

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365497	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/17/2024
NAME OF PROVIDER OR SUPPLIER  Village at the Greene		STREET ADDRESS, CITY, STATE, ZIP CODE  4381 Tonawanda Trail Dayton, OH 45430	

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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46613</p> <p>Based on medical record review, staff interview, and policy review, the facility failed to provide care and services to prevent a resident fall. This affected one (#32) resident of the three residents reviewed for falls. The facility census was 78.</p> <p>Findings include:</p> <p>Review of the medical record for the Resident #32 revealed an admitted [DATE] with medical diagnoses of diabetes mellitus, vascular dementia, chronic obstructive pulmonary disease (COPD), chronic kidney disease (CKD) stage IV, hypertension, and history of transient ischemic attack. Review of the medical record for Resident #32 revealed the resident was hospitalized on [DATE], returned to the facility on [DATE], and then discharged to the hospital on 07/10/24.</p> <p>Review of the medical record for Resident #32 revealed a quarterly Minimum Data Set (MDS) assessment, dated 05/22/24, which indicated Resident #32 had severe cognitive impairment and required supervision to light touching for eating, ambulation up to ten feet, and bed mobility. The MDS revealed Resident #32 required substantial/maximum staff assistance with toilet hygiene and bathing and partial/moderate staff assistance with personal hygiene and transfers. The MDS also indicated Resident #32 used a wheelchair and a walker for mobility, received Hospice services, and no falls were indicated.</p> <p>Review of the medical record for Resident #32 revealed a fall risk assessment dated [DATE] which indicated Resident #32 was at a high risk for falls. Review of the medical record did not contain documentation to support the facility had completed any other fall risk assessment since admission to the facility on [DATE].</p> <p>Review of the medical record for Resident #32 revealed a fall care plan, dated 06/19/2020, which stated Resident #32 was at risk for falls related to muscle weakness and dementia. The care plan included interventions dated 02/02/23 for resident to be toileted after meals and assisted to her recliner, 06/14/24 to position chair behind the resident so she can sit down, do not have her turnaround, 06/20/24 to use gait belt for transfers/ambulation, and 07/06/24 for staff to stay in bathroom when resident was on the toilet. Further review of the medical record for Resident #32 revealed an Activities of Daily Living (ADL) care plan, dated 12/02/21, which stated Resident #32 required limited to extensive staff participation with transfers.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of medical record for Resident #32 revealed physician orders dated 04/04/24 for non-skid socks/shoes when out of bed and 06/28/24 Broda chair when out of room as needed for patient safety.</p> <p>Review of the medical record for Resident #32 revealed a nurse's note, dated 06/14/24 at 7:30 A.M., which stated the nurse was made aware that Resident #32 fell in the dining room. While entering the dining room, the resident was observed lying on her left side in the fetal position. This nurse checked the range of motion, vital signs, did pain assessment and Resident #32 stated that her head hurt. The note stated Resident #32 denied any nausea, and/or blurred vision, hand grips were equal, and neurological checks were within normal limits. The note stated Resident #32 had a small laceration to the back of her head with minimal bleeding and Resident #32 was assisted off the floor and into a chair. The note stated Resident #32 was eating her breakfast when the squad arrived. The note continued to state Resident #32 was assisted to the dining room as per order and the STNA pulled out the dining room chair for Resident #32 so she could be seated to eat. The note stated the STNA was behind the chair, directing the resident to turn around and back up to the chair and take a seat. The note stated Resident #32 became unsteady on her feet, possibly confused and lost her balance and started to fall to the floor. The STNA was unable to stop Resident #32 from falling. The note stated Resident #32 fell to her bottom first, then backwards and hit her head then staff stated she just rolled over into the fetal position. The note stated the nurse notified Resident #32's daughter and physician. The note stated the Director of Nursing (DON) assessed Resident #32 as well and the emergency squad was called for transfer to the emergency room .