STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365221	A. Building B. Wing	06/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edgewood Manor of Greenfield	850 Nellie Street Greenfield, OH 45123

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on medical record review, staff interview, and review of the facility policy, the facility failed to notify the resident and the resident's representative of a change in medical condition. This affected one (Resident #10) of three residents reviewed for notification of change in medical condition. The facility total census was 46 residents. Findings include: Review of the medical record for Resident #10 revealed an admission date of 08/24/25 with diagnoses including chronic obstructive pulmonary disease, diabetes, anxiety disorder, peripheral vascular disease, and vascular dementia. Review of the physician's note for Resident #10 dated 06/16/26 at 11:59 P.M. revealed the resident was readmitted with a non-pressure chronic ulcer due to peripheral artery disease after post-acute care and vascular surgery and debridement on 06/011/26 resulting in a wound vac treatment placement. Review of the nursing note for Resident #10 dated 06/15/26 at 5:02 P.M. revealed the resident returned from hospital a hospital stay with the left lower extremity wrapped with dressing. Review of the nursing notes for Resident #10 dated 06/15/26 to 06/23/25 revealed they did not include documentation of notification to the resident and/or the resident's representative of changes to the resident's wound. Interview on 06/23/26 at 9:12 A.M with the Director of Nursing, (DON) confirmed Assistant Director of Nursing (ADON) #30 notified her on 06/20/26 early in the morning after midnight that Licensed Practical Nurse, (LPN) # 54 had found fly maggots in Resident #10's dressing to the left leg. The DON stated the facility staff should have notified Resident #10 and/or the resident's representative of the change in the wound. Interview on 06/23/26 at 9:31 A.M with ADON #30 verified LPN #54 had contacted her in the early hours of 06/20/26 and reported the staff found fly maggots Resident #10's leg wound. ADON #30 verified the facility staff had not notified Resident #10 nor the resident's representative of the wound change observed on 06/19/26 Interview on 06/23/26 at 12:52 P.M. with LPN #54 confirmed early on 06/20/26 she discovered fly maggots in Resident #10's leg wound when she removed the wound vac dressing. LPN #54 stated she asked the Agency Nurse (AN) #80 and Certified Nursing Assistant (CNA) # 25 to observe the fly maggots under the dressings. LPN #54 stated Resident #10 had asked several times during the dressing change why so many staff were looking at her wounds. LPN #54 verified she did not tell the Resident #10 and she did not contact the family representative regarding the maggots to the wound. Interview on 06/23/26 at 1:14 P.M. with CNA #25 verified on 06/20/26 in the early hours PN #54 called her to Resident #10's room and she observed approximately 12 fly magots smaller than a grain of rice on the surface of the wound and five fly maggots under the wound vac treatment. CNA #25 stated Resident #10 asked several times why staff were looking at her wounds. CNA #25 verified neither she nor LPN #54 told Resident #10 of the fly maggots in her wounds. Review of facility policy titled Change in a Resident's Condition or Status dated 2001 revealed the facility should promptly notify the resident, his or her attending physician and the resident's representative of changes in the resident's medical condition or status.

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **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 provide wound treatments as ordered by the physician and per professional standards of nursing practice. This affected three (Residents #10, #32 and #20) of three resident reviewed for wound care. The facility census was 46 residents. Findings include:1. Review of the medical record for Resident #32 revealed an admission date of 04/22/26 with diagnoses including fracture of the left femur, diabetes, and venous insufficiency. Review of the Minimum Data Set (MDS) assessment for Resident #32 dated 06/15/26 revealed the resident had intact cognition. Review of the physician's orders for Resident #32 dated June 2026 revealed an order to cleanse the left heel with wound cleanser, pat dry, apply Betadine and pad and kerlix once daily on day shift. Review of the nurse progress notes for Resident #32 dated 06/20/26 to 06/23/26 revealed the notes did not include documentation regarding why the resident's dressing to the left heel was not changed as ordered. Observation on 06/23/26 at 9:35 A.M. revealed the treatment to Resident 32's left heel was dated 06/20/26 with no time noted on the treatment. Interview on 06/23/26 at 9:35 A.M. with Assistant Director of Nursing (ADON) #30 verified Resident #32 had a treatment to the left heel ordered to be completed once daily. ADON #30 confirmed Resident #32's dressing was dated 06/20/26 indicating the treatment had not been completed daily as ordered. ADON #30 stated nurses should label wound treatments with the nurse's initials and the date and time of the treatment. 2. Review of the medical record for Resident #10 revealed an admission date of 08/24/25 with diagnoses including chronic obstructive pulmonary disease, diabetes, anxiety disorder, peripheral vascular disease, and vascular dementia. Review of physician's orders for Resident #10 revealed an order dated 06/19/26 for a daily dressing change wound treatment to the resident's left lower extremity. Observation on 06/23/26 at 4:20 P.M. of Resident #10 with Wound Nurse Practitioner (WNP) #70 revealed the dressing to the resident's left lower extremity was initialed by a nurse and dated 06/23/26, but there was no time noted on the treatment. Interview on 06/23/26 at 4:20 P.M. with WNP #70 verified the wound treatment to Resident #10's left lower extremity had no time noted on the treatment. WNP #70 stated it is nursing standard of practice for a nurse to label the wound dressing with the nurse's initials and the date and time of the treatment. 