

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366426	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/16/2026
NAME OF PROVIDER OR SUPPLIER Woods on French Creek Nursing & Rehab Center The		STREET ADDRESS, CITY, STATE, ZIP CODE 37845 Colorado Avenue Avon, OH 44011	
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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews and facility policy review, the facility failed to ensure care plans were developed and updated specifically to the individualized needs of the resident. This affected two residents (Resident #9 and #79) out of 18 residents reviewed for care plans. The facility census was 67. Findings include: 1. Review of the medical record revealed Resident #79 was admitted to the facility on [DATE] and discharged on 01/27/26. Review of the admission pressure injury condition report dated 12/16/25 revealed an unstageable dark purple/red area on Resident #79's sacrum. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #79 was admitted with an unstageable pressure ulcer. Review of the non-pressure wound condition report dated 01/26/26 identified Resident #79 had two open wounds to the right mid-thigh, one measuring 1.2 centimeters (cm) length, 0.5 cm width and 0.5 cm depth, and the other measured 0.7 cm length, 0.5 cm width and 0.5 cm length. Review of the care plan initiated 12/17/25 revealed Resident #79 was at risk for developing alteration in skin integrity. Interventions included providing skin assessment, elevating heels, assisting with turning and repositioning, inspecting skin, and notifying the physician of changes. The care plan did not identify Resident #79 had an unstageable wound to the sacrum on admission or the development of two open wounds to the mid-thigh and its subsequent needs or services. Interview on 06/16/26 at 9:47 A.M. with the wound Certified Nurse Partitioner (CNP) #720 stated she was consulted on 01/27/26 for Resident #79's wounds which were previously healed surgical incisions reopened and draining fluid. CNP #720 ordered antibiotics, a wound treatment dressing, and referred the resident to orthopedics for a follow-up evaluation. Interview on 06/16/26 at 1:30 P.M. with Director of Nursing (DON) verified a wound care plan specific to Resident #79's wound care needs and services was not implemented. 2. Review of the medical record for Resident #9 revealed he was admitted to facility on 02/27/26 with (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	diagnoses of encephalopathy, dysphagia, gastrostomy status, and severe protein-calorie malnutrition. Review of the most recent MDS assessment dated [DATE] revealed Resident #9 had a Brief Interview for Mental Status (BIMS) of six which indicated severe cognitive impairment. The resident required substantial assistance for all activities of daily living, had an indwelling urinary catheter and was always incontinent of bowels. Review of progress notes from 02/27/26 through 06/16/26 revealed resident had a gastrostomy tube placed on 03/19/26 at the hospital. Review of the hospital after visit summary dated 03/26/26 revealed discharge instructions to place a single layer of four-by-four gauze under the gastrostomy tube bumper and avoid stacking multiple layers of gauze under it. Review of the care plan updated 05/27/26 revealed no focus area, goals, or interventions related to the presence of a gastrostomy tube, or the care and management of the device. Interview with Administrator and Infection Control Nurse #678 on 06/16/26 at 11:20 A.M. verified Resident #9's care plan did not include any goals and interventions specific to the gastrostomy tube or the care and management of the gastrostomy tube. Review of facility policy titled, Care Conference revised on 03/20/24, revealed the facility's interdisciplinary team shall periodically review the resident's care plan and make necessary revisions based on the goals, preferences, and needs of the resident. This deficiency represents non-compliance investigated under Complaint Number 2705952.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide adequate care and treatment for Resident #9's gastrostomy tube. This affected one resident (Resident #9) out of two residents reviewed for enteral feeding. The census was 67. Findings include: Review of the medical record for Resident #9 revealed he was admitted to facility on 02/27/26 with diagnoses of encephalopathy, dysphagia, gastrostomy status, and severe protein-calorie malnutrition. Review of the most recent MDS assessment dated [DATE] revealed Resident #9 had a Brief Interview for Mental Status (BIMS) of six which indicated severe cognitive impairment and required substantial assistance for all activities of daily living. Review of progress notes from 02/27/26 through 06/16/26 revealed resident had a gastrostomy tube (a flexible tube through the abdominal wall into the stomach used for the delivery of liquid and nutrition) placed on 03/19/26 at the hospital. Review of the hospital after visit summary dated 03/26/26 revealed discharge instructions to place a single layer of four-by-four gauze under the gastrostomy tube bumper and avoid stacking multiple layers of gauze under it. Review of the progress notes from 02/27/26 through 06/16/26 revealed Resident #9 was admitted to hospital on [DATE] for a clogged nasogastric feeding tube (a medical tube through the nose directly into the stomach used for temporary feeding). A gastrostomy tube was placed while at the hospital on [DATE] and Resident #9 was discharged back to facility on 03/24/26 with discharge instructions to place a single layer of four-by-four gauze under the gastrostomy bumper and avoid stacking multiple layers of gauze under it. Review of the physician orders, and the medication and treatment administration records since Resident #9's admission revealed no orders or evidence of the care and management of the gastrostomy tube. However, there was an order for daily nocturnal enteral feedings of Isosource 1.5 Cal (a calorically dense nutrition formula) at 60 milliliters (ml) per hour for nine hours. Review of the care plan updated 05/27/26 revealed no focus area, goals, or interventions related to the presence of a gastrostomy tube, or the care and management of the device. Observation on 06/15/26 at 12:00 P.M. of Resident #9's gastrostomy tube with Registered Nurse (RN) #682 during medication administration revealed the resident had a patent gastrostomy tube that was clamped. The gastrostomy stoma site (surgical opening in the skin) was open to air and had some dried crusting around the site. There was no split gauze dressing observed covering the stoma site. Interview at the time of the observation with RN #682 stated Resident #9 has had the gastrostomy tube for a while after a previous hospitalization in March 2026. Resident #9 received nocturnal enteral feedings of Isosource 1.5 Cal at 60 ml per hour for nine hours. Resident #9 was now able to also tolerate a mechanical soft diet but continued to receive the nocturnal enteral feedings for protein-calorie malnutrition. RN #682 confirmed Resident #9 did not have specific orders for the access, care, or management of the gastrostomy tube. Interview with Director of Nursing on 06/15/26 at 12:30 P.M. verified there were no active orders for the access, care, and management of Resident #9's gastrostomy tube, and the care plan did not contain any goals or interventions specific to it.		