

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 01/06/2025
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 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34291</p> <p>Based on medical record review, staff interview, review of facility self-reported incidents, and policy review the facility failed to ensure the abuse policy was implemented. This affected one (#57) of three residents reviewed for abuse. The census was 73.</p> <p>Findings include:</p> <p>Medical record review for Resident #57 revealed an admitted [DATE]. Diagnoses included non-traumatic brain dysfunction, renal insufficiency, Alzheimer's disease, and dementia.</p> <p>Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #57 was severely cognitively impaired. Resident #57's functional status required setup and clean-up for eating, moderate assistance for toileting, and supervision for bed mobility and transfers. Resident #57 was always incontinent for bladder and frequently incontinent for bowel.</p> <p>Interview with Certified Nursing Assistant (CNA) #116 on 12/31/24 at 10:59 A.M. revealed at the end of her shift on 12/29/24 a message was sent over What's AP (which is a program the facility used to send out messages to the staff) to the Administrator and the Director of Nursing. CNA #116 stated she wanted to report an incident which happened on 12/29/24 around lunch time between Resident #57 and CNA #165. CNA #116 reported CNA #165 was rough with Resident #57 and CNA #116 did not like the way the CNA #165 spoke to Resident #57.</p> <p>Interview with the Administrator on 12/31/24 at 11:27 A.M. revealed CNA #116 did send a text through the What's AP program on 12/29/24 at 3:21 P.M. to a facility phone and not to the Administrator's personal phone. The Administrator stated she was off on 12/29/24 and did not get the message until returning to work on 12/31/24. The Administrator stated the staff are to report any abuse concerns immediately to the supervisor on duty and then the supervisor would report such concerns to management. At the time of the interview, the Administrator reported she had not yet spoke to CNA #116.</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 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with the Director of Nursing (DON) on 12/31/24 at 11:39 A.M. revealed a text message was received from CNA #116 on the What's AP program at the end of CNA #116's shift on 12/29/24. CNA #116 stated she wanted to report CNA #165. The DON claimed she responded via text, for what and then called CNA #116. The DON stated CNA #116 wanted to report CNA #165 for the way talked to Resident #57. The DON told CNA #116 if the situation was clinical, CNA #116 needed to call the Administrator. The DON then stated she hung up on CNA #116 and went back to sleep. The DON verified CNA #165 worked on 12/30/24 on the day shift from 7:45 A.M. to 3:00 P.M., and further verified the abuse policy was not followed, and, she, the DON should have immediately suspended CNA #165 pending an investigation.</p> <p>A subsequent interview with CNA #116 on 12/31/24 at 11:45 A.M. revealed she needed help with transferring Resident #57 around lunch time and asked CNA #165 to help. CNA #116 said Resident #57 could be combative at times and was not being cooperative at the time and CNA #165 said to the resident I don't have time for this and grabbed Resident #57's arm and threw her into the wheelchair. CNA #116 stated she attempted to report the incident to the nurse on duty, but the nurse was not listening to her, so she texted the Director of Nursing and the Administrator. CNA #116 verified she did not follow the policy for reporting the incident as soon as it happened.</p> <p>Review of the time punch for Certified Nursing Assistant (CNA) #165 dated 12/29/24 revealed CNA #165 worked from 7:08 A.M. to 3:00 P.M. and on 12/30/24 she worked the same unit from 7:45 A.M. to 3:00 P.M.</p> <p>Review of the facility Self-Reported Incidents (SRIs) dated 12/29/24 and 12/30/24 revealed no evidence this allegation was reported to the state agency.</p> <p>Review of the policy entitled Abuse, Neglect, Exploitation, Misappropriation of Resident Property revised on 10/01/22 revealed the facility will not tolerate Abuse, Neglect, Exploitation of its residents or the Misappropriation of Resident Property. Facility staff are to immediately report all such allegations to the Administrator. All alleged violations involving abuse, neglect, misappropriation of resident property, exploitation or mistreatment, including injuries of unknown source, are investigated immediately and reported to the Ohio Department of Health (ODH) in accordance with the procedures in the policy. In cases where a crime is suspected, staff should also report the same to local law enforcement in accordance with the facility's crime reporting policy.