STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365604	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Green Meadows Skilled Nursing and Rehab	7770 Columbus Road NE Louisville, OH 44641

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on record review, observation of dining, interview, and review of facility policy, the facility failed to promote resident dignity and independence while dining, by standing over residents while assisting them to eat and not assisting the resident into a position to be able to feed themselves. This affected four residents (#24, #87,#92, and #65) of eleven residents observed for dining needs. The facility census was 93. Findings include:Review of the medical record for Resident #24, revealed an admission date of 04/11/23. Diagnoses included but were not limited to Alzheimer's Disease, dementia, gastroesophageal reflux, major depressive disorder, hyperlipidemia, type two diabetes, peripheral vascular disease, and anxiety disorder.Review of a quarterly Minimum Data Set (MDS) 3.0 assessment for Resident #24, dated 03/19/26, revealed a Brief Interview for Mental Status (BIMS) of two on a 0-15 scale. A BIMS score of 0 to 7 points suggests severe cognitive impairment.The MDS indicated the resident required substantial/maximum assistance with eating, was dependent for toileting and required substantial/maximal assistance for bathing. She ambulated with touch assistance with no assistive devices. The resident was frequently incontinent of both bowel and bladder.Review of the care plan for Resident #24 revealed a focus of care for ADL self-care deficit, initiated on 10/27/22, and last updated 02/12/26. Interventions included offering assistance with meals if needed.Review of the medical record for Resident #87, revealed an admission date of 10/01/22. Diagnoses included but were not limited to cerebral infarction due to embolism of unspecified cerebral artery, unspecified dementia, vitamin B12 deficiency, other specified peripheral vascular disease, atherosclerotic heart disease of native coronary artery, major depressive disorder, gastroesophageal reflux disease, vascular dementia, mild, without behavioral disturbance, and presence of pacemaker.Review of a quarterly Minimum Data Set (MDS) version 3.0, dated 05/03/26, revealed a Brief Interview of Mental Status (BIMS) score of 0 on a 0-15 scale. A BIMS score of 0 would indicated severe cognitive impairment. The MDS further indicated the resident required partial to moderate assistance for all Activities of Daily living (ADLs) except she was dependent for toileting.Review of a care plan for Resident #87 revealed a focus of care for ADL (activities of daily living) assistance, initiated 10/27/22 and updated 02/12/26. Interventions included assisting with meals as needed.On 05/19/26 from 11:15 A.M. to 12:00 P.M., observation of the dining room of E-Wing revealed the following: At 11:15 A.M., Resident #65 was in the dining room and was at a table with Resident #64. Resident #64 received his tray at 11:15 A.M., and finished eating at 11:24 A.M. Resident #65 received his tray at 11:34 A.M. He was noted to not be eating. At 11:55 A.M., he was still not eating. LPN #213 arrived in the dining room at 11:57 A.M., and sat to assist Resident #65 with eating. This was confirmed by CNA #301 at the time of the observation.At 11:20 A.M., Resident #24 received her tray. No staff member was sitting with the resident assisting her with eating. Resident #87 was sitting at the same table with Resident #24 and being assisted with eating by an unknown Speech Therapist. Certified Nurse Aide (CNA) #236 walked past Resident #24, stopped and put some food in the resident's mouth and walked away to assist another resident. This was confirmed by CNA #301 at the time of the observation.At 11:25 A.M., Resident #92 was brought to the dining room. She was placed at the end of a table with one other resident who was already eating. Her wheelchair was (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	sideways, facing away from the table. At 11:38 A.M., her tray was placed on the table, however there was no way for the resident to reach her food to feed herself. The resident required assistance to set up her tray and to position herself to be able to eat. This was confirmed by CNA #301 at the time of the observation.At 11:32 A.M., an observation revealed CNA #221 stood over Resident #24 and was assisting the resident with eating while talking with another resident at the table behind her. After several bites, licensed practical nurse (LPN) #210 advised CNA #221 to sit while assisting the resident. When CNA #221 sat to assist Resident #24, the Speech Therapist left the table and did not finish assisting Resident #87, leaving CNA #221 to assist both residents who required total assistance with eating. This was confirmed by CNA #301 at the time of the observation.At 11:50 A.M. on 05/19/26, an interview with CNA #301 confirmed Resident #24 and Resident #87 both required total assistance for eating. Resident #92 needed set-up assistance and occasional queuing to eat, and Resident #65 required assistance with feeding more than half the time, otherwise he would not eat. She confirmed observations which included: Staff assisting with eating for Resident #24 as they passed by her, then while they stood over her; Speech Therapist leaving the dining room in the middle of assisting Resident #87 with eating, leaving CNA #221 to assist both residents at the same time with eating; Resident #92 not being placed in a position to be able to reach her tray or feed herself; and Resident #65 sat for over 20 minutes with his tray in front of him and no one assisting or encouraging him to eat. On 05/19/26 