

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366109	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/02/2025
NAME OF PROVIDER OR SUPPLIER Woodland Country Manor Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 4166 Somerville Rd Somerville, OH 45064	
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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on record review and staff interviews, the facility failed to ensure services were provided by a Registered Nurse (RN) for at least eight consecutive hours a day, seven days a week. This had the potential to affect all residents residing in the facility. The facility census was 52. Findings include: Review of the schedules and timecard punches from 10/21/25 to 12/01/25 revealed there was only documentation of hours for one RN (#378). RN #378 worked less than eight hours on 10/22/25, 10/26/25, 10/27/25, 10/29/25, 11/02/25, 11/03/25, 11/05/25, 11/06/25, 11/10/25, 11/13/25, 11/15/25, 11/16/25, 11/18/25, 11/20/25, 11/24/25, and 11/25/25. Interview on 12/01/25 at 3:39 P.M., the Administrator verified the facility had been unable to meet the requirements for RN coverage. The Administrator stated the facility only had one RN (#378) that was not salaried and part of management because of a lack of applications for the position.		

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on record review, staff interview and review of online resources from Centers for Disease Control (CDC), the facility failed to have a comprehensive Water Management Plan to assess, measure, monitor and prevent the growth of Legionella and other opportunistic waterborne pathogens in building water systems. This had the potential to affect all 52 residents in the facility. Findings include: Review of the Water Flushing & Temperature Monitoring forms revealed in January 2025 one resident room (312) had the shower water ran for five minutes with a temperature of 101 degrees Fahrenheit (F) on 01/09/25, one resident room (104) had the sink water ran for six minutes with a temperature of 102 degrees F on 01/24/25, and one resident room (205) had the toileting flushed. Review of the Water Flushing & Temperature Monitoring forms revealed in February 2025 one resident room (104) had the sink water ran for four minutes with a temperature of 115 degrees F on 02/05/25, one resident room (210) had the sink water ran for seven minutes with a temperature of 112 degrees F on 02/13/25, and one resident room (304) had the sink water ran for six minutes with a temperature of 113 F degrees on 02/21/25. Review of the Water Flushing & Temperature Monitoring forms revealed in March 2025 Rooms #106, #205, #214, #315, #318 sinks and showers were flushed for five minutes and temperatures ranged from 110 to 112 degrees F. Review of the Water Flushing & Temperature Monitoring forms revealed in April 2025 the activities room sink was run for 11 minutes with a temperature of 111 degrees F on 04/01/25, the kitchen water was run for seven minutes with a temperature of 109 degrees F on 04/09/25. Review of the Water Flushing & Temperature Monitoring Forms revealed in May 2025 one resident room (510) had the shower water ran for six minutes with a temperature of 110 degrees F on 05/05/25, one resident room (302) had the sink water ran for five minutes with a temperature of 110 degrees F on 05/12/25, one resident room (214) had the sink water ran for eight minutes with a temperature of 112 degrees F on 05/19/25, and one resident room (106) had the shower water ran for four minutes with a temperature of 113 degrees F on 05/26/25. Review of the Monthly Flushing Logs revealed on 06/02/25 the 300 area / outlet was flushed, on 06/09/25 the 200 area / outlet was flushed, and on 06/23/25 the 100 area / outlet was flushed, on 07/03/25 the rehab area / outlet was flushed, on 07/16/25 the kitchen area / outlet was flushed, on 07/25/25 the activities area / outlet was flushed, on 08/04/25 the 300 area / outlet was flushed, on 08/11/25 the 200 area / outlet was flushed, on 08/18/25 the 100 area / outlet was flushed, 09/01/25 the 300 area / outlet was flushed, on 09/08/25 the 200 area / outlet was flushed, on 09/15/25 the 100 area / outlet was flushed, on 10/09/25 the office wing was flushed, and on 10/17/25 the conference room was flushed. Review of the facility's Infection Control Manual on 12/02/25 at 3:00 P.M., revealed no Water Management Plan to monitor and prevent the growth of Legionella and other opportunistic waterborne pathogens in the building's water systems. Interview on 12/02/25 at 3:12 P.M., Licensed Practical Nurse (LPN) #383 confirmed she is the Infection control nurse for the facility. LPN #383 verified the facility did not have a Water Management Plan in place to monitor and prevent the growth of Legionella and other opportunistic waterborne pathogens in building water systems. Review of online resources from the CDC (https://www.cdc.gov/control-legionella/php/wmp/wmp-steps.html) titled Steps to Develop a Water Management Program revealed multi-step process that required continuous review. An approved plan consisted of the following seven steps to building an effective Legionella water management program: 1) Establish a Water Management Program team. 2) Describe the building water systems. 3) Identify areas where Legionella could grow and spread. 4) Decide where to apply and how to monitor control measures. 5) Establish interventions when control limits aren't met. 6) Make sure the program runs as designed and is effective. 7) Document and communicate all the activities.		

