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	04/16/2026

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

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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 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. Based on observation, staff interview, record review, and review of the facility policy, the facility failed to maintain a clean and sanitary kitchen. This had the potential to affect 75 of 77 residents who received food from the kitchen. Two residents received no food by mouth. The facility census was 77 residents.Findings include: 1.Observation on 04/13/26 at 9:06 A.M. of two deep freezers with Dietary Manager (DM) #12 revealed there was debris and scum at the bottom of each deep freezer. In one of the freezers there were 100 unlabeled and undated strawberry shortcakes and 50 unlabeled and undated vanilla pudding cups. One deep freezer did not have a thermometer. Observation of the food preparation area revealed there was no soap in the dispenser at the sink used for staff hand hygiene. A box of hair nets contained a dirty used facemask and two used hair nets. Observation of walk-in freezer revealed it contained two unlabeled and undated pitchers of juice. Observation of the walk-in refrigerator revealed it contained the following unlabeled and undated items: 10 sandwiches, 25 cups of pre-poured cranberry juice, 25 cups of pre-poured water. Interview on 04/13/26 at 9:16 A.M. with DM #12 confirmed the debris in the bottom of the freezers, the freezer without a thermometer, the unlabeled and undated items throughout the kitchen, the lack of soap in the dispenser, and the dirty mask and hairnets discarded in the clean box of hair nets. 2.Observation of breakfast preparation on 04/15/26 at 7:47 P.M. revealed DM #12 made pancakes on the griddle using a ladle to scoop pancake batter onto the griddle and the using a spatula to flip the pancakes. Then DM #12 moved the pancakes to a pan on the tray line with his gloved hands. After moving a stack of pancakes into the pan on the tray line, DM #12 reached over and patted the pancakes down with his gloved hands. Interview on 04/15/26 at 7:57 A.M. with DM #12 confirmed he had touched the pancakes with his gloved hand that had been used to touch the ladle from the pancake batter. 3.Observation on 04/14/26 at 2:44 P.M. of the refrigerator/freezer on C-wing it did not include a thermometer in the freezer compartment and there was a buildup of ice in the freezer approximately three inches in depth. The refrigerator compartment thermometer read 50 degrees Fahrenheit (F.) Both the freezer and refrigerator compartments had food and drink spills throughout. Interview on 04/14/26 at 2:45 P.M. with Licensed Practical Nurse (LPN) #6 confirmed the freezer had spills and needed to be defrosted. She also confirmed the temperature of 50 degrees in the refrigerator was too high and the refrigerator needed to be cleaned of spills. 4. Observation on 04/14/26 at 2:46 P.M. revealed the resident ice cooler on the unit had a can of soda lying on the top of the ice. Interview on 04/14/26 at 2:47 P.M. with LPN #6 confirmed there was a can of pop laying on the ice and confirmed the soda should not be stored in the ice. 5. Observation on 04/14/26 at 3:01 P.M of the medical wing resident refrigerator/ freezer revealed there was ice buildup in the freezer compartment and spills and debris throughout freezer and refrigerator. Interview on 04/14/26 with Certified Nursing Assistant (CNA) #69 confirmed the freezer needed to be cleaned and defrosted and the refrigerator needed to be cleaned. 6. Observation on 04/16/26 at 10:22 A.M. of the men's locked unit resident refrigerator-freezer revealed the refrigerator and freezer had spills and debris throughout. Interview on 04/16/25 at 10:23 A.M. with LPN # 88 confirmed the refrigerator and freezer compartments both had spills and debris and needed to be cleaned. Review of the facility policy titled Food Storage dated August 2018 revealed all (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	refrigerators should be kept clean and in good working condition at all times and refrigerator temperatures should range between 36 and 41 degrees F. Review of the facility policy titled Storage of Frozen Foods dated August 2018 revealed freezer units should be defrosted as frequently as necessary to maintain efficiency.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, staff interview, and review of the facility policy, the facility failed to properly label and store medications. This affected seven residents (Resident #20, Resident #55, Resident #36, Resident #37, Resident #58, Resident #75, and Resident #7) of 18 residents reviewed for medication storage. The facility census was 77 residents. Findings include: 1. Review of the medical record for Resident #20 revealed an admission date of [DATE] with a diagnosis of type two diabetes. Review of the physician's orders for Resident #20 revealed an order dated [DATE] for insulin glargine 12 units subcutaneously at bedtime. Observation on [DATE] at 10:15 A.M. with Licensed Practical Nurse (LPN) #112 revealed Resident #20's insulin glargine was opened and had not been dated. Interview on [DATE] at 10:16 A.M with LPN #112 confirmed Resident #20's insulin glargine had not been dated upon opening. 