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34291</p> <p>Based on medical record review, staff interview, review of facility self-reported incidents, and policy review the facility failed to ensure the abuse policy was implemented. This affected one (#57) of three residents reviewed for abuse. The census was 73.</p> <p>Findings include:</p> <p>Medical record review for Resident #57 revealed an admitted [DATE]. Diagnoses included non-traumatic brain dysfunction, renal insufficiency, Alzheimer's disease, and dementia.</p> <p>Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #57 was severely cognitively impaired. Resident #57's functional status required setup and clean-up for eating, moderate assistance for toileting, and supervision for bed mobility and transfers. Resident #57 was always incontinent for bladder and frequently incontinent for bowel.</p> <p>Interview with Certified Nursing Assistant (CNA) #116 on 12/31/24 at 10:59 A.M. revealed at the end of her shift on 12/29/24 a message was sent over What's AP (which is a program the facility used to send out messages to the staff) to the Administrator and the Director of Nursing. CNA #116 stated she wanted to report an incident which happened on 12/29/24 around lunch time between Resident #57 and CNA #165. CNA #116 reported CNA #165 was rough with Resident #57 and CNA #116 did not like the way the CNA #165 spoke to Resident #57.</p> <p>Interview with the Administrator on 12/31/24 at 11:27 A.M. revealed CNA #116 did send a text through the What's AP program on 12/29/24 at 3:21 P.M. to a facility phone and not to the Administrator's personal phone. The Administrator stated she was off on 12/29/24 and did not get the message until returning to work on 12/31/24. The Administrator stated the staff are to report any abuse concerns immediately to the supervisor on duty and then the supervisor would report such concerns to management. At the time of the interview, the Administrator reported she had not yet spoke to CNA #116.</p> <p>Interview with the Director of Nursing (DON) on 12/31/24 at 11:39 A.M. revealed a text message was received from CNA #116 on the What's AP program at the end of CNA #116's shift on 12/29/24. CNA #116 stated she wanted to report CNA #165. The DON claimed she responded via text, for what and then called CNA #116. The DON stated CNA #116 wanted to report CNA #165 for the way talked to Resident #57. The DON told CNA #116 if the situation was clinical, CNA #116 needed to call the Administrator. The DON then stated she hung up on CNA #116 and went back to sleep. The DON verified CNA #165 worked on 12/30/24 on the day shift from 7:45 A.M. to 3:00 P.M., and further verified the abuse policy was not followed, and, she, the DON should have immediately suspended CNA #165 pending an investigation.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A subsequent interview with CNA #116 on 12/31/24 at 11:45 A.M. revealed she needed help with transferring Resident #57 around lunch time and asked CNA #165 to help. CNA #116 said Resident #57 could be combative at times and was not being cooperative at the time and CNA #165 said to the resident I don't have time for this and grabbed Resident #57's arm and threw her into the wheelchair. CNA #116 stated she attempted to report the incident to the nurse on duty, but the nurse was not listening to her, so she texted the Director of Nursing and the Administrator. CNA #116 verified she did not follow the policy for reporting the incident as soon as it happened.</p> <p>Review of the time punch for Certified Nursing Assistant (CNA) #165 dated 12/29/24 revealed CNA #165 worked from 7:08 A.M. to 3:00 P.M. and on 12/30/24 she worked the same unit from 7:45 A.M. to 3:00 P.M.</p> <p>Review of the facility Self-Reported Incidents (SRIs) dated 12/29/24 and 12/30/24 revealed no evidence this allegation was reported to the state agency.</p> <p>Review of the policy entitled Abuse, Neglect, Exploitation, Misappropriation of Resident Property revised on 10/01/22 revealed the facility will not tolerate Abuse, Neglect, Exploitation of its residents or the Misappropriation of Resident Property. Facility staff are to immediately report all such allegations to the Administrator. All alleged violations involving abuse, neglect, misappropriation of resident property, exploitation or mistreatment, including injuries of unknown source, are investigated immediately and reported to the Ohio Department of Health (ODH) in accordance with the procedures in the policy. In cases where a crime is suspected, staff should also report the same to local law enforcement in accordance with the facility's crime reporting policy.