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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 record review, staff interview, physician services interview, and policy review, the facility failed to complete thorough investigations following a resident's falls and do neurological (neuro) checks following a resident's fall. This affected one (Resident #57) of seven residents reviewed for accidents. The facility census was 52. Findings include: Review of the medical record for Resident #57 revealed an admission date of 12/27/22. Diagnosis included multiple fractures of pelvis with stable disruption of pelvic ring, subsequent encounter for fracture with routine healing, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. There was no documented history of seizures. Review of the Incidents Log dated 04/01/25 through 09/29/25, revealed Resident #57 had un-witnessed falls on 05/08/25, 05/09/25, 06/27/25, 06/30/25, 07/13/25, 07/14/25, and 08/15/25. Resident #57 had a witnessed fall on 08/31/25. Review of the Falls Report revealed Resident #57 had falls on 05/08/25, 05/09/25, 06/27/25, 06/30/25, 07/13/25, 07/14/25, and 08/15/25. Thorough investigations, neuro checks and fall assessments were not completed. There was also no Interdisciplinary Team (IDT) follow-up. Review of the Falls Report revealed Resident #57 had a fall on 07/14/25 at 4:45 A.M. when the resident was found on the floor lying beside her bed. Resident #57 was sent to the emergency room (ER) due to hip pain and diagnosed with a pelvic ring fracture. The fall intervention implemented was to educate the staff on placement of pressure alarms on the resident's wheelchair and bed. Resident #57 had an additional fall on 08/31/25 at 5:17 P.M. in the dining room where she fell from her wheelchair and was sent to the hospital. Following the fall on 08/31/25, a thorough investigation to determine a root cause analysis was not completed. Review of the Significant Change Minimum Data Set (MDS) dated [DATE], revealed resident had moderate cognitive impairment and was dependent on staff for assistance with oral hygiene, toileting hygiene, showering, personal hygiene, and transfers. Interview on 12/01/25 at 2:00 P.M., Director of Nursing (DON) stated Resident #57 had an unwitnessed fall from her bed on 07/14/25 and sustained a pelvic fracture. The intervention was to educate the staff on placement of pressure alarms on the resident's wheelchair and bed and for the alarms to be in place at all times. The DON stated Resident #57 fell out of her wheelchair in the dining room on 08/31/25 after suffering a seizure. The DON also confirmed there were no neuro checks completed following Resident #57's falls on 05/08/25, 05/09/25, 06/27/25, 06/30/25, 07/13/25, and 08/15/25. The DON also verified thorough investigations or fall assessments were not completed following the resident's falls. Interview on 12/01/25 at 2:15 P.M., LPN #375 stated when Resident #57 fell out of her bed on 07/14/25 at 4:45 A.M., the pressure alarm was not in place. LPN #375 stated Resident #57 was sent to the ER and found to have a pelvic fracture. Interview on 12/02/25 at 10:02 A.M., Nurse Practitioner (NP) #395 stated Resident #57 was a very high fall risk, and the pressure alarms were to be used to try and prevent falls. NP #395 stated neuro-checks should be completed on any un-witnessed falls and if the resident was unable to say what happened. Interview on 12/02/25 at 10:37 A.M., the DON verified Resident #57 had an unwitnessed fall in the dining room on 08/31/25 and she did not get witness statements from any of the employees. The DON stated she completed the incident report instead of the nurse who was working at the time of the fall. The DON stated she noted the resident had a seizure, then fell, but she has no documented evidence confirming the resident had a seizure which caused the fall. Interview on 12/02/25 at 10:50 A.M., Certified Nursing Assistant (CNA) #300 stated she was working the evening of 08/31/25 when Resident #57 fell in the dining room. CNA #300 stated she was not in the dining room when the resident fell, but she heard the alarms going off and the dietary staff yelling. CNA #300 stated when she arrived in the dining room, the resident was on the floor having a seizure. Interview on 12/02/25 at 12:21 P.M. LPN #356 stated she was the nurse on duty on 08/31/25 when Resident #57 fell from her wheelchair in the dining (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	room. LPN #356 stated Dietary Staff #386 told her Resident #57 stood up, was shaking, and fell to the ground. Review of the Fall and Incident Protocol dated 04/01/25, revealed when a fall occurs, a resident will be assessed for injuries prior to moving resident, neuro checks will be started if assessment indicates resident hit their head, and physician will be notified of the fall and related injuries. Review of the Fall Policy dated 06/01/25, revealed residents will be safe and free of injury while allowing residents to be as mobile as they choose. After a resident's fall a fall evaluation will be completed in the risk management system, cranial checks will be initiated if indicated, and a new fall intervention will be initiated.		