</p> <p>Review of the fall investigation dated 06/14/24 revealed Resident #32 had unsteady gait and generalized weakness at the time of the fall. The investigation stated Resident #32 was using her walker and tried to sit in a chair in the dining room at the time of the fall. Resident #32 sustained a laceration and was sent to the emergency room for evaluation. The investigation noted the fall intervention put in place was for Resident #32 to be brought to meals in a wheelchair.</p> <p>Interview on 07/17/24 at 7:55 A.M. with STNA #212 stated she was the STNA walking Resident #32 to the dining room on 06/14/24 when the fall occurred. STNA #212 stated she assisted Resident #32 with ambulation to the dining room without the use of a gait belt. STNA #212 stated she pulled out a chair in the dining room for Resident #32 to sit in and the STNA stated she stood behind the chair to hold it in place while Resident #32 turned and backed into the chair. STNA #212 stated Resident #32 lost her balance while she attempted to turn and fell backwards. STNA #212 confirmed she did not provide Resident #32 with hands on assistance for the transfer into the dining room chair.</p> <p>Review of the facility policy titled, Accidents and Incidents, stated the facility would ensure that the resident's environment remained as free of accident hazards as is possible and each resident received adequate supervision and assistive devices to reduce accidents.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00155633 and OH00155733.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46613</b></p> <p>Based on medical record review, staff interview, and review of the Medication Administration checklist, the facility failed to ensure medications were administered as ordered. This affected two (#18 and #32) residents out of the five residents reviewed for medication administration. The facility census was 78.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #18 revealed an admitted [DATE] with medical diagnoses of paraplegia, spinal stenosis, asthma, depression, and morbid obesity.</p> <p>Review of the medical record for Resident #18 revealed a quarterly Minimum Data Set (MDS), dated [DATE], which indicated Resident #18 was cognitively intact and required substantial/maximum staff assistance for toileting hygiene, bathing, and transfers and was supervision with eating.</p> <p>Review of the medical record for Resident #18 revealed a physician order dated 01/25/23 for Lisinopril (antihypertensive medication) 5 milligram (mg) by mouth daily and to hold if systolic blood pressure (SBP) less than 120 millimeters of mercury (mmHg).</p> <p>Review of the medical record for Resident #18 revealed the June 2024 Medication Administration Record (MAR) contained documentation to support staff administered Resident #18 Lisinopril on 06/04/24, 06/06/24, 06/08/24, 06/09/24, 06/12/24, 06/17/24, 06/19/24, 06/20/24, 06/22/24, 06/23/24, 06/27/24, and 06/28/24. Review of the medical record for Resident revealed no documentation to support the facility staff obtained Resident #18's blood pressure on 06/04/24, 06/06/24, 06/08/24, 06/09/24, 06/12/24, 06/17/24, 06/19/24, 06/20/24, 06/22/24, 06/23/24, 06/27/24, and 06/28/24. Further review of the medical record for Resident #18 revealed the July 2024 MAR which indicated on 07/14/24 Resident #18 received Lisinopril and her blood pressure reading was 116 mmHg systolic and 72 mmHg diastolic.</p> <p>Interview on 07/16/24 at 10:38 A.M. with Administrator confirmed the medical record for Resident #18 did not contain documentation to support the facility staff obtained Resident #18's blood pressure prior to administration of Lisinopril on 06/04/24, 06/06/24, 06/08/24, 06/09/24, 06/12/24, 06/17/24, 06/19/24, 06/20/24, 06/22/24, 06/23/24, 06/27/24, and 06/28/24 as ordered. Administrator also confirmed the facility staff administered Lisinopril to Resident #18 on 07/14/24 with a SBP reading of 116 mmHg.</p> <p>2. Review of the medical record for the Resident #32 revealed an admitted [DATE] with medical diagnoses of diabetes mellitus, vascular dementia, chronic obstructive pulmonary disease (COPD), chronic kidney disease (CKD) stage IV, hypertension, and history of transient ischemic attack. Review of the medical record for Resident #32 revealed the resident was hospitalized on [DATE], returned to the facility on [DATE], and then discharged to the hospital on 07/10/24.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the medical record for Resident #32 revealed a quarterly Minimum Data Set (MDS) assessment, dated 05/22/24, which indicated Resident #32 had severe cognitive impairment and required supervision to light touching for eating, ambulation up to ten feet, and bed mobility. The MDS revealed Resident #32 required substantial/maximum staff assistance with toilet hygiene and bathing and partial/moderate staff assistance with personal hygiene and transfers.