2.) Review of the medical record for Resident #55 revealed an admission date of [DATE] with a diagnosis of diabetes mellitus. Review of the physician's orders for Resident #55 revealed an order dated [DATE] for Novolog insulin per sliding scale which was discontinued on [DATE]. Observation on [DATE] at 10:30 A.M with LPN #117 revealed Resident #55's Novolog insulin was opened and had not been dated. Interview on [DATE] at 10:31 A.M. with LPN #117 confirmed Resident #55's Novolog was still in the cart even though it had been discontinued and the Novolog insulin had not been dated upon opening. 3. Review of the physician's orders for Residents #7, #58, and #75 dated [DATE] revealed the residents had orders for multivitamins with minerals tablets. Review of the physician's orders for Residents #36 and #37 dated [DATE] revealed the residents had orders for guaifenesin liquid. Observation on [DATE] at 10:40 A.M of medication storage room one revealed it contained five bottles of multiple vitamin and mineral tablets with expiration dates of [DATE] and four bottles of guaifenesin liquid with expiration dates of [DATE]. Interview on [DATE] at 10:50 A.M with the Director of Nursing (DON) confirmed the five bottles of multiple vitamins-minerals tablet and the four bottles of guaifenesin liquid in medication storage room one were expired and should have been discarded. Review of facility policy titled Medication Administration undated revealed the nurse should verify the expiration date of all medications.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on medical record review, observation, resident interview, and staff interview, the facility failed to ensure call lights were within reach. This affected one (Resident #47) of 18 residents reviewed for call lights. The facility census was 77 residents.Findings include: Review of the medical record for Resident #47 revealed an admission date of 04/14/17 with diagnoses including chronic kidney disease, cardiomegaly, peripheral vascular disease, and schizoaffective disorder, Review of the Minimum Data Set (MDS) assessment for Resident #47 dated 03/09/26 revealed the resident was moderately cognitive impaired and was dependent on staff assistance with activities of daily living (ADLs.) Review of the care plan for Resident #47 dated 03/22/26 revealed the resident had an ADL deficit and the staff were to encourage the resident to use the call light to request assistance. Observation on 04/13/26 at 11:47 A.M. revealed Resident #47 was lying in bed and the call light was hanging on the wall out of reach of the resident. Interview on 04/13/26 at 11:50 A.M. with Resident #47 confirmed the resident was concerned about not being able to reach the call light, because she was dependent on staff for help. Interview on 04/13/26 at 11:57 A.M. with Certified Nursing Assistant (CNA) # 46 verified that the call light was out of reach for Resident #47.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on medical record review, observation, resident interview, staff interview, and review of the facility policy, the facility failed to ensure a clean and sanitary environment. This affected one (Resident #38) of 18 residents sampled. The facility census was 77 residents. Findings include: Review of the medical record for Resident #38 revealed an admission date of 02/15/23 with diagnoses including obsessive-compulsive disorder, delusional disorder, psychosis, and major depressive disorder. Review of the Minimum Data Set (MDS) assessment for Resident #38 dated 03/21/26 revealed the resident was cognitively intact and required supervision with activities of daily living (ADLs.) Observation on 04/13/26 at 12:05 P.M. revealed the wall air conditioning unit next to Resident #38's bed was covered with a black substance. Interview on 04/13/26 at 11:45 AM with Resident #38 confirmed he was concerned about the black substance on his air conditioning unit because he thought it could negatively impact his health. Interview on 04/13/26 at 12:05 P.M. with Certified Nursing Assistant (CNA) #111 verified that the wall air conditioning unit next to Resident #38's bed was coated with a black substance and confirmed the unit should be kept clean. Review of facility policy titled Cleaning of Residents' Rooms dated July 2022 revealed walls, blinds, and window curtains in resident areas would be kept clean when those surfaces are visibly contaminated or soiled.