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34291</p> <p>Based on medical record review, staff interview, review of facility self-reported incidents, and policy review the facility failed to ensure the abuse policy was implemented. This affected one (#57) of three residents reviewed for abuse. The census was 73.</p> <p>Findings include:</p> <p>Medical record review for Resident #57 revealed an admitted [DATE]. Diagnoses included non-traumatic brain dysfunction, renal insufficiency, Alzheimer's disease, and dementia.</p> <p>Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #57 was severely cognitively impaired. Resident #57's functional status required setup and clean-up for eating, moderate assistance for toileting, and supervision for bed mobility and transfers. Resident #57 was always incontinent for bladder and frequently incontinent for bowel.</p> <p>Interview with Certified Nursing Assistant (CNA) #116 on 12/31/24 at 10:59 A.M. revealed at the end of her shift on 12/29/24 a message was sent over What's AP (which is a program the facility used to send out messages to the staff) to the Administrator and the Director of Nursing. CNA #116 stated she wanted to report an incident which happened on 12/29/24 around lunch time between Resident #57 and CNA #165. CNA #116 reported CNA #165 was rough with Resident #57 and CNA #116 did not like the way the CNA #165 spoke to Resident #57.</p> <p>Interview with the Administrator on 12/31/24 at 11:27 A.M. revealed CNA #116 did send a text through the What's AP program on 12/29/24 at 3:21 P.M. to a facility phone and not to the Administrator's personal phone. The Administrator stated she was off on 12/29/24 and did not get the message until returning to work on 12/31/24. The Administrator stated the staff are to report any abuse concerns immediately to the supervisor on duty and then the supervisor would report such concerns to management. At the time of the interview, the Administrator reported she had not yet spoke to CNA #116.</p> <p>Interview with the Director of Nursing (DON) on 12/31/24 at 11:39 A.M. revealed a text message was received from CNA #116 on the What's AP program at the end of CNA #116's shift on 12/29/24. CNA #116 stated she wanted to report CNA #165. The DON claimed she responded via text, for what and then called CNA #116. The DON stated CNA #116 wanted to report CNA #165 for the way talked to Resident #57. The DON told CNA #116 if the situation was clinical, CNA #116 needed to call the Administrator. The DON then stated she hung up on CNA #116 and went back to sleep. The DON verified CNA #165 worked on 12/30/24 on the day shift from 7:45 A.M. to 3:00 P.M., and further verified the abuse policy was not followed, and, she, the DON should have immediately suspended CNA #165 pending an investigation.</p> <p>A subsequent interview with CNA #116 on 12/31/24 at 11:45 A.M. revealed she needed help with transferring Resident #57 around lunch time and asked CNA #165 to help. CNA #116 said Resident #57 could be combative at times and was not being cooperative at the time and CNA #165 said to the resident I don't have time for this and grabbed Resident #57's arm and threw her into the wheelchair. CNA #116 stated she attempted to report the incident to the nurse on duty, but the nurse was not listening to her, so she texted the Director of Nursing and the Administrator. CNA #116 verified she did not follow the policy for reporting the incident as soon as it happened.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the time punch for Certified Nursing Assistant (CNA) #165 dated 12/29/24 revealed CNA #165 worked from 7:08 A.M. to 3:00 P.M. and on 12/30/24 she worked the same unit from 7:45 A.M. to 3:00 P.M.</p> <p>Review of the facility Self-Reported Incidents (SRIs) dated 12/29/24 and 12/30/24 revealed no evidence this allegation was reported to the state agency.</p> <p>Review of the policy entitled Abuse, Neglect, Exploitation, Misappropriation of Resident Property revised on 10/01/22 revealed the facility will not tolerate Abuse, Neglect, Exploitation of its residents or the Misappropriation of Resident Property. Facility staff are to immediately report all such allegations to the Administrator. All alleged violations involving abuse, neglect, misappropriation of resident property, exploitation or mistreatment, including injuries of unknown source, are investigated immediately and reported to the Ohio Department of Health (ODH) in accordance with the procedures in the policy. In cases where a crime is suspected, staff should also report the same to local law enforcement in accordance with the facility's crime reporting policy.