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	09/11/2025

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

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on record review, resident interview, staff interview, and policy review the facility failed to ensure care conferences were conducted quarterly. This affected four (#12, #38, #39, and #51) of four residents reviewed for care conferences. The facility census was 67. 1.Review of medical record for Resident #12 revealed an admission date of 04/29/25 with diagnoses including but not limited to type two diabetes, congestive heart failure, chronic atrial fibrillation, and major depressive disorder. Review of Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #12 was cognitively intact. Review of care conference notes revealed the last care conference was held on 11/19/24 and only two members of the interdisciplinary team (IDT) were present. 2.Review of Resident #38's medical record revealed an admission date of 12/18/24, diagnoses included cerebral infarction, fistula of stomach and duodenum, ventral hernia, atrial fibrillation, acute gastric ulcer with perforation, type 2 diabetes, dysphagia, gastrointestinal hemorrhage, and bed confinement status. Review of Resident #38's MDS assessment dated [DATE] revealed the resident was cognitively intact. Review of Resident #38's care plan dated 7/17/25 revealed the resident has cognition related issues stemming from episodes of confusion with interventions to encourage resident to make decisions and choices related to care and daily routine. Review of Resident #38 medical records from 1/25 through 9/25 revealed no care conferences were conducted. 3.Review of medical record for Resident #39 revealed an admission date of 08/26/22 with diagnoses including but not limited to type two diabetes, dementia, major depressive disorder, and hypertension. Review of MDS assessment dated [DATE] revealed Resident #39 had moderately impaired cognitive impairment. Review of care conference summary dated 05/20/25 revealed the conference was attended by the Director of Nursing and Activities and the resident representative. The summary form was blank (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	except for the activities section. 4.Review of medical record for Resident #51 revealed an admission date of 05/23/23 with diagnoses including but not limited to chronic obstructive pulmonary disease, essential tremor, hypertension, and emphysema. Review of MDS assessment dated [DATE] revealed Resident #51 was cognitively intact. Review of care conference documentation revealed the last care conference was held on 08/21/23 with no one in attendance besides the social worker. Interview on 09/10/25 at 3:14 P.M. with the Administrator revealed the home office had conducted a mock survey on 08/08/25 and identified an issue with care conferences being completed. The Administrator stated she received the report on 08/20/25 and started education with the IDT on care conferences. The Administrator verified the care conference have not been completed as of the survey date. The Administrator verified that Residents #12, #38, #39, and #51 did not have quarterly care conferences or the appropriate IDT members in attendance. Review of policy titled Comprehensive Care Planning Policy dated 11/13/2017 revealed the facility encourages the resident and/or resident representative to participate in the care planning process.

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview, and policy review the facility failed to ensure resident dignity when giving insulin injections. This affected one (#39) resident of one resident reviewed for insulin injections. The facility census was 67.Review of medical record for Resident #39 revealed an admission date of 08/26/22 with diagnoses including type two diabetes, dementia, and major depressive disorder.Review of Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #39 had moderate cognitive impairment.Review of current physician orders revealed an order initiated on 09/08/25 following the observation in the dining room indicating may give medications, check blood sugar and give insulin in public spaces and dining room.Observation on 09/08/25 at 11:22 A.M. of Registered Nurse (RN #360) revealed the nurse came up to Resident #39 sitting at a table in the dining room and informed the resident she had her insulin to administer. RN #360 proceeded to lift the resident's shirt and administer the insulin in the resident's abdomen. One family member and three other residents were observed sitting at the same table. RN #360 did not have gloves on during the administration of the insulin, nor did she perform hand hygiene prior to administering the insulin.Interview on 09/08/25 at 11:23 A.M. with RN #360 revealed the nurse verified she gave insulin in the dining room with other residents at the table. RN #360 stated she should have pulled the resident away from the table before administering the insulin. RN #360 stated she should have donned gloves prior to administering the insulin.Review of policy provided by the facility titled Subcutaneous injection revised 05/19/2025 revealed perform hand hygiene, provide privacy, explain the procedure to the patient, position the patient and expose the injection site, perform hand hygiene, put on gloves if contact with blood or bodily fluids is likely or if your skin or the patient's skin isn't intact. Gloves are not required for routine subcutaneous injections because they do not protect against needlestick injury.This deficiency represents noncompliance investigated under Complaint Number 2601174.

