

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366127	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2024
NAME OF PROVIDER OR SUPPLIER Woodlands Health and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 6831 North Chestnut Street Ravenna, OH 44266	

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)
<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38522</p> <p>Based on record review, interview and facility policy review, the facility failed to ensure advance directive orders were consistent across electronic and paper medical records. This affected two residents (#5 and #29) out of 24 resident records reviewed. Facility census was 84.</p> <p>Findings include:</p> <p>1. Review of Resident #5's medical record revealed an admitted [DATE] and diagnoses including depression, peripheral vascular disease, cerebral aneurysm, aphasia, dysphagia, anxiety and dementia.</p> <p>Review of Resident #5's quarterly minimum data set (MDS) 3.0 assessment dated [DATE] revealed Resident #5 had cognitive impairment, was dependent on toileting and required substantial/maximal assistance for bathing.</p> <p>Review of Resident #5's electronic medical record revealed she had an advance directive of Do Not Resuscitate Comfort Care Arrest (DNRCCA).</p> <p>Review of Resident #5's paper medical record revealed there was an advance directive of DNRCCA on file dated [DATE] as well as a full measures advance directive dated [DATE].</p> <p>Interview on [DATE] at 8:12 A.M. with the Director of Nursing (DON) confirmed there were advance directives of full code and DNRCCA for Resident #5 in her paper chart and should not have been as this was conflicting information. The DON indicated in the event of a code, staff were to check both the electronic and paper charts for advance directives prior to proceeding with cardiopulmonary resuscitation (CPR) as indicated.</p> <p>2. Review of Resident #29's medical record revealed an admitted [DATE] and diagnoses including dementia, suicidal ideations, hypertension, depression, anxiety, chronic kidney disease and muscle weakness.</p> <p>Review of Resident #29's quarterly MDS 3.0 assessment dated [DATE] revealed Resident #29 had severe cognitive impairment, required supervision for eating and was dependent on staff for toileting.</p> <p>Review of Resident #29's electronic medical record revealed she had an advance directive of Do Not Resuscitate Comfort Care (DNRCC).</p> <p>(continued on next page)</p>

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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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #29's paper medical record revealed there was an advance directive of DNRCC on file dated [DATE] as well as a full measures advance directive dated [DATE].</p> <p>Interview on [DATE] at 8:12 A.M. with the DON confirmed there were advance directives of full code and DNRCC for Resident #29 in her paper chart and should not have been as this was conflicting information. The DON indicated in the event of a code, staff were to check both the electronic and paper charts for advance directives prior to proceeding with CPR as indicated.</p> <p>Review of the facility policy, Advance Directives Protocol, no date revealed the clinical chart will identify any chosen advance directives including any applicable forms such as Do Not Resuscitate (DNR) forms. Advance directives will be reviewed at minimum annually according to MDS schedule. Utilize Advanced Directive audit tool to maintain current advance directive status readily available for review.</p>