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34291</p> <p>Based on observation, medical record review, staff and family interview the facility failed to ensure bathing was provided for residents at least twice a week. This affected two (#27 and #17) of three residents reviewed for bathing. The census was 74.</p> <p>Findings include:</p> <p>1. Medical record review for Resident #27 revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease (COPD), cancer, neurogenic bladder, cerebrovascular attack (CVA), non-Alzheimer's dementia, hemiplegia, or hemiparesis, and respiratory failure.</p> <p>Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #27 was severely cognitively impaired, had impaired functional status on one side for both upper and lower extremities, used a wheelchair, required maximal assistance for bathing, and was dependent for bed mobility, and transfers.</p> <p>Review of care plan dated 02/21/24 for Resident #27 revealed the resident required one to two person assistance for bathing in the bed and two-person for showering.</p> <p>Review of the bathing records for Resident #27 from 11/01/24 through 12/20/24 revealed out of 16 bathing opportunities, Resident #27 had nine episodes of bathing.</p> <p>Observation of Resident #27 on 12/30/24 at 12:40 P.M. revealed oily hair.</p> <p>Interview with Resident #27's family on 12/30/24 at 12:43 P.M. revealed Resident #27 had not received bathing on a regular basis. The family was upset Resident #27 had not received bathing twice a week.</p> <p>2. Medical record review for Resident #17 revealed an admitted [DATE]. Diagnoses included traumatic subdural hemorrhage without loss of consciousness, down syndrome and vascular dementia.</p> <p>Review of the five-day admission MDS dated [DATE] revealed Resident #17 was rarely or never understood and the resident required maximal assistance for bathing.</p> <p>Review of care plan dated 11/04/24 revealed Resident #17 had impaired activities of daily living (ADL) related to confusion, dementia, impaired balance, stroke, and weakness. Interventions included for assistance with ADLS to be provided by staff as needed.</p> <p>Review of bathing record for Resident #17 from 11/01/24 through 11/20/24 revealed no evidence of bathing.</p> <p>Interview with the Administrator on 12/31/24 at 9:00 A.M. confirmed if the showers were not documented for Residents #17 and #27 then the showers were not t completed.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility policy titled Quality of Care, dated 04/01/16 revealed each resident will receive and the facility will provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care. For activities of daily living, a resident unable to carry out an activity will receive the necessary services to maintain good nutrition, grooming, personal and oral hygiene.</p> <p>This violation represents non-compliance investigated under Complaint Number OH00160612.</p>		

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<p>F 0689</p> <p>Level of Harm - 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34291</p> <p>THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY.</p> <p>Based on medical record review, staff interview, resident and family interview, review of video camera footage, review of facility investigation and incident report, and policy review the facility failed to ensure a resident was properly transferred and provided a mechanical lift (Hoyer) during transfer. This resulted in actual harm when Resident #27 who was a high fall risk, dependent for transfers, and required the utilization of a mechanical lift (Hoyer) for all transfers suffered a right distal femur fracture from a fall that occurred during a transfer. This affected one (#27) of three residents reviewed for falls. The census was 83.</p> <p>Findings include:</p> <p>Medical record review for Resident #27 revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease (COPD), cancer, neurogenic bladder, cerebrovascular attack (CVA), non-Alzheimer's dementia, hemiplegia, or hemiparesis, and respiratory failure.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #27 was severely cognitively impaired, had impaired functional status on one side for both upper and lower extremities, used a wheelchair, required supervision for eating, required maximal assistance for toileting and bathing, and was dependent for bed mobility, and transfers.