STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365497	A. Building B. Wing	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village at the Greene	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)
F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interviews, and policy review, the facility failed to ensure a resident was not inappropriately discharged when the facility issued a resident a 30- day discharge notice without proper cause. This affected one (#52) out of three residents reviewed for discharge notices. The facility census was 47. Findings include:Review of the medical record for Resident #52 revealed an admission date of 07/05/24 with medical diagnoses of multiple sclerosis, left hemiplegia, cerebral infarction, diabetes mellitus, and chronic kidney disease stage IV. Further review, revealed Resident #52 was transferred to the hospital on [DATE], readmitted to the facility on [DATE], and then discharged to another facility on 09/24/25. Review of the medical record for Resident #52 revealed a quarterly Minimum Data Set (MDS) assessment, dated 06/30/25, which indicated Resident #52 was cognitively intact and was dependent for bed mobility, bathing, toileting and transfers. The MDS indicated Resident #52 received nutrition via tube feeding. Review of the medical record for Resident #52 revealed a Social Service note, dated 08/28/25 at 10:47 A.M. which stated daughter was informed of 30-day discharge notice due to resident does not have any remaining bed hold days and would be returning skilled. The note stated the daughter understood the information and was notified a list of facilities for her to choose from would be emailed to her. Review of a nurse's note, dated 08/28/25 at 2:09 P.M. stated resident arrived to the facility at approximately 1:30 P.M. Further review revealed a Social Service note dated 09/03/25 at 4:13 P.M. which stated 30-day discharge noticed was mailed to resident's daughter. The note stated the discharge was due to the welfare and needs of the resident could no longer be met in the facility. Review of the medical record revealed a document titled, Discharge Notice dated 09/03/25 which stated this was a notice that the resident would be discharged from the facility. The document indicated date of discharge was 10/03/25 to another skilled nursing facility and the reason for discharge was that the welfare and needs of the resident could not be met at the facility. Interview on 02/25/26 at 10:03 A.M. with Resident Service Coordinator (RSC) # 158 confirmed Resident #52 was sent to the hospital on [DATE] and returned to the facility on [DATE]. RSC #158 confirmed she had notified Resident #52's daughter on 08/028/25 that Resident #52 did not have any bed hold days available and that insurance denied a skilled stay at the facility. RSC #158 stated Resident #52 was issued a 30-day discharge notice due to not having a payer source. RSC #158 stated she was not aware if Resident #52 had been issued a bill for her stay since her return to the facility on [DATE] or if Resident #52 had failed to pay any bills. RSC #158 stated the 30-day discharge form issued to Resident #52's daughter was filled out incorrectly and that Resident #52 was being discharged due to payment concerns not that the welfare and needs of the resident could not be met at the facility. RSC #158 confirmed Resident #52 discharged to another nursing facility. Interview on 02/25/26 at 2:16 P.M. with Regional Business Office Manager (RBOM) #501 stated Resident #52 stay at the facility was covered by a managed Medicaid product and was approval of (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

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	coverage was from 08/23/25 to 09/11/25. RBOM #501 confirmed the Notice of Discharge was issued on 09/04/25 even though Resident #52's insurance had approved coverage until 09/11/25 and confirmed Resident #52 or representative had not been issued a bill for non-payment at the time the Notice of Discharge was issued. Review of the facility policy titled, Admissions, Transfers, Discharge, and Room Change, stated it would be the responsibility of the Director of Nursing to assure that resident discharges are made only upon the physician's written order unless the resident is leaving AMA and that transfers and discharges are documented in the resident's clinical record. The policy stated residents for discharge included: 1) welfare and needs cannot be met in the Manor 2) has improved sufficiently so that the resident no longer needs the services provided by the Manor, 3) the safety of other individuals in the Manor would otherwise be endangered, 4) the health of ither individuals in the Manor would otherwise be endangered, 5) resident has failed to pay, or to have payment made on their behalf, for the care provided by the Manor, 6) the Manor's license has been revoked, the Manor is being closed, or otherwise ceases to operate, or 7) resident is recipient of Medicare, Medicaid, or Veteran's Affair benefits and the Manor's participation in such program is terminated or denied. The policy stated the Manor's policy to notify residents and/or responsible party in writing, by certified mail, return receipt requested, in advance to any proposed transfer or discharge from the Manor. The notice shall be provided at least thirty days in advance of the proposed transfer or discharge.This deficiency represents non-compliance investigated under Complaint Number 2631508.

