STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365362	A. Building B. Wing	09/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Green Hills Center	6557 US 68 South West Liberty, OH 43357

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47988 Based on medical record review, review of the facilities Self-Reported Incident (SRI) including investigation, observations, staff interview, and review of the facilities abuse policy, the facility failed to ensure a resident was free from physical abuse. This affected one (#200) of four residents reviewed for abuse. The facility census was 66. Findings include: Review of the medical record for Resident #200 revealed an admitted [DATE]. Diagnoses included Alzheimer's disease with late onset, dementia with psychotic disturbance, major depression, anxiety, mild neurocognitive disorder, psychosis, and primary insomnia. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #200's cognition was impaired. Resident #200 required substantial/maximal assistance from staff with eating and shower/bathe and dependent on staff for toileting, upper and lower body dressing, and personal hygiene. Review of the revised care plan dated 08/06/24 revealed Resident #200 was at risk for social isolation related to dementia, psychotic disorder and new environment. Resident #200 should be encouraged to participate in recreational activities, social situations, and provide positive enforcement with resident participates in activities. Review of the facilities SRI dated 08/24/24 revealed an allegation of physical abuse when State tested Nursing Aide (STNA) #3 positioned a desk chair to block Resident #200's wheelchair from moving back away from the counter. Resident #202 reported two STNAs sitting at the nurses' station and were pushing Resident #200's head down onto the pillow positioned on the counter periodically trying to get her to sleep. The facility substantiated the allegation of abuse by verified evidence and notified the local police department (LPD) that staff physically abused Resident #200. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365362	A. Building B. Wing	09/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Green Hills Center	6557 US 68 South West Liberty, OH 43357

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's investigation and witness statements dated 08/24/24 revealed on 08/24/24, STNA #44 and Hospitality Aide #33 reported to work at 5:49 A.M. to find Resident #200 sitting in her wheelchair at the nurses' station desk with STNA #3 (who worked for agency staffing) sitting next to Resident #200. A desk chair was positioned to block Resident #200's wheelchair from moving back away from the counter blocking her movement. Witness statement from STNA #44 stated she witnessed Resident #200's wheelchair lodged with a chair underneath the wheelchair wheel. Witness statement from STNA #3 acknowledged placing the chair in that position. The witness statement from Resident #202 revealed she was awakened by noise at the nurses' station and got up about 2:00 A.M. and observed two STNAs sitting at the nurses' station and were pushing Resident #200's head down onto the pillow positioned on the counter periodically trying to get her to sleep. Resident #200's wheelchair was pushed up to the counter and the desk chair was blocking her chair. Review of the LPD report dated 08/24/24 at 3:00 P.M. documented a report of allegation of abuse had occurred overnight, to which an STNA held Resident #200's head down onto a pillow to make the resident sleep and placed a desk chair against the resident's wheelchair from moving away from the desk. Further documentation on 08/29/24 at 4:00 P.M. reported the Administrator contacted the LPD stating the allegation was substantiated and wanted the police to investigate as a criminal matter. Observation on 09/04/24 from 8:47 A.M. to 9:22 A.M. revealed Resident #200 sitting at the nurse's station and Resident #200 was asleep. Interview on 09/04/24 at 9:50 A.M. with the Director of Nursing (DON) verified Resident #200 was physically abused by two STNAs on 08/24/24. Interview on 09/04/24 at 11:30 A.M. with the Administrator verified Resident #200 was physically abused by two STNAs on 08/24/24. The Administrator stated the SRI was substantiated after the investigation found that an agency staff restrained Resident #200 in wheelchair using another chair to block her ability to move the chair or stand. The facility was unable to obtain statements from the two Alleged Perpetrators, STNA #3 and STNA #4 as they were uncooperative with the investigation. STNA #3 and STNA #5 were put on the Do Not Return and were barred from picking up shifts at the facility. Attempts to contact STNAs #3 and #4 during the survey were unsuccessful. Review of the policy titled Abuse and Neglect with a revision date of 11/21/16, revealed abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. This deficiency represents non-compliance investigated under Control Number OH00157383 and Complaint Number OH00157352.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365362	A. Building B. Wing	09/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Green Hills Center	6557 US 68 South West Liberty, OH 43357