</p> <p>Review of the care plan dated 02/21/24 revealed Resident #27 was at risk for falls related to her current diagnoses and change in environment. Interventions included the need for a safe environment with even floors that were free from spills and/or clutter, adequate lighting, a workable call light within reach, a bed in the lowest position and personal items within reach. Additionally, staff were to anticipate and meet resident needs by keeping items within reach, assisting with toileting, and encouraging Resident #27 to use the call light for assistance. Resident #27 required the use of side rails to assist with turning and repositioning while in bed, physical therapy (PT) and occupational therapy (OT) consults as needed.</p> <p>Review of therapy notes dated 07/16/24 revealed Resident #27 and the staff were provided education on the importance of utilizing appropriate assistive devices properly to increase Resident #27's mobility in the facility and reduce the burden of care for staff. Resident #27 was educated on proper safety techniques for in-room mobility along with safety education to increase functional mobility. Therapy also communicated with staff the need for increased monitoring of Resident #27 due to risk of falls.</p> <p>Review of the fall risk assessment dated [DATE] revealed Resident #27 had an increased risk of falling due to impaired balance.</p> <p>(continued on next page)</p>		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	<p>Review of a fall risk assessment dated [DATE] revealed Resident #27 was a high risk for falls as Resident #27 was unable to independently come to a standing position and exhibited loss of balance while standing.</p> <p>Review of the progress notes dated 12/17/24 at 6:50 A.M. revealed Resident #27 had a fall that was witnessed by Certified Nurse Aides (CNA) #93 and #95. Resident #27 was unable to bear weight while transferring and was lowered to the floor. The resident had on non-skid footwear at the time of the fall, was wearing prescribed oxygen and was incontinent at the time of the fall. The physician and the family were notified.</p> <p>Further review of a progress note dated 12/18/24 revealed family reported to LPN #125 Resident #27 had a swollen knee and upon observation of Resident #27's knee with family the physician was notified and an order for an x-ray was obtained.</p> <p>Resident #27 had an x-ray completed on 12/18/24 at 12:25 P.M. with results reported at 2:06 P.M. Resident #27 had an acute right distal femur fracture.</p> <p>Resident #27 was transferred to the hospital for further evaluation on 12/18/24 after x-rays completed revealed a right distal femur fracture.</p> <p>Review of the incident report dated 12/17/24 revealed Resident #27 was not able to perform functions for gait and balance.</p> <p>Review of the hospital report dated 12/18/24 revealed Resident #27 fell at the nursing home after being dropped and developed a right distal femur fracture. Family was undecided on surgical intervention and Resident #27 was sent back to the facility with a knee immobilizer.</p> <p>Review of the Interdisciplinary Team (IDT) note dated 12/18/24 revealed the IDT collaborated and determined the root cause of Resident #27's fall was weakness, requiring Resident #27 to be lowered to the floor during two-person transfer from a shower chair to bed. Interventions put into place included to educate staff on proper transfer techniques including the utilization of proper assistive devices for lifting a resident. Resident #27's care plan and Kardex (a resource that provides a brief overview of each resident's needs) was updated to reflect the need to utilize a mechanical lift (Hoyer) for all transfers.</p> <p>Review of the statement dated 12/19/24 written by CNA #95 revealed she was asked by CNA #93 to help with Resident #27's transfers on 12/17/24. The statement revealed CNA #93 put her hands under resident's arm and her other hand grabbed the back of the resident's pants to transfer Resident #27 into the shower chair from the wheelchair. After the shower, CNA #95 returned to the shower room to help CNA #93 transfer Resident #27 into a wheelchair. During the transfer Resident #27 had a bowel movement, both CNA #93 and #97 escorted Resident #27 to her room to put Resident #27 on the bed, during the transfer Resident #27 started to fall (drop). CNA #93 yelled for Resident #27 to stand, and the resident said, I am trying. CNA #95 said the resident was heavy and should have been transferred using a mechanical lift (Hoyer). CNA #93 said to the resident twice you are not standing and the resident dropped into a squatting position. CNA #93 was on the resident's right side holding the resident under the arm and CNA #95 was on the left side holding the resident under the other arm. CNA #93 pushed Resident #27's feet out from under her and the resident was lowered to the floor.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Village at the Greene		STREET ADDRESS, CITY, STATE, ZIP CODE 4381 Tonawanda Trail Dayton, OH 45430	