at 11:59 A.M., an interview with Licensed Practical Nurse (LPN) #210 revealed staff members should be seated when assisting residents with eating. She further explained Resident #92 could feed herself, however the position she was in left her unable to reach her tray or her food. She also occasionally needed queuing to eat. Finally, Resident #64 needed assistance with set up of his food as well as assistance with eating or queuing to eat, otherwise he would not eat. She also reported all residents at a table should get their food at the same time, and should not have to wait with food in front of them for assistance.Review of an undated facility prepared document titled Residents that Need Fed revealed both Resident #24 and Resident #87 required feeding.Review of a facility policy titled Resident Rights, revised September 2022, revealed employees should always treat residents with kindness, respect and dignity. Rights included the right to a dignified existence.Review of an undated facility policy titled Activities of Daily Living (ADLS) revealed the residents would be provided with care, treatment and services to maintain or improve their ability to carry out ADLS. If the resident was unable to do so independently, they would receive services necessary to maintain good nutrition, grooming and personal and oral hygiene. In accordance with their plan of care, residents would receive assistance with hygiene, mobility, toileting, dining and communication.Review of an undated facility policy titled Dignity revealed each resident would be care for in a manner which promoted and enhanced their sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. When assisting with care, residents were to be provided with a dignified dining experience. Standards of care which compromised dignity were prohibited. Staff were expected to promote dignity.This deficiency represents non-compliance investigated under Complaint Number 2742642.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview and record review, the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior and to maintain a temperature between 71 degrees Fahrenheit (F) and 81 degrees F in the shower room of the E-Wing, which was the facility memory care unit. This affected all 26 of 26 residents residing on the facility's E-Wing. The facility census was 93. Findings include:On 05/18/26 at 1:08 P.M., an observation of the shower room of the E-Wing revealed a wall mounted shower with a handheld shower head which could not be shut off. Hot water was continually running. There was no thermometer in the room, however the room was very warm. The shower contained a wall-mounted shower, which had light green corrosion surrounding the bottom and had a built-in soap tray which was covered in the light green corrosion which would come off to touch. The heater and the floor drain of the shower were both rusted. The shower room was attached, without any doors, to the dirty laundry and trash room, and the odor of ammonia was strong throughout the room. This was confirmed by Licensed Practical Nurse (LPN) #210 at the time of the observation.On 05/18/26 at 1:08 P.M., an interview with LPN #210 confirmed the shower in the shower room could not be turned off, and there was light green corrosion on the wall mounted shower and soap dish, which residents would use during their showers. She confirmed the floor drain and the vent beside the shower were both rusted.LPN #210 further confirmed there was a strong odor coming from the dirty linen/trash room. During the observation, the LPN was notably perspiring and reported she would not feel clean if she had to shower in the E-Wing shower due to the heat and the odor. On 05/18/26 at 3:37 P.M., an observation of the Maintenance Director checking the temperature in the E-Wing Shower room revealed the temperature of the room was 82 degrees Fahrenheit (F). This was confirmed by the Maintenance Director at the time of the observation.On 05/18/26 at 3:40 P.M., interview with the Maintenance Director revealed he thought the temperature in the facility should be kept between 70 and 80 degrees Fahrenheit (F), and the temperature of the E-Wing shower room was 82 degrees F. He further revealed there were no ventilation or exhaust fans in any of the facility shower rooms, there were only transfer grills, which he believed contributed to the heat. He had been unable to get any parts to fix the shower, and had been asking for months to be able to fix it and update the shower room.On 05/19/26 at 10:10 A.M., an interview with LPN #210 revealed the only shower on the E-Wing was the shower room. There were no showers in the resident rooms. All residents of the unit had to use the shower room. The unit census was 26.On 05/19/26 at 10:24 A.M., an interview with Certified Nurse Aide (CNA) #248 revealed the E-Wing shower room was so hot I almost puke or pass out whenever she had to shower someone. It was hard to catch her breath in the room. Setting anything on the soap dish in the room would be unsanitary because of the green corrosion. Personally, I would not take a shower in there and I feel like I need to take a bleach shower when I leave that room. She confirmed all 26 residents used the shower room on E-Wing and there was nowhere else to safely take the residents of this unit to shower because they could not be taken off of the unit, and there were no other shower areas available on the E-Wing.On 05/20/26 at 2:10 P.M., an interview with Resident #51 revealed she did not like to leave her room unless she had to. Left only to go to the shower room once a week. She indicated the shower never stops and it was very hot in the shower room. She said often there would be things piled up