STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366209	A. Building B. Wing	06/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woods Edge Rehab and Nursing	1171 Towne Street Cincinnati, OH 45216

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. 42731 Based on observation, staff interview, and policy review, the facility failed to ensure residents were fed in a safe and dignified manner. This affected one (Resident #64) of one resident reviewed for dignity. This had the potential to affect all 89 residents in the facility. Findings include: During an observation on 06/03/24 at 12:21 P.M., State tested Nursing Assistant (STNA) #300 was standing in the hallway at the nurse station on the 400-hall feeding Resident #64. Resident #64 was seated in a reclining geri-chair facing away from the nurse station. STNA #300 was standing behind Resident #64, reaching around him and putting food into his mouth. There was a cart containing trays for the lunch meal approximately three feet away from the resident's geri-chair. There was no chair in the vicinity for STNA #300 to sit on. During an interview at the time of the observation, STNA #300 verified she was standing to feed Resident #64 and was not facing him as she fed him. STNA #300 stated she was standing to feed Resident #64 because the cart was in her way. STNA #300 did not say why she was not facing the resident to feed him. Review of the facility policy titled, Resident Rights and Dignity, undated, revealed all residents should be treated in a dignified manner. This deficiency is based on incidental findings discovered during the course of this complaint investigation.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42731 Based on record review, observation, and interview, the facility failed to ensure a resident's compression stockings were applied as ordered to treat edema. This affected one (Resident #80) of three residents reviewed for edema. The facility census was 89. Findings include: Review of the medical record revealed Resident #80 was admitted on [DATE]. Diagnoses included nerve root and plexus disorder, wernicke's encephalopathy, alcohol abuse with alcohol-induced sleep disorder, insomnia, legal blindness, depression, anxiety, and iron deficiency anemia. Resident #80 had a physician order 05/24/24 to apply compression wraps to bilateral lower extremities, on in the morning, off at night. During an observation on 06/03/24 at 12:27 P.M., Resident #80 had swelling in her legs and was not wearing any compression hose. During interview at the time of the observation, Resident #80 stated she asked for compression hose, however had not been provided with any. During an observation on 06/03/24 at 5:04 P.M., Resident #80 was not wearing any compression hose. During an interview on 06/03/24 at 5:06 P.M., Licensed Practical Nurse (LPN) #400 verified Resident #80 had an order to apply compression hose but did not have compression hose applied. LPN #400 stated Resident #80 did not ask about having them applied nor did she try to apply them, however she was told the resident sometimes refuses to have them applied. LPN #400 affirmed there was no documentation regarding Resident #80's refusal to wear the compression hose for 06/03/24. LPN #400 stated the nurse was responsible for ensuring the compression hose were applied as there was a physician's order for them to be applied. During an observation on 06/04/24 at 12:25 P.M., Resident #80 was observed sitting on the edge of her bed. The resident had edema in her legs and was not wearing compression hose. Resident #80 stated nobody had offered to apply the compression hose. During observations on 06/04/24 at 2:06 P.M., 2:30 P.M., and 4:00 P.M., Resident #80 was sitting up in her wheelchair in her room and in the hallways and was not wearing compression hose. During an interview on 06/04/24 at 4:00 P.M., LPN #400 verified Resident #80 was not wearing compression hose. LPN #400 stated she talked with night shift about the compression hose and was, again, told the resident sometimes refused to have them applied, but stated she did not attempt to apply Resident #80's compression hose on 06/04/24. LPN #400 further verified she did not document anything in the medical record about Resident #80's refusal to wear the compression hose. This deficiency represents non-compliance investigated under Complaint Number OH00153742.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42731 Based on record review, interview and policy review, the facility failed to ensure residents were seen by the physician as required. This affected one (Resident #80) of three residents reviewed for physician visits. The facility census was 89. Findings include: Review of the medical record of Resident #80 revealed an admitted [DATE]. Diagnoses included nerve root and plexus disorder, wernicke's encephalopathy, alcohol abuse with alcohol-induced sleep disorder, insomnia, legal blindness, depression, anxiety, and iron deficiency anemia. Review of the comprehensive Minimum Data Set (MDS) assessment, dated 04/02/24, revealed the resident had moderately impaired cognition. Review of facility physician, physician assistant (PA), and nurse practitioner (NP) visits revealed Resident #80 was seen by the physician on 03/29/24, physician assistant on 04/05/24, and the nurse practitioner on 05/24/24 and 05/30/24. During an interview on 06/04/24 at 10:52 A.M., the Director of Nursing (DON) verified Resident #80 was not seen by the physician as required. The DON verified residents should been seen at least every 30 days during the first 90 days of their admission. During interview on 06/04/24 at 12:08 P.M., the DON stated the physician tried to see Resident #80 two weeks ago but she would not get off the phone The physician tried again today 06/04/24 and the resident would not get off the phone. Interview on 06/04/24 at 2:26 P.M., Medical Director (MD) #420 verified she had not seen Resident #80 since her initial visit. MD #420 stated she attempted to see Resident #80 last month but she was on the phone and did not want to participate in a medical visit. MD #420 stated she was in the facility on the morning of 06/04/24 but did not try to see Resident #80 that day, nor had she tried to see the resident after the resident refused to participate in the medical visit during the prior month. Review of the facility policy titled, Physician Visits, dated 01/2024, revealed the physician will see the resident once every 30 days for the first 90 days after admission. After the initial physician visit, a qualified NP or PA may make every other required visit.