility kitchen. The facility identified one Resident (#82) as receiving no food from the kitchen. The facility census was 134. Findings include: Observation of the kitchen during the initial kitchen tour on 04/09/24 at 8:10 A.M. with the Registered Dietician (RD)#801 and the Administrator and revealed the following: a) The reach in refrigerator contained thirteen bowls of salads with no label and/or date, nine cups of pears with no label and/or date, six cups of pureed fruit with no label and/or date, and a large fast-food container with no label and/or date. b) The kitchen floor under the dishwasher was dirty with dried food particles. c) There was an unknown black substance on the walls and under the appliances. d) The ceiling had an unknown brown substance splattered on it. e) A long metal table in front of the dishwasher had a large, rusted bottom shelf and the rusted shelf had chunks of metal missing. f) The trash receptacles had dried food debris and a dried, splattered substance running down the sides. g) The light fixtures above the dishwasher contained dead bugs. Interview with RD #801 on 04/09/24 at 8:20 A.M. confirmed the findings of the kitchen. Review of the facility policy titled, Environment, dated 09/2017, revealed all food preparation areas, food service areas, and dining areas will be maintained in a clean and sanitary condition. The Dining Services Coordinator will ensure that the kitchen is maintained in a clean and sanitary manner, including floors, walls, ceilings, lighting, and ventilation. Review of the facility policy titled, Food Storage: Cold Food, dated 09/2017, revealed all foods will be stored wrapped or in covered containers, labeled and dated, arranged in a manner to prevent cross contamination.

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	04/15/2024

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 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** 34291 Based on medical record review, staff, and resident interviews, the facility failed to ensure information was documented in the medical record. This affected one (#15) resident out of the 27 sampled for accurate documentation. The facility census was 134. Findings include: Review of the medical record review for Resident #15 revealed the resident was admitted on [DATE]. Medical diagnoses included Alzheimer's disease, dementia, coronary artery disease, heart failure, peripheral vascular disease, diabetes, and renal insufficiency. Review of the progress notes dated 07/07/23 through 07/31/23 for Resident #15 revealed no documented notes regarding an iPad or pictures that were found on the iPad. Review of the quarterly Minimum Data Set (MDS) assessment for Resident #15 dated 03/15/24 revealed the resident was moderately cognitively impaired. Interview with Resident #15 on 04/09/24 at 11:51 A.M. revealed he had his personal iPad taken away from him about three days after admission and he did not know why. Resident #15 stated there was personal banking information on the tablet. Interview with the Licensed Social Worker (LSW) #123 on 04/11/24 at 11:36 A.M. revealed Resident #15's iPad tablet was taken from him three days after admission because the Veterans Administration (VA) representative said there were passwords for different accounts on the resident's iPad. LSW #123 stated she removed the iPad from the resident's possession and when she tried to shut the iPad off, there was a gallery of child pornography pictures that came up on the screen. LSW #123 stated she reported this to the Administrator who called the police. LSW #123 stated the police removed the iPad and took it for evidence. LSW #123 verified there was no documentation regarding the residents iPad being taken from him. Interview with the Administrator on 04/11/24 at 11:45 A.M. stated the LSW #123 informed her what was on the iPad but didn't do any type of investigation. The Administrator stated she called the police and they talked to the resident. The Administrator confirmed there was no documentation entered into the resident's electronic record because she called the police, and it was a police matter. Review facility policy revised on 07/16/20, titled Social Services, revealed the social service worker shall enter an initial progress note within the facility protocol time frames and shall document progress pertain to adjustment, quality of life and general behavioral manifestations and the documentation shall cover progress towards social service goals as well as pertinent information about the residents' changes effecting the resident's health and wellbeing.

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	04/15/2024

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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43062 Based on observation, staff interviews and review of facility policy, the facility failed to ensure a resident's mattress fit properly on the bed frame. This affected one (#91) resident out of the one resident reviewed for bed safety. The facility census was 134. Findings include: Review of medical record for Resident #91 revealed the resident was admitted to the facility on [DATE]. Diagnoses included, dementia, conversion disorder, epilepsy, borderline personality disorder, major depressive disorder, asthma, diabetes mellitus, anxiety disorder, post-traumatic stress disorder (PTSD), congestive heart failure (CHF) and gastro-esophageal reflux disease (GERD). Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] for Resident #91 revealed the resident had impaired cognition. The assessment revealed the resident was dependent on staff for all activities of daily living (ADLs). Review of facility document titled, Bed Safety Evaluation dated 02/12/24 for Resident #91, revealed the resident demonstrated poor bed mobility and difficulty sitting on the side of the bed. Resident #91 was unable to transfer independently from the bed and not capable of using her call light if she required help. Observation of Resident #91's bed on 04/09/24 at 10:13 A.M. with Stated tested Nursing Aide (STNA) #87 revealed a gap approximately 12 inches at the top of Resident #91's bed between the headboard and the mattress. Interview with STNA#87 at the same time verified the gap between the mattress and the headboard. Interview with Regional Clinical Nurse (RCN) #250 on 04/11/24 at 11:39 A.M. revealed the facility utilized a mattress assessment for bed safety review. RCN #250 confirmed a large open gap between Resident #91's mattress and the headboard could be a safety risk and could result in harm to a resident. Review of the facility policy titled, Use of Support Surfaces, undated, confirmed the facility will inspect the Resident's mattresses are inspected as part of the facility regular maintenance program and identify areas of possible entrapment. Further review of the policy revealed the facility mattresses are designed to fit the bed frame properly limiting entrapment zones.