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	11/05/2024

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 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** 44083 Based on staff interviews, observations and record review, the facility failed to provide adequate supervision to prevent the elopement of one (#59) of the three residents reviewed. The facility census was 90. Findings Include: Review of the medical record for Resident #59 revealed the resident was admitted to the facility on [DATE]. Diagnoses included schizophrenia, dementia, chronic obstructive pulmonary disease (COPD), diabetes, drug abuse, and tobacco use. Review of a physician order dated 01/24/24 for Resident #59, revealed the resident was ordered to be on a secured unit due to vascular dementia and schizophrenia. Review of the Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #59 had moderately impaired cognition and was independent for ambulation. The resident resided on a secured behavior unit. Review of the most recent care plan for Resident #59, revealed the resident resided on a secured unit to promote the resident's safety related to cognitive impairment, elopement risk, exit seeking behaviors, and wandering. Review of an unsigned /unlocked nurse's note dated 11/03/24 at 9:45 P.M. and authored by Licensed Practical Nurse (LPN) #500, revealed she was completing medication administration on A-Wing when she heard a noise coming from the 200-Hall door which leads to the second-floor secured unit. When LPN #500 opened the door, STNA #216 was in the stairwell asking if she had seen Resident #59 come down the stairs. STNA #216 stated Resident #59 was missing from the smoking room. The staff immediately searched inside and outside of the faciity and was unable to locate the resident. STNA #216 reported the police were outside the facility investigating a possible break in when they called the facility about the person they found walking around. The facility described the missing resident, and the police returned the resident within 15 minutes. The resident's assessment revealed no injuries and all vital signs within normal limits. The resident was returned to the secured unit and placed on 15-minutes checks by staff. All notifications were made to the responsible party and the physician, with no new orders. (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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility elopement investigation dated 11/03/24 completed by the Assistant Director of Nursing, (ADON) #304, revealed she was called by the staff on 11/03/24 around 10:00 P.M. indicating Resident #59 was missing from the facility. Resident #59 had been observed at 9:30 P.M. by State tested Nurse Aide (STNA) #216 in the smoking area. STNA #216 provided the Resident #59 with an unlit cigarette and upon lighting his cigarette, he was gone from the area. Resident #59 was returned to the facility 40 minutes later by the police after they found him walking around near the facility. When ADON #340 arrived at the facility, the police and Resident #59 were standing outside the facility. he investigation revealed the Resident #59 had taken a stairwell exit to the exterior of the facility while the STNA #216 was in an adjacent resident smoking room. The resident returned to the facility with no injuries upon return. Review of the witness statement by STNA #216 dated 11/03/24, revealed Resident #59 was in the smoking room on the second floor and was given a cigarette. When STNA #216 went to light the resident's cigarette, he was not present in the room. STNA #216 indicated the resident went down a set of stairs to a door at the bottom of the stairs near A-wing which led to the courtyard. Resident #59 exited the courtyard and off the premises. The staff started searching for him and couldn't find him when the authorities brought him back. Review of witness statement by LPN #500 dated 11/03/24, revealed at approximately 9:45 P.M., she heard a pulling noise coming from the 100-hall side door. When LPN #500 got to the door, STNA #216 was in stairwell looking for Resident #59. STNA #216 indicated Resident #59 was not in the smoking room and walked down the stairs. The staff searched the inside and outside of the facility. LPN #500 reported STNA #216 called her and indicated the local police called the facility indicating there was a potential break in next to the facility and inquired about any missing residents . When STNA #216 provided the description of the resident, the police officer verified it was Resident #59. LPN #500 went to the area where Resident #59 was found, and the police returned him to the facility at 10:15 P.M. Interview on 11/05/24 at 11:23 A.M. with the ADON #304 and the Administrator verified on 11/03/24 at 9:30 P.M. Resident #59 eloped from the facility through a stairwell adjacent to the resident smoke room, being supervised by STNA #216. Resident #59 returned to the facility by the policy without injury on 11/03/24 at 10:15 P.M. put on one-on-one increased checks.

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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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 44083 Based on interview, observations and record review, the facility failed to serve specialized diets as planned by the Registered Dietitian (RD). This affected 15 residents, (#01, #15, #20, #21, #22, #32, #41, #52, #61, #66, #67, #69, #72, #77, and #87) of the 89 residents receiving food from the kitchen. The facility census was 90. Findings Include: Review of the physician orders revealed Residents #01 and #69 had diet orders for puree food texture consistency. Residents #15, #20, #21, #22, #32, #41, #52, #61, #66, #67, #72, #77, and #87 had physician orders for a mechanical soft food texture consistency. Review of the lunch menu diet spreadsheet revealed the puree texture diet was to be served puree green beans. The mechanical foods texture diets were to be served green beans. Observation on 11/04/24 at 11:40 A.M. of the lunch meal service revealed the puree texture diets of Resident #01 and #69 and mechanical soft texture diets for Residents #15, #20, #21, #22, #32, #41, #52, #61, #66, #67, #72, #77, and #87 received no green beans or other like vegetable. Interview on 11/04/24 at 11:40 A.M., [NAME] #41 verified Residents #01, #15, #20, #21, #22, #32, #41, #52, #61, #66, #67, #69, #72, #77, and #87 did not receive green beans or any other like vegetable. The [NAME] #41 stated she did not know the puree and mechanical soft diets were to receive green beans as the planned texture vegetable because she had not reviewed and followed the diet spreadsheet. [NAME] #41 verified the diet menu spreadsheet was available for review during meal preparation for all diets planned by the Registered Dietitian. Interview on 11/04/24 at 12:00 P.M. the RD #600 verified the diet spreadsheet is available for the cooks to prepare the textured diet foods. RD #600 verified Residents #01, #15, #20, #21, #22, #32, #41, #52, #61, #66, #67, #69, #72, #77, and #87 were not served the correct alternate food for the puree and mechanical soft food textures. Review of facility policy Spreadsheet Guidelines for Menu Planning,, dated 2024, revealed spreadsheets are designed to meet therapeutic requirements. The [NAME] is to refer to the spreadsheet for details in preparing therapeutic diet foods as ordered by the physician. This deficiency represents non-compliance investigated under Complaint Number OH00158767 and Complaint Number OH00158338.