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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 medical record reviews, staff interviews, and review of the facility policies, the facility failed to complete discharge summary/recapitulation of stays and failed to obtain physician discharge orders prior to discharge. This affected two (#48 and #52) out of three residents reviewed for discharges. The facility census was 47. Findings include: 1.Review of the medical record for Resident #48 revealed an admission date of 01/01/22 with medical diagnoses of anemia, diabetes mellitus, morbid obesity, bipolar disease with psychotic features, and congestive heart failure. Review of the medical record revealed a discharge date of 10/16/25. Review of the medical record revealed a quarterly Minimum Data Set (MDS) assessment dated [DATE], which indicated Resident #48 was cognitively intact and was dependent upon staff for bathing, toilet hygiene, bed mobility and transfers and required set-up assistance with eating. Review of the medical record for Resident #48 revealed no documentation to support a discharge summary/recapitulation of stay was completed or the facility obtained physician orders for the residents discharge from the facility on 10/16/25. 2. Review of the medical record for Resident #52 revealed an admission date of 07/05/24 with medical diagnoses of multiple sclerosis, left hemiplegia, cerebral infarction, diabetes mellitus, and chronic kidney disease stage IV. Further review, revealed Resident #52 was transferred to the hospital on [DATE], readmitted to the facility on [DATE], and then discharged to another facility on 09/24/25. Review of the medical record for Resident #52 revealed a quarterly MDS assessment, dated 06/30/25, which indicated Resident #52 was cognitively intact and was dependent for bed mobility, bathing, toileting and transfers. The MDS indicated Resident #52 received nutrition via tube feeding. Review of the medical record for Resident #52 revealed no documentation to support a discharge summary/recapitulation of stay was completed or the facility obtained physician orders for the resident's discharge from the facility on 09/24/25. Interview on 02/25/26 at 10:15 A.M. with Director of Nursing (DON) confirmed the medical records for Residents #48 and #52 did not contain documentation to support the facility completed discharge summary/recapitulation of stay or obtained physician orders prior to discharges. Review of the facility policy titled, Admissions, Transfers, Discharge, and Room Change, stated it would be the responsibility of the Director of Nursing to assure that resident discharges are made only upon the physician's written order unless the resident is leaving AMA and that transfers and discharges are documented in the resident's clinical record. Review of the facility policy titled, Discharge Summary, stated when the Manor (facility) anticipates discharge of a resident they must have a discharge summary that includes recapitulation of resident's stay, a final summary of the resident's health status at the time of discharge that is available for release to authorized persons and agencies, with consent of the resident or representative, reconciliation of all pre-discharge medications with the resident's post-discharge medications, and a post discharge plan of care that was developed with the participate of the resident and his/her family, which will assist the resident to adjust to his/her new living environment. This deficiency was based on incidental findings discovered during the course of this complaint investigation.