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 42731 Based on observation, record review and interview, the facility failed to ensure menus were followed and residents were notified of menu changes prior to the meal. This had the potential to affect 88 of 89 residents. The facility identified one Resident (Resident #33) who did not receive food from the kitchen. The facility census was 89. Findings include: During observations on 06/03/24 between 10:50 A.M. and 11:10 A.M., the menus posted on each unit indicated the residents were to receive turkey and rice casserole, green peas, and a biscuit for the supper meal on 06/03/24 and were to receive a baked pork chop, stuffing, green beans, and a dinner roll for the supper meal on 06/02/24. Review of the menu for the current week had had turkey and rice casserole, green peas, and a biscuit for the supper meal on 06/02/24. Review of the Daily Menu for 06/02/24 listed a baked pork chop, stuffing, green beans, and a dinner roll for supper The menu for 06/03/24 had turkey and rice casserole, green peas, and a biscuit for the supper meal. During an observation on 06/03/24 at 4:44 P.M., the tray line had shredded pork, potatoes with peas, and a roll for the supper meal. During an interview on 06/03/24 at 4:46 P.M., Dietary Supervisor (DS) #405 stated the residents were not being served the turkey and rice casserole, green peas, and a biscuit as was on the menu. DS #405 stated she ran out of biscuits and the turkey and rice casserole meal was served on 06/02/24 because the meal scheduled for 06/02/24 had not been taken out to thaw. DS #405 stated menus are posted on all units and verified the posted menu did not match what was served on 06/02/24 and 06/03/24 at the supper meals. DS #405 verified the residents had not been notified of the menu changes prior to the meals and further verified residents should be notified of menu changes prior to the meal. This deficiency is based on incidental findings discovered during the course of this complaint investigation.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 42731 Based on observation, record review and interview, the facility failed to ensure recipes were followed and that the food was visually appealing. This had the potential to affect 88 of 89 residents. The facility identified one resident (Resident #33) who did not receive meals from the kitchen. The facility census was 89. Findings include: Review of the menu for the current week revealed the residents were to receive an open-faced turkey sandwich with gravy, roasted potatoes, and a California vegetable blend for lunch on 06/03/24. Review of the daily menu for 06/03/24 revealed the residents were to receive an open faced turkey sandwich with gravy, mashed potatoes, and a California vegetable blend. Review of the recipe revealed the open faced turkey sandwich was to consist of a slice of toast with three ounces of sliced turkey, mashed potatoes on top of the turkey, and turkey gravy over the sandwich. During observations on 06/03/24 between 12:10 P.M. and 1:00 P.M., residents on all units received a piece of white bread with a chopped meat with a reddish-brown gravy served on top with mashed potatoes and mixed vegetables on the side. During an interview on 06/03/24 at 12:19 P.M., Resident #66 stated the meal looked like dog food and she was not going to eat it. During an interview on 06/03/24 at 12:22 P.M., Resident #71 looked at the meal she had just been served, and pushed it away and stating it looked awful and she would not eat it. During an interview on 06/03/24 at 12:27 P.M., Resident #80 stated the meal did not look at all appetizing. During an observation on 06/03/24 at 12:42 P.M., Resident #38 looked at the contents of the plate as staff served it. He stated it looked gross and immediately asked for a peanut butter and jelly sandwich. During an interview on 06/04/24 at 9:00 A.M., Dietary Supervisor (DS) #405 verified the recipe for the open face turkey sandwich did not match what was served at lunch on 06/03/24. Meat was cubed instead of sliced and the gravy was dark/red in color and did not appear to be turkey gravy. DS #405 stated the correct food had not been taken out to thaw. This deficiency represents non-compliance investigated under Complaint Number OH00153742.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 42731 Based on observation, interview and policy review, the facility failed to ensure employees wore hair nets while preparing and serving food and beverages. This had the potential to affect 88 of 89 residents. The facility identified one resident (Resident #33) who did not receive food from the kitchen. The facility census was 89. Findings include: During an observation on 06/03/24 at 4:28 P.M., Dietary Aide (DA) #415 was standing at the juice machine in the kitchen, pouring drinks, in preparation for the dinner meal. DA #415 was not wearing a hairnet. During interview at the time of the observation, Dietary Supervisor (DS) #405 verified DA #415 was not wearing a hairnet and told DA #415 to go put a hairnet on. During an observation on 06/03/24 at 4:29 P.M., DA #415 put a hairnet on, however his braids were not fully covered. During observation on 06/03/24 at 4:34 P.M., Dietary [NAME] (DC) #430 was standing at the steam table stirring the food that would be served for the dinner meal. DC #430 was wearing a hairnet, however her braids were sticking outside of the hairnet, not fully covered. During an observation on 06/03/24 at 4:42 P.M., DC #430 plated food for the meal and DA #415 placed drinks and silverware on the trays. DA #415 and DC #430 wore hairnets but their braids were not secured beneath the hairnets. During an interview on 06/03/24 at 4:49 P.M., DS #405 verified DA #415 and DC #430 did not have their hair fully covered and affirmed all hair should be contained within the hairnet. Review of the facility policy titled, Dietary/Food Handling, dated 01/2023, revealed hairnets must be worn in food service areas.