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	12/01/2025

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 - 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. (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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, staff interview, and facility policy review, the facility failed to ensure a resident's falls were thoroughly investigated, properly documented in the medical record, a fall risk assessment was completed, a post-fall evaluation completed and assure immediate fall interventions were implemented. This affected one (Resident #39) of the three residents review for falls. The facility also failed to ensure residents were assessed following a fall. This affected one (Resident #49) out of three residents reviewed for falls. The facility census was 75. Findings include: 1) Review of the medical record for Resident #49 revealed the resident was admitted to the facility on [DATE]. Diagnoses included dementia, delusional disorder, essential primary hypertension, major depressive disorder, hypothyroidism, osteoarthritis, urinary tract infection, and Alzheimer's disease. Review of the Minimum Data Set (MDS) assessment dated [DATE] for Resident #49, revealed the resident was cognitively impaired. Resident #49 was dependent on staff for activities of daily living (ADL). Review of the progress note for Resident #49 dated 09/22/25 at 3:05 P.M., revealed the resident had an unwitnessed fall and was found on the floor near her roommate's bed. There was no documented fall interventions listed, or a post fall evaluation completed. Review of the fall care plan for Resident #49 revised on 10/08/25, revealed the resident was at risk for falls related to confusion, impaired safety awareness, incontinence, and psychoactive medications. The following interventions were listed: non-skid fall strips to the sides of resident's bed, complete a fall risk assessment per facility policy, anticipate the resident's needs, review past falls and attempt to determine contributing factors, promote a safe environment, keep the resident's call light accessible, and non-skid strips to the open side of Resident #49's bed. Review of the progress note for Resident #49 dated 11/21/25 at 3:51 P.M., revealed the resident had a fall on 11/21/25 at 2:30 A.M. There was no documentation related to this fall at the time of the fall. The resident was not acting at her baseline, and the resident was sent to the emergency room (ER) for evaluation. Resident #49 was admitted to the hospital with a diagnosis of UTI. There was no documented evidence of the thorough investigation being completed for this fall. Interview on 11/24/25 at 2:23 P.M., the Director of Nursing (DON) verified Resident #49 had a fall on 11/21/25 at 2:30 A.M. The DON also verified that the facility failed to complete a thorough investigation of fall. The DON stated a fall investigation should have started when the incident occurred at 2:30 A.M. and Licensed Practical Nurse (LPN) #176 failed to document the fall and failed to complete the proper paperwork related to the fall. The DON also verified the fall on 11/21/25 at 2:30 A.M. was not listed on the incident / accident log due to an investigation being completed. The DON stated LPN #176 did not complete the proper documentation and failed to complete a fall risk assessment and a post fall evaluation. The DON stated she did not have very much information to provide related to Resident #49's fall on 11/21/25 at 2:30 A.M. and stated she only knew Resident #49 was found on the floor next to her bed on the night of 11/21/25. Interview on 11/24/25 at 4:03 P.M., LPN #176 stated she was the nurse responsible for Resident #49 on 11/21/25 when Resident #49 was found on the floor around 2:30 A.M. LPN #176 stated Resident #49 was found on the floor with blood coming from her nose and a hematoma over her left eye. LPN #176 stated she called 911 for Resident #49 to be sent to the emergency room. LPN #176 stated when Emergency medical Services (EMS) arrived, they felt Resident #49 was stable and did not need to be taken to the ER for evaluation. LPN #176 verified she did not start an accident/incident investigation, completed a fall risk assessment, properly documented the fall in Resident #49's chart, and put an immediate intervention in place. LPN #176 stated she was behind on charting and focused on other assignments and could not complete the required tasks after Residents #49's fall. A subsequent interview on 12/01/25 at 9:46 A.M., the DON verified Resident #49 had a fall on 09/22/25 and the staff failed to complete a post-fall evaluation and implement any new fall interventions. Observation on 12/01/25 at 10:40 A.M. with Certified Nursing Assistant (CNA) #135, revealed Resident #49 was seated in her wheelchair next to her bed. Resident #49's call light was not within reach and was resting on the wall across the room and there were no non-skid fall strips next to Resident #49's bed per orders. Interview CNA #135 at the same time verified Resident #49's call light was located across the room from Resident #49 and rested on the switch on the wall and stated there should be non-skids strips on the floor. Subsequent interview on 12/01/25 at 11:58 P.M., the DON stated Resident #49 should always have her call light within reach to aid in the prevention of a fall. The DON stated Resident #49 had a room change recently and stated the staff forgot to apply the non- skid strips to the floor when the resident changed rooms. 2) Review of the

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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 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 77. 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.