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observations, resident and staff interviews and policy review, the facility failed to obtain a physician order prior to administering a c-pap machine and oxygen. This affected one (#09) out of three residents reviewed for following physician orders. The facility census was 47. Findings include: Review of Resident #09's medical record revealed an admission date of 12/06/25 with diagnoses of stress fracture of the left femur, chronic obstructive pulmonary disease, type 2 diabetes mellitus with other specified complication, and morbid (severe) obesity due to excess calories. Review of the care plan for Resident #09, dated 12/08/25 revealed resident had altered cardiovascular status r/t Hypertension, iron deficiency anemia with intervention of to give oxygen as ordered by the physician. Further review of the care plan, dated 12/08/25 revealed resident had altered respiratory status/difficulty breathing related to sleep apnea and chronic obstructive pulmonary disease (COPD) with intervention of provide oxygen as ordered. Review of admission Medicare 5-Day Minimum Data Set (MDS) dated [DATE] revealed Resident #09 was cognitively intact. Resident #09 required set-up assistance with eating and oral hygiene. Resident #09 required supervision assistance with personal hygiene. Resident required partial assistance with bathing. Resident #09 required substantial assistance with toileting hygiene, bed mobility, and transfers. Resident #09 was dependent on staff assistance with dressing and wheelchair. Resident #09 used oxygen therapy. Review of the physician orders for Resident #09 revealed no physician order to a c-pap machine. Further review revealed no physician order for oxygen administration. Review of the clinical admission progress note dated 12/07/25 at 12:10 A.M. revealed Resident #09 on oxygen (O2) via mask with oxygen saturation at 94 %. Review of the skilled evaluation note dated 12/25/25 at 3:43 A.M. revealed Resident #09 on oxygen (O2) via continuous positive airway pressure (CPAP) oxygen saturation at 93%. Review of the skilled evaluation note dated 01/03/26 at 2:58 A.M. revealed Resident #09 on oxygen (O2) via nasal cannula with oxygen saturation at 95%. Review of the skilled evaluation note dated 02/01/26 at 10:16 A.M. revealed Resident #09 on oxygen (O2) via nasal cannula with oxygen saturation at 92%. Review of the skilled evaluation note dated 02/08/26 at 10:52 A.M. revealed Resident #09 on oxygen (O2) via nasal cannula with oxygen saturation at 96%. Review of the skilled evaluation noted dated 02/11/26 at 12:33 A.M. revealed Resident #09 was on room air with oxygen saturation at 96%. Review of the skilled evaluation noted dated 02/22/26 at 8:44 A.M. revealed Resident #09 was on room air with oxygen saturation at 90%. Observation on 02/23/26 at 9:40 A.M. revealed a CPAP machine, and oxygen concentrator and a portable oxygen tank in Resident #09's room. All of the items were off and not in use. Observation on 02/24/26 at 7:06 A.M. revealed Resident #09 in bed with CPAP mask on resident with oxygen on at 2 liters attached through CPAP tubing with CPAP on at 6 cmH20. Interview on 02/24/26 at 7:15 A.M. with Resident #09 revealed uses her CPAP with oxygen attached every night while sleeping. Interview with Resident #09 also confirmed she uses two liters of oxygen and she has used both since admission. Observation on 02/25/26 at 7:08 A.M. revealed Resident #09 in bed with CPAP mask on resident with oxygen on at 2 liters attached through CPAP tubing with CPAP on at 6 cmH20. Interview on 02/25/26 at 7:47 A.M. with Licensed Practical Nurse (LPN) #132 confirmed Resident #09 uses her CPAP and oxygen every night and it is removed by staff off the resident in the morning when she wakes up. Interview also confirmed the resident did not have a physician's order for the CPAP setting of 6cmH20 or the oxygen of 2 liters. Interview on 02/25/26 at 11:48 A.M. with the Director of Nursing (DON) confirmed Resident #09 is on oxygen and has oxygen in her room. Interview on 02/25/26 at 12:00 P.M. with the DON confirmed Resident #09 has not had a physician's order for oxygen or a physician's order for the CPAP use since admission on [DATE]. Review of the (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Oxygen Policy, dated 11/2022 revealed oxygen will be used in a safe manner. This deficiency represents non-compliance investigated under Complaint Number 1319833 (OH00165332).