3. Review of the medical record for Resident #20 revealed the resident was admitted to the facility on [DATE] with diagnoses including diabetes, thrombosis of deep veins, and history of cardiac arrest. Review of the MDS assessment for Resident #20 dated 05/26/26 revealed the resident had severely impaired cognition and was dependent of staff for all care. Review of the physician's orders for Resident #20 dated June 2026 revealed an order to cleanse the left heel with wound cleanser, pat dry, apply Betadine, apply pad and Kerlix gauze once daily on day shift. Observation on 06/23/26 at 10:07 A.M. revealed Resident #20 had a treatment to the left heel dated 06/22/26 but the there was no time noted. Interview on 06/23/26 at 10:07 A.M. with Licensed Practical Nurse (LPN) # 9 verified Resident #20's wound dressing was not labeled with the time of the treatment. LPN #9 stated the time should be listed on the dressing as a nursing standard of practice for wound treatments. Interview on 06/23/26 at 3:35 P.M. with Regional Nurse (RN)#75 verified it was a standard of nursing practice for nurses to write the initials of the nurse performing the treatment and the date and time of the treatment on the dressing. Review of facility policy titled Wound Treatment Management dated 2025 revealed the facility would provide evidence based treatment as ordered by the physician in accordance with current standards of practice. This deficiency represents noncompliance investigated under Complaint Number 3049933.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on medical record review, staff interview. and review of the facility policy, the facility failed to document changes in a resident's medical condition in the medical record. This affected one (Resident #10) of three residents reviewed for documentation of a change in condition. The facility total census was 46 residents. Findings include: Review of the medical record for Resident #10 revealed an admission date of 08/24/25 with diagnoses including chronic obstructive pulmonary disease, diabetes, anxiety disorder, peripheral vascular disease, and vascular dementia. Review of the physician's note for Resident #10 dated 06/16/26 at 11:59 P.M. revealed the resident was readmitted with a non-pressure chronic ulcer due to peripheral artery disease after post-acute care and vascular surgery and debridement on 06/011/26 resulting in a wound vac treatment placement. Review of the nursing note for Resident #10 dated 06/15/26 at 5:02 P.M. revealed the resident returned from hospital a hospital stay with the left lower extremity wrapped with dressing. Review of the nursing notes for Resident #10 dated 06/15/26 to 06/23/25 revealed they did not include documentation of notification to the resident and/or the resident's representative of changes to the resident's wound. Interview on 06/23/26 at 9:12 A.M with the Director of Nursing, (DON) confirmed Assistant Director of Nursing (ADON) #30 notified her on 06/20/26 early in the morning after midnight that Licensed Practical Nurse, (LPN) # 54 had found fly maggots in Resident #10's dressing to the left leg. The DON stated ADON #30 told her Regional Nurse, (RN) # 75 had been contacted and had directed LPN #54 to not document the change in condition of the Resident #10 wounds. Interview on 06/23/26 at 9:31 A.M with ADON #30 verified LPN #54 had contacted her in the early hours of 06/20/26 and reported the staff found fly maggots Resident #10's leg wound. ADON #30 stated she contacted RN #75 who directed no documentation should be recorded in the medical record of the fly maggots to Resident #10's leg wound. ADON #30 verified any change of condition should be documented in the nursing notes timely and there should be documentation of notification provided to the resident and /or family representative and physician of the change in condition. Interview on 06/23/26 at 12:52 P.M. with LPN #54 confirmed early on 06/20/26 she discovered fly maggots in Resident #10's leg wound when she removed the wound vac dressing. LPN #54 stated she asked the Agency Nurse (AN) #80 and Certified Nursing Assistant (CNA) # 25 to observe the fly maggots under the dressings. LPN #54 stated on 06/20/26 ADON #30 had directed her per the direction of the RN #75 to not document the wound changes to Resident #10's wound in the nursing progress notes. LPN #54 verified the wound condition change and notifications should have been documented in the nursing progress notes. Interview on 06/23/26 at 1:14 P.M. with CNA #25 verified on 06/20/26 in the early hours LPN #54 called her to Resident #10's room and she observed approximately 12 fly maggots smaller than a grain of rice on the surface of the wound and five fly maggots under the wound vac treatment. Interview on 06/23/26 at 3:35 P.M. with RN #75 denied she had given directions to the ADON #30 for LPN #54 to not document on Resident #10's wound changes found on 06/20/26. RN #75 stated nursing documentation should be timely and accurate to what the nurse had observed, assessed and reported. Review of facility policy titled Change in a Resident's Condition or Status dated 2001 revealed the nurse should record in the resident's medical record information relative to changes in the resident's medical condition.