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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the statement dated 12/19/24 written by CNA #93 revealed when transferring Resident #27 from the wheelchair to the bed with CNA #95, they tried to stand Resident #27, and when the resident was unable to fully stand she proceeded to drop to her knees and was lowered to the floor by CNA #93 and #95.</p> <p>Interview with CNA #95 on 12/30/24 at 9:41 A.M. verified she assisted CNA #93 transfer Resident #27 from the wheelchair to the bed on 12/17/24. CNA #95 stated she had previously helped CNA #93 transfer Resident #27 to and from the shower chair and with cueing the resident was able to transfer. CNA #95 stated when they took Resident #27 back to her room in the wheelchair, they did not utilize a gait belt or a mechanical lift (Hoyer) to transfer Resident #27 back to bed. CNA #95 stated Resident #27 was not able to stand and when CNA #93 told Resident #27 to stand up and transfer and the resident told her she could not, and Resident #27 was lowered to the ground in a sitting position. CNA #95 stated she told CNA #93 Resident #27 was too heavy and a mechanical lift (Hoyer) should have been used. CNA #95 assumed CNA #93 was doing the transfer per Resident #27's care planned needs, but later found out Resident #27 should have been transferred using a mechanical lift (Hoyer). CNA #95 verified she did not review Resident #27's medical record or Kardex prior to the transfer and further denied the use of a gait belt, stating a gait belt should have been used.</p> <p>Interview with CNA #93 on 12/30/24 at 9:49 A.M. revealed Resident #27 was a two-person assist with a mechanical lift (Hoyer). CNA #93 denied the used of mechanical lift device (Hoyer) or a gait belt when transferring Resident #27 on 12/17/24. CNA #93 stated she and CNA #95 had assisted Resident #27 out of bed on 12/17/24 and transferred the resident in and out of the shower chair with maximal assistance. CNA #93 said Resident #27 must have been tired after the shower because when they attempted to transferred Resident #27 out of the wheelchair in her room the resident was not able to stand and needed to be lowered to the floor. CNA #93 said when the resident was lowered to the floor the resident was bouncing in a sitting position, almost like squatting. CNA #93 stated there was no way the resident broke her hip because she did not complain about her hip and denied pain at the time.</p> <p>Interview with the Administrator on 12/30/24 at 10:40 A.M. revealed in August 2024 therapy recommended to use a mechanical lift (Hoyer) for Resident #27 and an order was entered into the medical record. The order was discontinued after the family did not know if they wanted to use the mechanical lift after Resident #27's arm got crinkled in the lift pad. The Administrator stated she did not have any evidence regarding the family request not to use the mechanical lift for transfers. The Administrator stated some of the aides were using the mechanical lift (Hoyer) for Resident #27's transfers and others where not. The Administrator also verified the Kardex for Resident #27 did not reflect the need to use a mechanical lift (Hoyer) for transfers, and further stated the expectation was for a mechanical lift (Hoyer) to be used for all of Resident #27's transfers.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the video from the camera in Resident #27's room with Resident #27's family on 12/30/24 at 11:30 A.M. revealed on 12/17/24 at 6:05 A.M. CNA's #95 and #93 transferred Resident #27 into a shower chair by lifting the resident from under her arms and it appeared Resident #27 was not bearing weight on her legs. The CNAs took Resident #27 out of the room and all three come back into the view at 6:36 A.M. and Resident #27 is now in a wheelchair. One of the CNAs is carrying a lift pad for the mechanical lift (Hoyer) and laid it on the bed. CNA #93 and #95 place their arms underneath Resident #27's arms and pulled Resident #27 out of the wheelchair. Resident #27 was observed as unable to stand, and you can hear the aides say, you got to help us and tells Resident #27 to stand. Resident #27 replies I am trying to stand, and I cannot. The aides trying to hold onto Resident #27, lower the resident to the floor. Resident #27's legs were not visible in the video due to the position of the bed. CNA #93 and #95 attempted twice to pick Resident #27 up off the floor before calling for assistance. LPN #125 came into the room, CNA's #93 and #95 reached under Resident #27's arms and LPN #125 grabbed both of Resident #27's legs and lifted Resident #27 onto the bed. LPN #125 did not assess Resident #27 and left the room within one minute of entering. CNA #93 and #95 provided incontinence care and changed Resident #27's brief. Using the mechanical lift (Hoyer) Resident #27 was transferred from the bed to the wheelchair and positioned in front of the television in the room. CNA #93 and #95 exited the room at 7:00 A.M.