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, resident and staff interviews, and policy review, the facility failed to provide therapy services to ensure a resident maintained highest practicable level of physical and functional mobility. This affected one (#10) out of three residents reviewed for cares and services. The facility census was 47. Findings include: Review of the medical record for Resident #10 revealed an admission date of 01/19/26 with medical diagnoses of malignant neoplasm of cerebellum, malignant neoplasm of right lung, congestive heart failure, and chronic obstructive lung disease (COPD). Review of the medical record for Resident #10 revealed an admission Minimum Data Set (MDS) assessment, dated 02/01/26, which indicated Resident #10 had modified independence with decision making, required substantial/maximum staff assistance with toilet hygiene and was dependent upon staff for bed mobility and transfers. The MDS indicated Resident #10 received physical therapy (PT), occupational therapy (OT), and speech therapy (ST) services. Review of the medical record for Resident #10 revealed an Activities of Daily Living (ADL) deficit care plan with interventions for one staff assistance with toilet use, transfers, and bathing and PT and OT evaluation and treatment per physician orders. Review of the medical record for Resident #10 revealed physician orders dated 01/19/26 for PT, OT, and ST to eval and treat. Review of the medical record for Resident #10 revealed PT, OT, and ST evaluations dated 01/20/26. Review of the OT Discharge summary dated [DATE]- 02/12/26 which stated Resident #10 had not met goals and would benefit from continued therapy for functional mobility, ADLs, transfers and safety. Review of PT discharge note dated 02/11/26-02/12/26 stated patient was discharged from PT services due to insurance exhaustion and would remain in the facility. The PT discharge note indicated Resident #10 had not met therapy goals. Review of the ST Discharge summary dated 02/1126-02/12/26 stated services discharged due to insurance exhaustion and appeal lost. The note stated Resident #10 remained with cognitive and communication deficits and dysphagia.Interview on 02/24/26 at 1:09 P.M. with Resident #10 stated she was no longer provided therapy services after her insurance ended her skilled services. Resident #10 stated her therapy services ended a few weeks ago. Resident #10 stated she had applied for Medicaid because she would not be able to return home until she got stronger and able to do more for herself. Resident #10 stated her goal was to discharge home eventually. Resident #10 stated nursing staff do not assist her with standing and only use a mechanical lift to transfer her to a chair. Resident #10 stated when she was participating in therapy services she was able to stand and transfer with one therapy staff assistance but is no longer able to transfer without hoyer lift. Interview on 02/24/26 at 1:18 P.M. with Case Manager (CM) #183 stated Resident #10's insurance discontinued her skilled service stay and Resident #10 was not on therapy caseload at this time due to change in payer source and was Medicaid pending. CM #183 confirmed Resident #10's goal was to return home. Interview on 02/24/26 at 1:43 P.M. with State Tested Nursing Assistant (STNA) #107 stated when Resident #10 was on therapy services she had observed Resident #10 transfer with one staff assistance. STNA #107 stated the nursing staff use a mechanical lift for all Resident #10 transfers and were not informed or instructed by therapy services that staff could manually assist Resident #10 with transfers. Interview on 02/24/26 at 2:33 P.M. with Physical Therapy (PT) #503 stated Resident #10 was discharged from therapy services due to skilled insurance coverage being discontinued. PT #503 stated Resident #10 would benefit from therapy services. Interview on 02/25/26 at 7:32 A.M. with Director of Rehab (DOR) #502 stated Resident #10' therapy services were discontinued on 02/12/26 because skilled services were denied by insurance company. DOR #502 stated if a resident's skilled services ended and the resident continued to need therapy services then services would be provided under their Part B coverage once (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the insurance had been verified. DOR #502 confirmed Resident #10's Part B coverage had not been verified by the facility yet and that Resident #10 had not received therapy services since 02/12/26. DOR #052 confirmed the facility did not have Restorative programs. Review of the facility policy titled, Specialized Rehabilitative/Restorative Services, stated Occupational, Physical, and Speech Therapy services are ordered by a physician, or upon a physician's referral and provided to a resident by or under the supervision of an OT, PT, or ST therapy. The policy stated therapy services are to assist the residents in reaching their maximum functional performance through specialized therapy interventions and to transition to restorative nursing program, when appropriate. The policy also stated therapy services would collaborate between therapy services and the interdisciplinary team. This deficiency represents non-compliance investigated under Complaint Number 2631508.