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	07/02/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (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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(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 - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on record review, staff interview and policy review, the facility failed to ensure medications were administered as ordered. This affected four (#50, #11, #29 and #19) out of four residents reviewed for medication administration. The facility census was 49. Findings include: 1. Review of Resident #50 closed medical record revealed an admission on [DATE] with diagnoses including atrial fibrillation, heart failure, kidney failure and hypothyroidism. Review of Resident #50 quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed intact cognition. Resident #50 required extensive assistance for bed mobility, transfers, and toileting. Review of the hospital discharge record dated 03/31/25 Resident #50 was prescribed Levothyroxine 125 micrograms (mcg) one tablet by mouth daily to start on 04/01/25. Review of the physicians' orders for Resident #50 for the month of March 2025 was silent for administration of levothyroxine. Review of the physicians' orders for Resident #50 for the month of April 2025 was silent for administration of levothyroxine. Review of the medication administration record (MAR) for Resident #50 was silent for any documentation of levothyroxine 125 mcg being administered. Review of the progress notes for Resident #50 dated 04/30/25 at 09:44 P.M. revealed the resident appeared to have blood in his stool and was not at baseline. The physician was notified, and resident was transferred to the emergency room (ER). Review of the progress note for Resident #50 dated 05/01/25 revealed levothyroxine 125 mcg one tablet by mouth was omitted during order entry of hospital discharge orders on 03/31/25 to begin on 04/01/25 and medication was not received. Resident #50 was transferred to the ER due to low blood pressure and blood in his stool. Resident #50 was admitted with hypothermia and hypothyroidism. Resident #50's physician and resident representative were notified. Review of the facility medication error report for Resident #50 dated 05/01/25 revealed levothyroxine 125 mcg should have been initiated on 04/01/25 and was not. Immediate corrective action revealed that new admission discharge orders will be brought to the morning meeting daily to ensure medication orders were entered into the electronic medical record correctly. In addition, the facility conducted a whole facility audit for all residents with thyroid diagnoses was conducted with emphasis on thyroid laboratory results being current and medication correctly being administered. This included seventeen residents in the facility. Interview on 07/02/25 at 12:00 P.M. with Director of Nursing (DON) verified the levothyroxine was not entered into the computer on readmission on [DATE] and should have been. DON stated a medication error report was completed on 05/01/25 and the family was notified of the error. 2. Review of current Resident #11's medical record revealed an admission on [DATE] with diagnoses including vascular dementia, atrial fibrillation, and myocardial infarction. Review of the quarterly MDS assessment dated [DATE] for Resident #11 revealed an impaired cognition. Resident #11 required extensive assistance for toileting, bed mobility and transfers. Resident #11 was coded as supervision for eating. Resident #11 was coded as receiving an anticoagulant during the assessment period. Review of the plan of care for Resident #11 dated 03/26/25 revealed resident is at risk for abnormal bleeding or hemorrhage related to anticoagulant therapy. Interventions include administering medications as prescribed, avoid activities that could cause injury, monitor for signs and symptoms of bleeding, obtain and monitor laboratory results, and review medications for adverse interactions. Review of the active physician orders for Resident #11 revealed an order for Xarelto 20 milligrams (mg) one tablet daily for left atrial thrombus dated 03/24/25. Review of the MAR for the month of March 2025 for Resident #11 revealed resident received Xarelto as ordered beginning on 03/24/25. Review of the Medication Error Report dated 03/24/25 for Resident #11 revealed Xarelto 20 mg was not entered into the electronic medical record during the transition to the new software effective on 03/01/25. Immediate corrective actions included notification of the physician to restart orders and obtain an echocardiogram. Further review of the medication error report revealed the resident representative was notified. Interview on 07/02/25 at 12:00 P.M. with DON verified the medication error occurred and the physician and Resident #11's representative was notified. DON verified the echocardiogram was completed without any negative findings. 3. Review of current Resident #19 revealed an admission date of 03/28/25 with diagnoses including chronic obstructive pulmonary disease, dementia, kidney disease, and type two diabetes with polyneuropathy. Review of the comprehensive MDS assessment dated [DATE] for Resident #19 revealed an intact cognition. Resident #19 required set up assistance for meals, supervision for bed mobility and