</p> <p>Interview with Resident #27's family on 12/30/24 at 12:21 P.M. revealed the staff had been using the mechanical lift (Hoyer) on all transfers for Resident #27 for the past couple of months. The family shared initially they were concerned about using the mechanical lift (Hoyer) because one day when observing a transfer, Resident #27 hit her head and developed a scratch when staff placed Resident #27 incorrectly in the mechanical lift (Hoyer). The family denied telling the facility not to use the mechanical lift (Hoyer).</p> <p>The interview with LPN #125 on 12/30/24 at 2:12 P.M. revealed she was the nurse on duty on 12/17/24 when Resident #27 fell . LPN #125 stated the aides asked her to help them get Resident #27 onto the bed after Resident #27 had been lowered to the floor. LPN #125 verified she did not complete a full head to toe assessment and only eye balled Resident #27 when she assisted the CNAs in getting the resident onto the bed. LPN #125 stated this was not her normal practice and Resident #27 should have been assessed but she was in a hurry.</p> <p>Interview with Therapy Manager (TM) #352 on 12/30/24 at 2:43 P.M. revealed during the time therapy was working with Resident #27 in July and August 2024 the recommendation was for a mechanical lift (Hoyer) to be used for transfers.</p> <p>The interview with the LPN #124 on 12/31/24 at 8:40 A.M. revealed she took care of Resident #27 on 12/18/24. LPN #124 stated Resident #27's family reported the resident had a swollen knee and upon assessment of Resident #27 the physician was notified and an order to x-ray Resident #27 lower extremities was obtained. LPN #124 when made aware of the x-ray results of a right femur fracture, the physician was notified and Resident #27 was sent to the hospital for further evaluation. LPN #124 stated LPN #125 informed her Resident #27 had a witnessed fall when the resident was lowered to the floor, but nothing about the Resident #27's knee.</p> <p>Review of the policy entitled Accidents and Incidents dated 06/21/05 revealed the facility will ensure the resident's environment remains as free of accident hazards and each resident receives adequate supervision and utilizes assistive devices to reduce accidents. A licensed professional nurse shall examine a resident for any physical injury following an accident or injury.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The deficient practice was corrected on 12/26/24 when the facility implemented the following corrective actions:</p> <p>-On 12/19/24 all staff were educated by the Director of Nursing to utilize the resident's plan of care to determine proper mode of transfer, including the use of gait belts when appropriate. Return demonstration was completed during the education by staff of where to find a residents plan of care.</p> <p>-On 12/20/24 all residents were assessed for fall risk, care plans were reviewed, Kardex were reviewed, and both were updated, as needed, to reflect each residents transfer status and the assistive devices needed for transfer. Each residents care plan and Kardex were compared for accuracy.</p> <p>-Audits were completed by the Director of Nursing and the Administrator on 12/26/24, 12/27/24 and 12/30/24 of resident transfers to ensure transfers were completed according to the residents care plan and Kardex. The care plan and Kardex for reach resident was also reviewed for accuracy. Ongoing audits to continue for two weeks.</p> <p>-Action plan was presented at an ad hoc Quality Assurance ad Performance Improvement QAPI meeting December 2024. Ongoing audits will be presented and reviewed at future QAPI meetings.</p> <p>Review of the medical records on 12/31/24 for Residents #39 and #52 revealed the resident's care plan and Kardex correctly represented the residents transfer status.</p> <p>Interview with CNAs #111 and #78 on 12/31/24 between 6:44 A.M. and 6:50 A.M. revealed they were recently trained on the proper use of a mechanical lift (Hoyer) and where to look in the Kardex to determine how a resident transfers. CNAs #111 and #78 verified they performed a resident transfer with a member of management.</p> <p>Interview with CNA #116 on 12/31/24 at 10:59 A.M. revealed a member of management watched her complete a transfer of a resident. CNA #116 was also shown how to use the Kardex to find out what kind of transfer a resident requires.</p> <p>This violation represents non-compliance investigated under Complaint Number OH00160906.</p>