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review the facility failed to ensure residents were provided written bed hold notices. This affected two (#75 and #78) of three reviewed for hospitalizations. The facility census was 67. 1. Review of Resident #75 medical record revealed an admission date of 6/10/25, diagnoses included acute and chronic respiratory failure with hypoxia, atrial fibrillation, heart failure, hypo-osmolality and hyponatremia, chronic lymphocytic leukemia of B-cell, atherosclerotic heart disease, chronic obstructive pulmonary disease, hypertension, and cerebral infarction. Review of Resident #75's Minimal Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact, required partial assistance with activities, and required a wheelchair for ambulation. Review of Resident #75's care plan dated 6/10/25 revealed the resident was at risk for alteration in their respiratory status related to chronic obstructive pulmonary disease. Interventions included to monitor for shortness of breath, chest pain, or change of condition. Review of Resident #75's progress notes dated 6/18/25 from 9:55 A.M. to 3:14 P.M. revealed the resident was alert and easily fatigued, had increased shortness of breath while on 4 liters of oxygen, was complaining of shortness of breath and was coughing and expelling white and pink tinged sputum. A new order for a chest x-ray was received. Chest x-ray results revealed the resident had bilateral airspace disease with modest pleural effusions, with pneumonia considered due the resident's clinical condition. Further review revealed that the resident's family was contacted and they requested that the resident be transported to the hospital. Review of Resident #75 discharge information revealed no bed hold notice was provided to the resident or their representative. Interview on 9/11/25 at 10:15 A.M. with the Executive Director confirmed the facility did not have documentation to support they provided a bed hold notice to Resident #75 or their representative upon Resident #75's discharge to the hospital. 2. Review of medical record for Resident #78 revealed an admission date of 07/10/25 and discharge date of 08/18/25. Diagnoses included metabolic encephalopathy, type two diabetes, hypertension, congestive heart failure, depression, seizures, and post traumatic seizures. Review of MDS assessment dated [DATE] revealed Resident #78 had moderate cognitive impairment. Review of progress note dated 07/27/25 revealed Resident #78 had a decline in speech, appetite, and alertness. Resident #78 was sent to the hospital and required admission. Family/representative was contacted regarding situation. Review of progress note dated 08/17/25 revealed Resident #78 was sent to the Emergency Department and returned at 10:08 A.M. with a diagnosis of urinary tract infection. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/11/25 at approximately 10:15 A.M. with the Administrator revealed the facility did not provide a bed hold notice for the hospital stay on 07/27/25 or the emergency room visit on 08/17/25. Review of policy titled Bed Hold Policy dated 11/14/2017 revealed all residents/elders and representatives are notified of the bed hold policy at the time of admission, prior to any transfer, therapeutic leave and at time of transfer. If the transfer is emergent, the resident/elder and representative must be notified within 24 hours.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review the facility failed to ensure wounds were assessed weekly for Resident #67, and the facility further failed to ensure treatments were in place and completed per physician order for Resident #52. This affected two (#67 and #52) residents of three residents reviewed for wounds. The facility census was 67. 1.Review of medical record for Resident #67 revealed an admission date of 01/19/25 with diagnoses including but not limited to acute transverse myelitis in demyelinating disease of central nervous system, paraplegia, pressure ulcer of right buttock stage four (severe form of skin damage involving full-thickness tissue loss exposing muscle, tendon, or bone), and major depressive disorder. Review of Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #67 was cognitively intact. Resident #67 had a stage four pressure ulcer not present on admission. Review of weekly skin observations revealed Resident #67 had weekly assessments completed from 06/07/25 through 07/19/25, on 07/29 and 08/19, and then again weekly from 08/19/25 through 09/02/25. None of the weekly skin observations completed by the nursing staff contained wound measurements or wound descriptions. Review of wound clinic documentation dated 06/30/25, 07/09/25, 07/21/25, 08/04/25, 08/18/25, and 09/08/25 revealed Resident #67 was not seen weekly. The wound clinic documentation did include wound measurements and a wound description. Interview on 09/11/25 at approximately 1:15 A.M. with the Director of Nursing (DON) revealed the DON verified Resident #67 did not go to the wound clinic weekly. The DON verified the weekly skin assessments completed by nursing did not contain wound measurements or wound descriptions. Review of policy titled Skin Care Management Procedure revised on 12/09/2022 revealed with each dressing change or at least weekly at a minimum, documentation should include the date observed, location and staging, size, depth, and the presence, location and extent of any undermining or tunneling/sinus tract, exudates if present, type, color, odor and approximate amount, pain if present, wound bed color and type of tissue/character, including evidence of healing or necrosis and percent of tissue, and description of wound edges and surrounding tissue. 