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47988 Based on medical record review, observations, staff interviews, and review of the facility policy, the facility failed to ensure a resident's plan of care was revised when changes were made for the resident's comfort and positioning. This affected one (#200) of four residents reviewed for plan of care. The facility census was 66. Findings include: Review of the medical record for Resident #200 revealed admitted [DATE]. Diagnoses included Alzheimer's disease with late onset, dementia with psychotic disturbance, major depression, anxiety, mild neurocognitive disorder, psychosis, and muscle weakness. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #200 had cognition impairment. Resident #200 was dependent on staff for upper and lower body dressing and personal hygiene. Review of Resident #200's comprehensive plan of care dated 05/06/24 revealed it was silent for the utilization of a custom wheelchair/ tilt and space wheelchair. Review of Resident #200's physician order revealed it was silent for orders for a tilt and space wheelchair. Interview with State tested Nursing Aide STNA #11 on 09/04/24 from 8:46 A.M. verified Resident #200 was in a tilt and space wheelchair with no footrests. STNA #11 stated Resident #200's wheelchair was supposed to have footrest but STNA #11 had not put them on yet. Observation on 09/04/24 from 8:47 A.M. to 9:22 A.M. revealed Resident #200 was asleep and sitting at the nurse's station in a tilt-space wheelchair, with no footrests and both feet dangling with the inability to touch the floor. Interview on 09/04/24 at 9:50 A.M. with the Director of Nursing (DON) verified Resident #200 was placed in the custom- tilt and space wheelchair after Resident #200 received therapy for positioning and comfort. Interview on 09/04/24 at 11:15 A.M. with Occupational Therapist (OT) #19 stated Resident #200 was seen by therapy for positioning/comfort and they placed her in the custom tilt and space wheelchair. OT #19 verified Resident #200 was to have wheelchair footrest for feet and tilted at a slight angle for comfort. Resident #200 was discharged from OT on 08/22/24. Interview on 09/05/24 at 3:30 P.M. with License Practical Nurse (LPN) #10 verified Resident #200's plan of care, and physician orders were silent for documentation of the utilization of a custom- tilt and space wheelchair with wheelchair foot rests. LPN #10 verified the care plan should have been updated when therapy placed Resident #200 in the chair. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365362	A. Building B. Wing	09/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Green Hills Center	6557 US 68 South West Liberty, OH 43357

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Comprehensive Resident Centered Care Plans dated 11/01/18 revealed the care plans are modified between care plan conferences with appropriate to meet the resident's current needs, problems and goals. This was an incidental finding discovered during the course of the complaint investigation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365362	A. Building B. Wing	09/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Green Hills Center	6557 US 68 South West Liberty, OH 43357

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47988 Based on observation, record review, staff interview, and facility policy review the facility failed to ensure medications were administered according to physician orders, resulting in a medication error rate exceeding five percent (%). 32 opportunities were observed with two medication errors, resulting in 6.3% error rate. This affected one (Resident #450) of four residents observed during the medication administration. The facility census was 66. Findings include: Review of the medical record for Resident #450 revealed an admitted [DATE]. Diagnoses included constipation. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #450 had severe cognitive impairment. Review of the physician orders dated September 2024 revealed Resident #450 was to receive Senna concentrate 8.6 milligrams (mg) give two tablets orally two times a day for constipation. The physician orders dated September 2024 were silent for physician orders for two bisacodyl (treats constipation) five mg tablets. Observation and interview on 09/05/24 between 8:25 A.M. to 8:40 A.M. revealed Licensed Practical Nurse (LPN) #25 was observed administering medication to Resident #450. At the time of the administration, LPN #25 provided medications scheduled for 8 A.M. including observation of two bisacodyl five mg tablets being administered to Resident #450. Review of Resident #450's medication administration record (MAR) with LPN #25 confirmed she documented she administered two Senna concentrate 8.6 mg tablets for 8:00 A.M. on 09/05/24. LPN #25 verified she had given the wrong medication to Resident #450. LPN #25 verified she administered two bisacodyl five mg tablets instead of two senna concentrate 8.6 mg tablets. LPN #25 verified Resident #450 did not have a physician's order for bisacodyl. Review of the undated facility policy titled Medication Administration General Policies and Procedures revealed medications are administered as prescribed in accordance with nursing principles and practices and only by persons legally authorized to do so. This deficiency represents non-compliance investigated under Complaint Number OH00157352.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365362	A. Building B. Wing	09/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Green Hills Center	6557 US 68 South West Liberty, OH 43357

