STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365505	A. Building B. Wing	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village Green Health Campus	1315 Kitchen Aid Way Greenville, OH 45331

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on medical record reviews, staff and resident interviews and review of facility incident/event reports, the facility failed to provide adequate care and services during transfers to prevent incidents (i.e. skin tears). This affected two (#13 and #38) out of three residents reviewed for accidents. The facility census was 45. Findings include: 1. Review of the medical record for Resident #13 revealed an admission date of 03/19/25 with medical diagnoses of atrial fibrillation, malignant neoplasm of prostate, congestive heart failure, anxiety, chronic obstructive pulmonary disease, and hypertension. Review of the medical record for Resident #13 revealed an admission Minimum Data Set (MDS) assessment, dated 03/24/25, which indicated Resident #13 was cognitively intact and was dependent upon staff for toilet hygiene, transfers, and showers and required substantial/maximum staff assistance with bed mobility. The MDS did not indicate Resident #13 had any skin issues. Review of facility Incident Report, dated 04/09/25, stated a State Tested Nursing Assistant (STNA) reported to nurse that Resident #13 had bumped his right forearm causing a skin tear. The report stated two STNA's were taking Resident #13 to the bathroom per sit to stand lift when the incident occurred. Interview on 04/23/25 at 8:12 A.M. with Resident #13 stated he received a skin tear a few weeks ago to right forearm/wrist area after staff wheeled him into the bathroom and bumped his arm in the bathroom doorframe. Interview on 04/23/25 at 11:29 A.M. with Director of Nursing (DON) confirmed Resident #13 sustained a skin tear to right forearm/wrist area on 04/09/25 after staff were pushing Resident #13 in his wheelchair into the bathroom and Resident #13's arm bumped into the bathroom doorframe causing a skin tear. DON confirmed the STNA's immediately reported the incident to nurse who measured the skin tear and initiated a treatment. 2. Review of the medical record for Resident #38 revealed an admission date 11/20/23 with medical diagnoses of hypertensive heart disease with heart failure, congestive heart failure, cardiomyopathy, and diabetes mellitus. (continued on next page)

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

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record for Resident #38 revealed a quarterly MDS assessment, dated 03/24/25, which indicated Resident #38 had moderate cognitive impairment and required substantial/maximum staff assistance with toilet hygiene, bathing, bed mobility, and transfers. No skin issues were noted on the MDS. Review of the medical record for Resident #38 revealed a nurse's note, dated 02/23/25 at 3:13 A.M. with stated Resident #38 received a skin tear to left elbow while transferring. The note stated education provided to staff and the resident. The skin tear measured 1.5 cm by 0.7 cm, partial wound bed exposed, and able to replace skin flap. The note stated the skin tear was cleaned, steri strips applied and covered with an island dressing. Review of an Interdisciplinary Team (IDT) note, dated 02/24/25 at 2:45 P.M., stated Resident #38 obtained a skin tear to her left elbow during transfers and the area cleansed with wound cleanser and covered with island dressing. Review of a facility Event Report, dated 02/23/25, stated Resident #38 received a skin tear to her left elbow while transferring. The report stated resident representative and physician was notified. Interview on 04/23/25 at 10:21 A.M. with Resident #38 stated she sustained a skin tear to her left arm after staff were rushing to transfer her from the bathroom. Resident #38 stated the incident caused pain to her left arm, but the skin tear has since healed and pain subsided. Interview on 04/24/25 at 9:40 A.M. with DON confirmed Resident #38 sustained a skin tear to her left during a transfer with staff on 02/23/25. This deficiency represents non-compliance investigated under Complaint Number OH00164925.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on medical record review, staff interviews, review of staff statement, and policy review, the facility failed to ensure a nurse observed a resident consume medications at the time of administration. Additionally, the facility failed to ensure the individual who removed medications from medication cart was the same individual who administered the medications to the resident. This affected one (#24) out of the three residents reviewed for medical administration. The facility census was 45. Findings include: Review of the medical record for Resident #24 revealed an admission date of 09/17/24 with medical diagnoses of chronic obstructive pulmonary disease, arthritis, hypertensive chronic kidney disease, hypothyroidism, and arteriosclerotic heart disease. Review of the medical record for Resident #24 revealed a quarterly Minimum Data Set (MDS) assessment, dated 02/13/25, which indicated Resident #24 was cognitively intact and required partial/moderate staff assistance with bathing and transfers, supervision with toilet hygiene, and set-up with eating. Review of the medical record for Resident #24 revealed a Medication Administration Record (MAR) which had documentation to support Licensed Practical Nurse (LPN) #100 signed the MAR on 12/20/24, 12/23/24, 12/24/24, 12/27/24, 12/28/24, 12/29/24, and 12/30/24 that she administered Resident #24's medications. Review of the medical record for Resident #24 revealed an Episodic event note, dated 12/14/24, which stated Resident #24's daughter accused LPN #100 of hitting the daughter in the arm. The root cause analysis stated Resident #24's daughter was attempting to stop LPN #100 from leaving Resident #24's room. Review of a statement by LPN #100, dated 12/15/24, stated the incident occurred on 12/14/24 at 6:00 P.M. after she observed Resident #24 had not taken the medications that LPN #100 had brought into the room at approximately 4:00-5:00 P.M. LPN #100 stated when she originally brought the medications into the room, Resident #24 was in the bathroom so the LPN #100 left the medications in Resident #24's room and trusted she would take them. Interview on 04/23/25 at 12:25 P.M. with LPN #100 confirmed she left medications in Resident #24's room unattended on 12/14/24 because Resident #24 was in the bathroom as per her statement dated 12/15/24. LPN #100 stated she returned to Resident #24's room about one hour after leaving the medications in Resident #24's room to discover Resident #24 had not taken the medications. LPN #100 stated she was removed from Resident #24's care for a few months after the incident with Resident #24's daughter on 12/14/24 but stated she continued to pull Resident #24's medications from the medication cart and another nurse would administer the medications to Resident #24. LPN #100 confirmed she was the nurse who signed off on the medication administration on the MAR in December 2024 even though she did not observe Resident #24 consume the medications. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Director of Nursing (DON) on 04/23/25 at 1:46 P.M. confirmed Resident #24 was removed from LPN #100 assignment after December 14, 2024, for a short period of time after an incident between Resident #24's daughter and LPN #100. DON confirmed that after the incident, LPN #100 would pull Resident #24's medications from the medication cart and another nurse would administer the medications to Resident #24. DON also confirmed Resident #24's December 2024 MAR had documentation to support LPN #100 administered medications on 12/20/24, 12/23/24, 12/24/24, 12/27/24, 12/28/24, 12/29/24, and 12/30/24. Review of the facility policy titled, Administering Medications, stated medications shall be administered in a safe and timely manner and as prescribed. The policy stated the individual administering medications must check the label to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. The individual administering the medication must initial the resident's MAR after giving the mediation. The policy stated for residents not in their room or otherwise unavailable to receive mediation on the pass, the MAR may be flagged and after completing the medication pass, the nurse would return to the missed resident to administer the medication. This deficiency represents non-compliance investigated under Complaint Number OH00161707.