</p> <p>Review of the medical record for Resident #32 revealed a hospital discharge summary, dated 06/19/24, which contained an order for Apixaban (anticoagulant) 5 milligram (mg) by mouth two times per day.</p> <p>Review of the medical record for Resident #32 revealed the June 2024 Medication Administration Record (MAR) did not contain documentation to support Resident #32 was administered Apixaban 5 mg by mouth two times per day as ordered on 06/19/24.</p> <p>Interview on 07/17/24 at 2:19 P.M. with Administrator confirmed the medical record for Resident #32 did not contain documentation to support Apixaban was administered as ordered on 06/19/24. The Administrator stated the facility did not have a policy for medication administration.</p> <p>Review of the facility form titled, Medication Administration Checklist stated staff would check blood pressure readings, chart when indicated, and medication would be held if appropriate.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00155633 and OH00154410.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46613</p> <p>Based on observation, medical record review, staff interview, and facility policy review, the facility staff failed to follow infection control procedures during medication administration. This affected one (#18) resident out of the three residents reviewed for medication administration. The facility census was 78.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #18 revealed an admitted [DATE] with medical diagnoses of paraplegia, spinal stenosis, asthma, depression, and morbid obesity.</p> <p>Review of the medical record for Resident #18 revealed a quarterly Minimum Data Set (MDS), dated [DATE], which indicated Resident #18 was cognitively intact and required substantial/maximum staff assistance for toileting hygiene, bathing, and transfers and was supervision with eating.</p> <p>Review of the medical record for Resident #18 revealed physician orders dated 10/24/22 for Calcium Carbonate with Vitamin D (supplement) 500-50 mg one tablet by mouth two times per day, 12/25/22 for Aspirin (analgesic) 81 milligram (mg) one tablet by mouth daily, Folbee plus (vitamin and supplement) oral tablet one tablet by mouth daily, Hydrochlorothiazide (diuretic) 25 mg one tablet by mouth daily, Multivitamin (vitamin) one tablet by mouth daily, 01/25/23 for Lisinopril (ACE inhibitor) 5 mg one tablet by mouth daily hold if systolic blood pressure (SBP) less than 120 millimeter of mercury (mmHg), 05/21/23 for Metoprolol (beta blocker) 12.5 mg one tablet by mouth two times per day, 05/22/23 for Clopidogrel Bisulfate (antiplatelet) 75 mg one tablet by mouth daily, 09/30/23 for Methocarbamol (muscle relaxer) 500 mg one tablet by mouth three times per day, 03/07/24 for Metamucil (laxative)one packet by moth daily, 04/14/24 for Gabapentin (anticonvulsant) 300 mg one tablet by mouth three times per day, 04/15/24 for Magox (supplement) 400 mg one tablet by mouth daily, and 06/26/24 for Senna plus (laxative) 8.6-50 mg two tablets by mouth daily.</p> <p>Observation on 07/16/24 at 7:45 A.M. revealed Licensed Practical Nurse (LPN) #242 prepared medications for Resident #18. LPN #242 was observed placing Calcium Carbonate, Senna plus, Aspirin, Clopidogrel Bisulfate, Folbee plus, Gabapentin, Hydrochlorothiazide, Magox, Methocarbamol, Metoprolol, Lisinopril, and Multivitamin tablets into a medication cup. The observation revealed LPN #242 empty all the pills from the medication cup into her bare hands. LPN #242 then used her bare hand to remove the Lisinopril from the medications in her hand and place the Lisinopril into a separate medication cup. LPN #242 proceeded to return all the medications remaining in her bare hand back into a medication cup and administered the medications to Resident #18. LPN #242 took Resident #18's blood pressure and administered the Lisinopril as ordered. Interview with LPN #242 confirmed she placed all the medications into her bare hands prior to administration and confirmed at no time did she perform hand hygiene or use gloves.</p> <p>Review of the facility policy titled, Infection Control, revealed the objective of the policy was to prevent and control the spread of communicable and contagious diseases. The policy stated the staff are to clean their hands after each direct resident contact using the most appropriate hand hygiene professional practices.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>This deficiency is based on incidental findings discovered during the course of this complaint investigation.</p>