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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. Based on medical record review, review of the facility fall investigation, staff interview, and review of the facility policy, the facility failed to provide adequate the adequate level of supervision and assistance during care to prevent falls. This affected one (Resident #84) of three residents reviewed for falls. The facility census was 77 residents.Findings include: Review of the medical record for Resident #84 revealed an admission date of 12/06/26 with diagnoses including cerebral infarction, hemiplegia and hemiparesis affecting left non-dominant side, and paranoid schizophrenia. Review of the fall risk assessment for Resident #84 completed 12/06/25 revealed the resident was at moderate risk for falls. Review of the Minimum Data Set (MDS) assessment for Resident #84 dated 12/11/25 revealed the resident was moderately cognitively impaired and was dependent on staff for toileting, dressing, bathing, personal hygiene, and turning and repositioning. Review of the care plan for Resident #84 dated 12/08/25 revealed the resident had a self-care deficit, impaired cognition, and was at risk for falls due to hemiplegia and hemiparesis. Interventions included two staff were to assist the resident with daily hygiene, grooming, and dressing. Review of the nurse progress note for Resident #84 dated 03/03/26 at 7:59 A.M. revealed at 6:10 A.M. Certified Nursing Assistant (CNA) #109 called out for assistance. Registered Nurse (RN) #59 ran to the room and observed CNA #109 attempting to assist Resident #84 onto the floor. RN #59 and CNA #109 assisted Resident #84 back into bed using the Hoyer lift. Review of the facility fall investigation for Resident #84 dated 03/03/26 revealed CNA #109 was completing Resident #84's incontinence care and bed bath. CNA #109 began to roll Resident #84 over toward the wall to perform care. When CNA #109 was done performing care the aide cleaned off the bed and turned around to grab dry linens. When CNA #109 turned around Resident #84 started to fall sliding feet first and then to his knees. Interview on 04/14/26 at 10:38 A.M. with CNA #109 confirmed Resident #84 required the assistance of two staff for all ADLs including bed baths. CNA #109 confirmed if they would have had another person assisting them Resident #84 would not have fallen. CNA #109 confirmed Resident #109 slid out of bed during the bed bath when the aide turned away from the resident to grab fresh linens. Interview on 04/14/26 at 2:37 P.M. with the Director of Nursing (DON) confirmed Resident #84 had a witnessed fall without injury on 03/03/26 during a bed bath provided by CNA #109. The DON verified the facility investigation determined Resident #84 required the assistance of two staff with transfers and CNA #109 had not followed the resident's care plan which resulted in the fall. Interview on 04/14/26 at 3:16 P.M. with RN #59 confirmed Resident #84 required the assistance of two staff for bed baths and CNA #109 should have had another staff member in the room. Review of the facility policy titled Accident and Incidents Protocol dated on March 2025 revealed the facility would implement interventions to prevent falls. This deficiency represents noncompliance investigated under Complaint Number 2964143.