2.Review of Resident #52's medical record revealed an admission date of 3/23/25 and diagnoses including of chronic diastolic heart failure, atherosclerotic heart disease, chronic pain, sarcoidosis of the lung, hyperlipidemia, protein-calorie malnutrition, history of venous thrombosis and embolism, pressure ulcer of right heal, pressure ulcer of left heel, pressure ulcer of left ankle and lymphedema. Review of Resident #52's wound care order dated 8/20/25 revealed the resident's right heel was to have Hydrofera blue moisten with saline to applied to the wound bed, covered with four by four gauze, secured with Kerlix and tape, and change daily starting on 8/21/25. Further review of the wound care orders revealed a second wound order also dated 8/20/25 for Resident #52's left ankle. The left ankle was to have silver alginate applied to the wound bed, covered with a four by four gauze, and secured with Kerlix with dressing changes daily, and start on 8/21/25. Review of Resident #52's August treatment records revealed no documentation the wound care orders (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dated 8/20/25 for the left and right heel were implemented until 08/23/25. Interview with the Director of Nursing on 09/11/25 at 11:50 A.M. confirmed the treatment order written on 08/20/25 for wounds to Resident #52's left and right heels were not started on 08/21/25 as ordered and further verified there was no evidence the wound treatments were completed on either 08/21/25 or 08/22/25. Review of the facility policy titled Skin Care Management Procedure, dated 12/09/22 stated the physician will be notified of all skin areas of concern and consulted for treatment orders.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure pre and post dialysis communication forms. This affected one (#55) resident of one resident reviewed for dialysis. The facility census was 67.Review of medical record for Resident #55 revealed an admission date of 06/20/25 with diagnoses including but not limited to type two diabetes, end stage renal disease, and dependence on renal dialysis.Review of Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #55 was cognitively intact.Review of current physician orders revealed an order to complete the pre dialysis communication form every night shift on Tuesday, Thursday, and Sunday and to complete the post dialysis form every Monday, Wednesday, and Friday.Review of pre dialysis communication forms revealed the following dates were not completed 07/07/25, 07/09/25, 07/11/25, 07/16/25,07/21/25, 07/28/25, 08/06/25, 08/11/25, 08/18/25, 08/20/25, 08/29/25, and 09/05/25.Review of post dialysis communication forms revealed the following dates were not completed 07/07/25, 07/11/25, 07/18/25, 07/21/25, 07/25/25, 08/04/25, 08/13/25, 08/15/25, 08/22/25, 08/25/25, and 08/27/25.Interview on 09/10/25 at 2:15 P.M. with the Administrator verified the pre and post dialysis forms for Resident #55 were not completed as ordered and they should have been.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and facility policy review the facility failed to ensure gloves and/or hand hygiene was completed prior to administering an insulin injection. This affected one resident #39 of one resident observed for insulin administration. Further more, the facility failed to provide sanitary environment when passing meal trays in resident's rooms. This affected two residents (#41 and #43) out of seven room trays observed. Census was 67. 1.Review of medical record for Resident #39 revealed an admission date of 08/26/22 with diagnoses including type two diabetes, dementia, and major depressive disorder. Review of Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #39 had moderate cognitive impairment. Review of current physician orders revealed an order initiated on 09/08/25 following the observation in the dining room indicating may give medications, check blood sugar and give insulin in public spaces and dining room. Observation on 09/08/25 at 11:22 A.M. of Registered Nurse (RN #360) revealed the nurse came up to Resident #39 sitting at a table in the dining room and informed the resident she had her insulin to administer. RN #360 proceeded to lift the resident's shirt and administer the insulin in the resident's abdomen. One family member and three other residents were observed sitting at the same table. RN #360 did not have gloves on during the administration of the insulin, nor did she perform hand hygiene prior to administering the insulin. Interview on 09/08/25 at 11:23 A.M. with RN #360 revealed the nurse verified she gave insulin in the dining room with other residents at the table. RN #360 stated she should have pulled the resident away from the table before administering the insulin. RN #360 stated she should have donned gloves prior to administering the insulin. Review of policy provided by the facility titled “Subcutaneous injection” revised 05/19/2025 revealed perform hand hygiene, provide privacy, explain the procedure to the patient, position the patient and expose the injection site, perform hand hygiene, put on gloves if contact with blood or bodily fluids is likely or if your skin or the patient's skin isn't intact. Gloves are not required for routine subcutaneous injections because they do not protect against needlestick injury. 2.Observation on 09/10/25 at 12:42 P.M. revealed Certified Nursing Assistant (CNA) #366 carried Resident #41's lunch tray into her room. Before placing lunch tray on bedside tray, CNA #366 removed tissue box and a cup. CNA #366 placed lunch tray on bedside table and removed the lid from the top of the food and took the silverware out of a plastic wrap, and adjusted bedside tray. CNA #366 walked out of Resident #41's room up to food cart and grabbed Resident #43's food tray, walked into Resident #43's took the lid off food, and walked out the door. No hand hygiene was performed at the start of meal tray pass and no hand hygiene was performed in between serving Residents #41 and #43 their meals in different rooms. Interview on 09/10/25 at 12:50 P.M. with CNA #366 verified no hand hygiene was completed before passing meal trays and no hand hygiene was completed between serving Resident #41 and Resident #43's their meal meal trays in their individual rooms. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy Hand Hygiene Procedure, dated 03/27/25, hand hygiene is to be after contact with inanimate objects in the immediate vicinity of the patient. This deficiency represents noncompliance investigated under Complaint Number 2601174.