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35765</p> <p>Based on observations, review of the medical record, interview with staff, and review of facility policy the facility failed to release a restraint every two hours as ordered for Resident #22. This affected one resident (Resident #22) of one resident reviewed for restraints. The facility census was 84.</p> <p>Findings include:</p> <p>Review of the medical record revealed Resident #22 was admitted to the facility on [DATE]. Diagnoses included Huntington's disease, dementia, anxiety disorder, dysphagia, adjustment disorder, hypertension, Alzheimer's disease, osteoarthritis, diabetes, sleep apnea, anorexia, ataxia, chronic obstruction pulmonary disease, anemia, repeated falls, dysphagia, and chorea.</p> <p>Review of the quarterly Minimum Data Set assessment dated [DATE] revealed Resident #22 had severely impaired cognition and used a trunk restraint daily.</p> <p>Review of the physician's orders revealed Resident #22 had an order for Broda chair with a torso support due to the diagnoses of Huntington's disease; release and reposition every two hours and as needed every shift for safety dated 07/02/24.</p> <p>Continuous observations on 09/18/24 from 11:00 A.M. through 1:05 P.M. revealed Resident #22 was up in the Broda chair with a pelvic restraint on without being released as ordered.</p> <p>On 09/18/24 at 1:05 P.M. an interview with State tested Nursing Assistant #454 revealed she had not released Resident #22 restraint and was not aware of when the least time it was released.</p> <p>On 09/18/24 at 1:07 P.M. an interview with State tested Nursing Assistant #449 revealed she had gotten Resident #22 up in the Broda chair around 9:30 or 10:00 A.M. and that was the last time her restraint was released. She verified it had been over two hours.</p> <p>On 09/18/24 at 1:09 P.M. an interview with Licensed Practical Nurse #422 revealed she had not released Resident #22's restraint and was not aware of when the least time it was released.</p> <p>Review of the facility policy titled, Restraints, dated 01/11 with a revision date of 09/16/24 revealed physical and/or chemical restraints would be initiated only after a comprehensive review determine they are necessary to treat the resident's medical symptoms that warrant their use. The plan of care would be updated and address the medical symptoms, safety issues, measures to minimize risk of resident decline and measures to maintain strength and mobility. The plan of care would also specify the type of restraint to be used, when the restraint is to be used and when it should be released. Physical restraints must be released at least 10 minutes of every 2 hours during normal waking hours to allow for resident movement, exercise, and/or toileting. If the resident does not want to exercise or toilet, their position will be changed at least every 2 hours.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the plan of care dated 05/08/24 with revision on 08/14/24 revealed Resident #22 was at risk for falling related to Huntington's disease and Alzheimer's dementia. Interventions included to ensure placement of floor mat alarm, two mattresses to the floor next to the bed with pad alarm, ankle weights to the Broda chair, bed against wall, bolsters to bed, Broda chair with a torso support enabler to be released and reposition every two hours and as needed, encourage helmet when up as tolerated, and nonskid socks.</p> <p>Review of the plan of care dated 05/08/24 with a revision date of 07/02/24 revealed Resident #22 used a physical restraint to the Broda chair with torso support related to diagnoses of Huntington's disease. It was to be release and resident reposition every two hours and as needed. Interventions included to check the restraint every 15 minutes and release every two hours and to shift the residents weight and/or change her position.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38522</p> <p>Based observation, interview, record review and review of the facility policy, the facility failed to ensure fall interventions were in place per the plan of care. This affected two residents (#22 and #29) of four residents reviewed for falls. Facility census was 84.</p> <p>Findings include:</p> <p>1. Review of Resident #29's medical record revealed an admitted [DATE] and diagnoses including dementia, suicidal ideations, hypertension, depression, anxiety, chronic kidney disease and muscle weakness.</p> <p>Review of Resident #29's quarterly minimum data set (MDS) 3.0 assessment dated [DATE] revealed Resident #29 had severe cognitive impairment, was dependent on staff for toileting and had two or more falls without injury since the last assessment.</p> <p>Review of Resident #29's physician's orders as of 09/18/24 revealed an order dated 09/10/24 for dycem (material added to provide grip to surfaces) to grab bar in bathroom.</p> <p>Review of a nurses note written by Registered Nurse (RN) #462 on 09/10/24 revealed on 09/06/24 at 8:15 A. M. Resident #29 was being assisted with toileting. Resident #29 was holding onto the grab bar in the bathroom and let go. Staff then lowered Resident #29 to the floor. Nonskid socks were in place. Vital signs stable and no injuries noted. New intervention listed was dycem to grab bar in the bathroom.</p> <p>Review of a plan of care dated 06/04/24 and revised 09/17/24 revealed Resident #29 was at risk of falling due to dementia and prior falls and listed an approach dated 09/11/24 for dycem to grab bar in bathroom.</p> <p>Review of the fall risk assessment dated [DATE] revealed Resident #29 was at high risk for falls.</p> <p>Observation on 09/18/24 at 2:36 P.M. with RN #467 revealed Resident #29 was in the bathroom in her room, sitting on the toilet with the door closed. No dycem was observed on either grab bar in the bathroom and no staff were present. Interview with RN#467 at the time of observation verified the dycem was not in place per Resident #29's plan of care.</p> <p>35765</p> <p>2. Review of the medical record revealed Resident #22 was admitted to the facility on [DATE]. Diagnoses included Huntington's disease, dementia, anxiety disorder, dysphagia, adjustment disorder, hypertension, Alzheimer's disease, osteoarthritis, diabetes, sleep apnea, anorexia, ataxia, chronic obstruction pulmonary disease, anemia, repeated falls, dysphagia, and chorea.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the physician's orders revealed Resident #22 had an order for Broda chair with a torso support due to the diagnoses of Huntington's disease; release and reposition every two hours and as needed every shift for safety dated 07/02/24 and ankle weights to broda chair dated 01/24/24.</p> <p>Review of the quarterly Minimum Data Set assessment dated [DATE] revealed Resident #22 had severely impaired cognition and used a trunk restraint daily.</p> <p>Review of the plan of care dated 05/08/24 with a revision date of 07/02/24 revealed Resident #22 used a physical restraint to the Broda chair with torso support related to diagnoses of Huntington's disease. It was to be release and resident reposition every two hours and as needed. Interventions included to check the restraint every 15 minutes and release every two hours and to shift the residents weight and/or change her position.</p> <p>Review of the plan of care dated 05/08/24 with revision on 08/14/24 revealed Resident #22 was at risk for falling related to Huntington's disease and Alzheimer's dementia. Interventions included to ensure placement of floor mat alarm, two mattresses to the floor next to the bed with pad alarm, ankle weights to the broda chair, bed against wall, bolsters to bed, Broda chair with a torso support enabler to be released and reposition every two hours and as needed, encourage helmet when up as tolerated, and nonskid socks.</p> <p>Observation on 09/17/24 at 5:05 P.M. revealed Resident #22 was up in the Broda Chair in the lounge area. She was sleeping with a torso/pelvic restraint and her helmet on. She did not have the ankle weights to the Broda chair.</p> <p>On 09/17/24 at 5:10 P.M. an interview with Licensed Practical Nurse #469 revealed she was from sister facility and this was the first time working in this building so she did not know about the ankle weights to Resident #22 Broda chair however she did verify there was an order for them to be on her Broda Chair and they were not on it.</p> <p>On 09/17/25 at 5:15 P.M. an interview with State tested Nursing Assistant (STNA) #438 revealed she did not know anything about the ankle weights and she had only worked at the facility for about a month.</p> <p>On 09/17/24 at 5:23 P.M. an interview with Registered Nurse # 462 revealed she did not know about the order for the ankle weights to the Broda chair but would find out more information about them.</p> <p>On 09/17/24 at 5:25 P.M. an interview with STNA #453 revealed Resident #22 had received a new Broda Chair and the ankle weights were not on it. He stated the wheels were wider on this chair and he did not think they really needed them on this chair like they did her other Broda Chair. He stated he would go look for them in her room and put them on her Broda Chair.</p>		