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	09/30/2025

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, staff interview, review of the facility's investigation, review of witness statements, review of the facility Self-Reported Incidents (SRI), review of emergency medical services (EMS) report, review of hospital records, review of emergency room (ER) notes, review of the local weather report, and review of the facility policy, the facility failed to provide adequate supervision and implement timely interventions for exit-seeking behaviors for Resident #11, to prevent his elopement from the facility. This resulted in Immediate Jeopardy and the potential for serious life-threatening harm and/or death on [DATE] when Resident #11 broke the window and exited the secured building by jumping out of the second story window, approximately 15 feet from the ground level. Resident #11 suffered an open fracture to the left ankle as a result of the jump. This affected one (Resident #11) of three residents reviewed for elopements. The facility identified 18 residents who were at risk for elopement from the facility. The facility census was 74 residents. On [DATE] at 11:35 A.M., the Administrator, the Director of Nursing (DON), and Regional Clinical Officer (RCO) #800 were notified Immediate Jeopardy began on [DATE] at 1:40 P.M. when Resident #11 made threats to jump out a window, and 1:59 P.M. staff found Resident #11 on the ground outside the unit. Staff assessed Resident #11 and transferred Resident #11 to the hospital via emergency medical services. The Immediate Jeopardy was removed on [DATE] when the facility implemented the following corrective actions: On [DATE], the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) began interviewing staff from the unit to gather statements regarding the incident. Beginning on [DATE], the DON and ADON immediately provided education to current staff on suicidal and threatening behavior protocols and interventions, behavior management, and how to deal with challenging behaviors and the need to immediately respond to resident threats of self-harm. The resident should not be left alone or out of line of sight for their safety. If the nurse does not respond, then they should notify the DON/ADON/ Administrator. On [DATE], the DON and the ADON reviewed the suicidal ideation (SI) risk assessment/questionnaire. The DON and the ADON educated staff on the abuse and neglect policies and procedures. This education was completed for all day and night shift staff working on [DATE] by approximately 7:30 P.M. Employees working on [DATE] received the education prior to their shifts. Education for current staff was completed on [DATE]. On [DATE], the DON notified staff who were not present on [DATE] and [DATE] via online communication, they must report to the DON/ADON for education before their next scheduled shift. Starting [DATE], training will continue ongoing for all employees who have not yet received it due to paid time off (PTO), sick leave, etc., and will also be provided to all new hires. On [DATE], the ADON completed suicide risk assessments and elopement assessments for all current residents on the male secured unit, and no other residents were identified with suicidal ideations or increased/current immediate elopement risk. On [DATE], the Maintenance Director (MD) audited all second-floor windows to ensure they were secured and in place with no further issues noted. Staff secured Resident #11's room to prevent re-entry and cleared glass debris from the courtyard for safety. On [DATE], the facility Administrator opened a Self-Reported Incident (SRI) and reported the incident to the Ohio Department of Health (ODH). On [DATE], the Administrator suspended Licensed Practical Nurse (LPN) #205 who was the unit nurse at the time of the incident, pending the outcome of the investigation. LPN #205 has remained suspended and/or has not worked since the incident due to being on vacation. On [DATE] at 4:30 P.M., the Administrator and the DON notified the Medical Director and a member of the governing body (GB)/Owner of the incident on [DATE] involving Resident #11. The facility then held an ad hoc Quality Assurance and Performance Improvement (QAPI) meeting by phone with the Administrator, the DON, the Medical Director and the Facility Owner. On [DATE], the Administrator and the DON completed a root cause analysis of the incident on involving Resident #11 and determined the root cause was staff did not stay with Resident #11 when the resident verbalized an intent to leave the facility by jumping out a window and LPN #205 failed to assess Resident #11 when notified by staff. On [DATE], the ADON began questioning random staff three times weekly to verify knowledge of resident safety protocols. Results are turned into the Administrator for ongoing monitoring and compliance. The ADON will continue the monitoring three times weekly for three months. Beginning on [DATE], the management team will conduct ongoing education and continue to address any issues related to suicidal and threatening behaviors. Staff have been and will continue to be questioned by the Administrator or designee on appropriate actions to take if a resident expresses an intent to harm themselves. This will be conducted three times per week for

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure infection control techniques were properly maintained during wound care. This affected one (Resident #15) of three Residents reviewed for wound care. The facility census was 75. Findings include:Medical record review for Resident #15 revealed he was admitted to the facility on [DATE]. His diagnoses included hemiparesis/hemiplegia, Alzheimer ' s dementia with associated cognitive and decision-making impairments, peripheral vascular disease, and hypertension. Resident #15 required a guardian for his care. Resident #15 was ordered to be in Enhanced Barrier Precautions (EBP) (an infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDROs] in nursing homes). Review of the Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #15 was cognitively impaired and dependent on staff for activities of daily living (ADL). Was assessed to have a stage IV pressure ulcer (a severe, full-thickness wound with extensive tissue loss, exposing muscle, tendon, ligament, or bone) on his left heel. An observation of wound care and dressing change to the left heel of Resident #15 on 11/25/25 at 1:21 P.M. with Licensed Practical Nurse (LPN) #106, LPN#174, and Certified Nursing Assistant (CNA) #120. Resident #15 was noted to be in EBP. Prior to putting on gowns and gloves, all staff washed and dried hands. While LPN #106 was holding Resident #15 ' s left leg up off the bed, LPN #174 used scissors to cut the old dressing, removed the soiled dressing and placed it in the trash with soiled gloves. LPN #174 washed hands and applied new gloves with no hand hygiene. LPN #106 asked where the wound cleanser was, then LPN #174 exited the resident ' s room with her isolation gown in place and returned with wound cleaner. LPN #174 applied gloves, cleansed the wound with gauze and cleaner, disposed of each gauze used to clean, removed soiled gloves and applied fresh gloves without any hand hygiene between. LPN #174 applied Santyl to gauze, applied gauze to left heel, wrapped the dressing in Kerlix, applied tape to dressing and exited room with her personal protective equipment (PPE) still in place. LPN #174 returned to room still in same gown and gloves, with a black marker, and initialed and dated the dressing. Interview on 11/25/25 at 1:47 P.M., LPN #174 verified she should have removed the gown and gloves prior to exiting resident ' s room. LPN #174 verified she should have completed hand hygiene after removing the soiled gloves following the wound cleansing and prior to applying new gloves when she applied the wound treatment. Interview on 11/25/25 at 9:21 A.M., DON stated the staff were expected to bring in all supplies prior to beginning any type of care the staff should be following the proper infection control techniques when doing wound care. Subsequent interview on 12/01/25 at 9:47 A.M., the DON stated the facility policy on EBP included the proper use of gloves and gown and the facility policy on Aseptic Dressing Change included the proper hand hygiene. The DON verified it was standard nursing practice to remove a gown prior to exiting a resident ' s room and applying a clean gown prior to re-entry, washing hands before you start wound care, anytime take your gloves off, touch anything soiled, going to clean dressing wash hands, and after you have completed the treatment. The DON stated the staff were expected to follow policies and procedures for infection control. Review of facility policy for Aseptic Dressing Change dated January 2024, revealed steps that include placing soiled dressing in trash, washing hands, applying clean gloves to cleanse wound, discarding cleansing supplies to trash, wash hands and apply gloves, apply medication and clean dressing, remove gloves and place in trash, tape dressing ion place, date and initial according to facility policy. Review of facility policy on EBP dated March 22, 2024, revealed EBP for residents with wounds regardless of MDRO colonization status should be ordered and followed by staff during high-contact resident care activities including wound care. These precautions include the proper application and removal of gloves and gown.