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to timely act upon pharmacist recommendations to address any medication irregularities in the medical record. This affected one resident (Resident #2) of six residents reviewed for unnecessary medications. The facility census was 67. Findings include: Resident #2 was admitted to the facility on [DATE] with diagnoses that included other seizures, major depressive disorder and type one diabetes. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #2 had moderate cognitive impairment and required assistance of one staff person for completing her activities of daily living (ADLs). The assessment also noted no verbal or physical behaviors toward staff or others. Review of the physician orders for April 2026 and May 2026 revealed Resident #2 had an order dated 04/23/26 for Haldol (an antipsychotic medication used to treat severe agitation, hallucinations, delusions or other psychotic symptoms) 1 milligram (mg) for anoxic brain damage (a brain injury caused when the brain does not get enough oxygen, which can affect thinking, movement, speech, memory, or consciousness). The order was subsequently discontinued on 06/06/26. Review of the pharmacy recommendation dated 05/13/26 revealed the facility pharmacist noted Resident receives haloperidol 1 mg TID (three times daily). Could we update this antipsychotic order to include an accepted diagnosis for use? Resident #2's primary care physician noted on the recommendation to ask psych. Additional review of Resident #2's medical record revealed no changes to Resident #2's Haldol order or diagnoses. Interview with the Assistant Director of Nursing (ADON) #678 on 06/15/26 at 7:11 A.M. verified the facility did not engage its psychiatrist or another provider regarding Resident #2's pharmacy recommendation from 05/13/26.		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and review of the Food and Drug Administration (FDA) medication guide, the facility failed to ensure antipsychotic medications had a valid clinically appropriate indication for use. This affected one resident (Resident #2) of six residents reviewed for unnecessary medications. The facility census was 67. Findings include: Resident #2 was admitted to the facility on [DATE] with diagnoses that included other seizures, major depressive disorder, and type one diabetes. Review of the most recent Minimum Data Set (MDS) assessment, dated 04/20/26, revealed Resident #2 had moderate cognitive impairment and required assistance of one staff person for completing activities of daily living (ADLs). The assessment also noted no verbal or physical behaviors toward staff or others. Review of the physician orders for April 2026 and May 2026 revealed Resident #2 had an order dated 04/23/26 for Haldol, an antipsychotic medication used to treat severe agitation, hallucinations, delusions, or other psychotic symptoms, 1 milligram (mg) for anoxic brain damage, a brain injury caused when the brain does not get enough oxygen, which can affect thinking, movement, speech, memory, or consciousness. The order was subsequently discontinued on 06/06/26. Review of behavior tracking records for April 2026, May 2026, and June 2026 revealed one single instance of crying and another single instance of yelling and screaming. No other behaviors were marked on Resident #2's behavior tracking sheet. Review of the Food and Drug Administration (FDA) medication guide for Haldol revealed Haldol was indicated for use to treat schizophrenia and was indicated for the control of tics and vocal utterances of Tourette's disorder. Review of Resident #2's medical record revealed no diagnoses of schizophrenia or Tourette's disorder. The guide also noted Haldol should be given cautiously to individuals with seizure disorders because Haldol may lower the convulsive threshold. Review of the pharmacy recommendation dated 05/13/26 revealed the facility pharmacist noted, Resident receives haloperidol 1 mg TID (three times daily). Could we update this antipsychotic order to include an accepted diagnosis for use? Resident #2's primary care physician noted on the recommendation to ask psych. No changes to Resident #2's Haldol order were noted in the medical record. Interview with Assistant Director of Nursing (ADON) #678 on 06/15/26 at 7:11 A.M. verified Resident #2's Haldol was administered between 04/23/26 and 06/06/26 without an appropriate diagnosis or indication for use.		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation and staff interview, the facility failed to ensure a safe, clean and sanitary laundry room. This had the potential to affect all the residents residing in the facility. The census was 67. Findings include: Observation on 06/14/26 at 9:52 A.M. of the laundry room with Laundry Aid (LA) #689 revealed in the dirty laundry area there was an empty large laundry cart used to keep dirty laundry. The cart had crumbled up paper towels and debris located at the bottom of the cart. The washer area had a plastic bag of garbage laying on the floor in the middle of the room. The floor in the area had multiple areas of splattered dirt and debris along both sides of the washing machines and throughout the laundry area. There was a window screen sitting under the window that was covered with lint and dirt. Behind the washer was a drain. Next to the drain contained a large pile of an unknown white substance. In the clean laundry area, there was a dryer filled with clothing which had a lint screen that was heavily covered with lint. Under the lint screen contained several large piles of lint. The floor in the clean area had multiple areas of splattered dirt and debris. The dryer filter cleaning log revealed there was no documentation for lint removal on 06/14/26 at 6:00 A.M., 7:00 A.M., 8:00 A.M or 9:00 A.M. Interview at 10:00 A.M. with LA #689 verified the dirty floors and lint in the dryer. LA #689 stated she completed drying two loads of laundry and has not cleaned the lint filters. Interview on 06/14/2026 at 1:01 P.M. with the Director of Environmental Services #637 stated the late shift staff were responsible for cleaning the floors Monday through Friday. Staff were expected to clean lint screens after every load.		