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47988 Based on record review, facility policy review and resident and staff interviews, the facility failed to ensure medications were administered to the residents without any significant medication errors. This affected two (#100 and #125) of six residents reviewed for medication administration. The facility census was 66. Findings include: 1. Review of the medical record for Resident #100 revealed an admitted [DATE]. Diagnoses included vascular dementia, protein calorie malnutrition, and gastrointestinal hemorrhage. Resident #100 did not have a diagnosis of diabetes mellitus. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #100 had cognitive impairment. Review of Resident #100's physician's orders revealed they were silent for physician orders for Lantus insulin, melatonin (sleep aide), Pepcid (treats heartburn), Risperdal (antipsychotic) or trazodone (antidepressant and sedative). Resident #100's medical record did not have any documentation of a medication error on 07/29/24 and the monitoring of the resident status post the medication error. Review of the facilities Resident Medication Incident Report dated 07/29/24 revealed Resident #100 received another resident's insulin during the 8:00 P.M. medication pass. The incident occurred on 07/29/24 at 7:00 P. M., with physician notification at 8:07 P.M. First aid/ treatment was blood sugar every hour and vitals every hour. The possible adverse side effects were complaints of head feeling funny and slurring speech. The follow up to the medication error revealed there were no residual effects, resident to be her normal baseline, and physician notification. Licensed Practical Nurse (LPN) #500 was the agency nurse who administered the wrong medication to Resident #100 on 07/29/24 and marked as a Do Not Return to the facility. There were no physician orders to complete blood sugar and vital signs every hour and no documentation to support this was completed. Interview with Physician #50 on 09/05/24 at 1:30 P.M. verified the staff should have written physician orders for his the order he gave for Resident #100 on 07/29/24, which was to complete blood sugar and vital signs every hour. The physician stated when a resident has a change of a change of condition including medication error/issues relating to a resident, he would expect the nursing staff to assess the resident, document and communicate those findings. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365362	A. Building B. Wing	09/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Green Hills Center	6557 US 68 South West Liberty, OH 43357

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/05/24 at 2:50 P.M. with Nurse Manager (NM) #18 revealed she completed the investigation of the medication error on 07/29/24 with Resident #100 and found that Resident #100 received Resident #300's 8 P.M. medications including, Lantus insulin 20 units, melatonin five milligrams (mg), Pepcid 20 mg, Risperdal 1.5 mg, and trazodone 50 mg. NM #18 verified Resident #100's medical record did not have any documentation of the medication error and the monitoring of the resident after the medication error was identified. NM #18 notified the physician regarding the error and a verbal order was obtained to monitor Resident #100's blood sugar and vital signs and NM #18 verified she did not write the physicians order resulting in only three blood sugars being obtained. NM #18 was unable to recall what the physician order was supposed to be, but verified Resident #100 should have had blood sugar monitoring three more times because of the long-acting effects of the 20 units of Lantus insulin that was administered. 2. Review of the medical record for Resident #125 revealed an admitted [DATE]. Diagnoses included heart failure, chronic obstructive pulmonary disease, osteoarthritis, hypertension, and dementia. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #125 had intact cognition. Review of Resident #125's physician orders revealed they were silent for orders for multivitamin, cetirizine duloxetine (antihistamine), hydrochlorothiazide (diuretic), losartan potassium (treats high blood pressure) and pregabalin (idiopathic neuropathy). Resident #125's medical record did not have any documentation of a medication error on 07/25/24 and the monitoring of the resident status post the medication error. Review of the facilities Resident Medication Incident Report dated 07/25/24 revealed Resident #125 received the roommates 5:00 A.M. medications. The incident occurred on 07/25/24 at 5:00 A.M., with physician notification at 7:55 A.M. on 07/25/24. There was nothing listed under first aid/ treatment. The possible adverse side effect was decreased blood pressure. The follow up included physician notification and monitoring of vital signs. Licensed Practical Nurse (LPN) #500 was an agency nurse and was the nurse who administered the medications to the wrong resident. LPN #500 was sent home and staffing agency was informed of LPN #500's medication error and requested LPN #500 be educated. Interview on 09/05/24 at 9:10 A.M. with Resident #125 stated she was not sure what medications was given to her, but remembers she was given another resident's medications. Resident #125 stated now she pays attention and ask about her medications since the medication error. Interview on 09/05/24 at approximately 2:50 P.M. with Nurse Manager (NM) #18 stated she completed the investigation of the medication error on 07/25/24 with Resident #125. NM #18 verified Resident #125 received Resident #126's morning medications including, multivitamin one tablet, cetirizine five milligrams (mg), duloxetine 60 mg, furosemide 20 mg, hydrochlorothiazide 25 mg, losartan potassium 50 mg, and pregabalin 25 mg. NM #18 verified nursing should have monitored for adverse reactions of the medication error and should have documented for at least 48 hours after the medication error. NM #18 verified she was unable to provide documentation of such monitoring for Resident #125. Review of the undated facility policy titled Medication Administration General Policies and Procedures revealed medications are administered as prescribed in accordance with nursing principles and practices and only by persons legally authorized to do so. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365362	A. Building B. Wing	09/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Green Hills Center	6557 US 68 South West Liberty, OH 43357

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficiency represents non-compliance investigated under Complaint Number OH00157352.