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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. Based on observation, staff interview and review of the facility policy, the facility failed to ensure nurses performed appropriate hand hygiene during medication administration. This affected three residents (Resident #11, Resident #76 and Resident # 38) of five residents observed for medication administration. The facility census was 77 residents.Findings include: 1.Observation on 04/15/26 at 8:30 A.M. of medication administration per Licensed Practical Nurse (LPN) #6 revealed the nurse popped Resident #11's medications out of the package into her bare hand and placed the pills in the medication cup. Interview on 04/15/26 at 9:00 A.M. with LPN #6 verified she should not touch resident medications with her bare hand. 2.Observation on 04/15/26 at 9:00 A.M. of medication administration per LPN #6 revealed the nurse did not wash or sanitize her hands before administering medications to Resident #76. Interview on 04/15/26 at 9:40 A.M. with LPN #6 confirmed she had not washed or sanitized her hands prior to medication administration to Resident #76. 3. Observation on 04/15/26 at 2:15 P.M. of medication administration revealed LPN #112 sanitized her hands and administered routine medications to Resident #38. Observation on 04/15/26 between 2:05 PM and 2:15 PM of medication administration revealed LPN # 112 sanitized her hands prior to administering medication to Resident # 38. Resident #38 then requested pain medication. LPN #112 went back to the medication cart to retrieve pain medicine for Resident #38 but did not wash or sanitize her hands between tasks. Interview on 04/15/26 at 2:15 P.M. with LPN #112 confirmed she should have sanitized her hands prior to each medication administration. Review of the facility policy titled Medication Administration undated revealed the first step in medication administration was to wash hands and to wash hands prior to proceeding to the next resident during medication administration.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on medical record review, staff interview, and review of the facility policy, the facility failed to ensure that residents were offered the pneumococcal vaccine upon admission and annually. This affected three residents (Resident #22, #38, and Resident #2) of five residents reviewed for vaccines. The facility census was 77 residents.Findings include: 1. Review of the medical record for Resident #22 revealed an admission date of 05/21/18 with diagnoses including alcoholic cirrhosis of liver without ascites, unspecified dementia, and schizophrenia. Review of the medical record for Resident #22 revealed the resident received one pneumonia vaccine on 10/17/25 and the facility did not offer additional pneumonia vaccines. 2. Review of the medical record for Resident #2 revealed an admission date of 03/14/26 with diagnoses including anoxic brain damage, hypertension, and chronic diastolic heart failure. Review of the medical record for Resident #2 revealed the resident was not offered the pneumonia vaccine nor the influenza vaccine upon admission. 3. Review of the medical record for Resident #38 revealed an admission date of 03/13/24 with diagnoses including chronic obstructive pulmonary disease, major depressive disorder, and diabetes mellitus. Review of the medical record for Resident #38 revealed the resident was not offered the pneumonia vaccine upon admission. Interview on 04/16/26 at 9:30 A.M with the Director of Nursing (DON) confirmed Resident #22 did not receive nor was offered the pneumonia vaccine after 10/17/25, Resident #2 did not receive nor was offered the pneumonia or influenza vaccines, and Resident #38 did not receive nor was offered the pneumonia vaccine. Review of the facility policy titled Pneumococcal Vaccine dated January 2026 revealed all residents would be offered pneumonia vaccines to aid in preventing infection.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on medical record review, staff interview, and review of the facility policy, the facility failed to offer Coronavirus (COVID-19) vaccines to residents upon admission and annually. This affected two residents (Resident #2 and Resident #38) of five residents reviewed for vaccines. The facility census was 77 residents.Findings include: 1.Review of the medical record for Resident #2 revealed an admission date of 03/14/26 with diagnoses including anoxic brain damage, hypertension, and chronic diastolic heart failure. Review of the medical record for Resident #2 revealed the resident was not offered the COVID-19 vaccine upon admission. 2. Review of the medical record for Resident #38 revealed an admission date of 03/13/24 with diagnoses including chronic obstructive pulmonary disease, major depressive disorder, and diabetes mellitus. Review of the medical record for Resident #38 revealed the resident was not offered the COVID-19 vaccine upon admission. Interview on 04/16/26 at 9:30 A.M with the Director of Nursing (DON) confirmed Residents #2 and #38 were not offered the COVID-19 vaccine upon admission. Review of the facility policy titled COVID-19 Protocols dated October 2025 revealed residents would be educated on the risks and benefits of the COVID-19 vaccination and would be offered the vaccination. Vaccination information should be documented in the resident's medical record.