all over the room. On 05/21/26 at 10:25 A.M., an interview with the Administrator revealed the shower on the E-Wing had been leaking for some time. The Maintenance Director had tried to order parts to fix it, however the company had discontinued the parts, since they were so old. She had a company come in on 05/19/26 and they were going to be able to order the parts. She was not sure how long they had been trying to get the parts, but she was aware it had been an issue for at least a few months.Review of facility TELS reports (TELS was a platform used by maintenance staff to document work orders) revealed the following work orders (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	related to the shower room on the E-Wing:a) Work Order #6126, dated 01/29/26, reported E-Wing shower faucet would not turn. The maintenance response was It turned for me.b) Work Order #6188, dated 03/02/26, reported E-Wing shower dripping all weekend. Could not get the water to stop, and it was so hot there was mold growing up the wall. The maintenance response was Completed.c) Work Order #6191, dated 03/03/26, reported E-Wing shower water was luke warm. Maintenance response was adjusted water temperature.d) Work Order #6206, dated 03/09/26, reported E-Wing shower dripping. Maintenance response cancelled.e) Work Order #6223, dated 03/18/26, reported E-Wing shower needs floor drain cover. Maintenance response was completed.These work orders were confirmed by the Maintenance Director on 05/19/26 at 2:00 P.M.Review of an undated facility policy titled Dignity revealed residents would be cared for in a manner which promoted and enhanced their sense of well-being, level of satisfaction with life, and feelings of self worth and self esteem.This deficiency represents non-compliance investigated under Master Complaint Number 2748123 and Complaint Number 2742642.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, policy review, resident observations, and staff and resident interviews, the facility failed to assist residents who were dependent on staff for their needs including timely incontinence care, getting up for meals timely, and bathing/showering as scheduled. This affected three residents (#109, #114, and #184) of three residents reviewed for provision of care. The facility identified 56 residents as needing assistance with incontinence care, bathing/showering, and required use of a mechanical lift to set up in chair for meals. The facility census was 93.Findings include:1.Review of the medical record for Resident #109 revealed admission to facility on 08/31/92 with most recent reentry on 08/29/13. The resident had diagnoses including stroke with hemiplegia, aphonia (difficulty speaking), heart failure, chronic lung disease, dysphagia (difficulty swallowing), major depression, bilateral retinopathy (affects vision to both eyes).Further review of the medical record for Resident #109 revealed his most recent quarterly minimum data set (MDS) assessment completed on 04/14/26 indicated a brief interview for mental status score of 15/15 indicating full cognition without deficit. The MDS 3.0 assessment further revealed that Resident #109 was dependent on staff for eating and oral hygiene, dependent on staff for bathing and dressing, and dependent on staff for transferring and mobility. Resident #109 required the use of a mechanical lift and two staff to transfer from bed to wheelchair and had both bowel and bladder incontinence.Observation on 05/19/26 at 12:45 P.M. of Resident #109 revealed he was lying in bed with his head elevated and no meal tray present. This was verified by licensed practical nurse (LPN) #217 at the time of the observation.Interview on 05/19/26 at 12:46 P.M. with LPN #217 revealed that Resident #109 had just eaten his lunch and was assisted by a nursing aide. LPN #217 further reported that Resident #109 preferred to get up in his wheelchair for meals, but the staff did not have time to get him up for lunch and are going to get him up in his wheelchair soon.Observation and interview on 05/20/26 at 12:52 P.M. with Resident #109 revealed he was dressed and groomed with no odor present and sitting up in his tilt wheelchair. The certified nurse aide (CNA) had just taken the tray from the room and Resident #109 was noted to have a clothing protector present. Resident #109 verified he likes to be up in his chair for lunch and dinner but sometimes eats his breakfast in bed. Resident #109 verified that the staff doesn't always get him up for lunch and when asked why he shrugged his shoulders.2.Review of the medical record for Resident #114 revealed admission to facility on 08/25/23 with most recent re-entry on 07/07/25. The resident had diagnoses including end stage renal disease, chronic respiratory failure, atrial fibrillation (irregular heartbeat), downs syndrome, morbid obesity, depression, mild intellectual disabilities, anemia (low blood count), kidney dialysis, and high blood pressure. Review of the medical record revealed Resident #114's BIMS score was 15/15 revealing he was cognitively intact. Further review revealed Resident #114 was continent of urine and bowel. Resident #114 was dependent on staff for transferring from bed to wheelchair and dependent on staff to assist with bathing and dressing. Interview on 05/21/26 at 12:22 P.M. with Resident #114 revealed he was able to control his bowels and bladder and would put his call light on for the staff to help him get on the bed pan to urinate or move his bowels. Resident #114 further reported that he sometimes had to wait too long and that he would have accidents with his bowels/bladder in his bed. Resident #114 reported that his bottom was sore that day and the nurse told him that his bottom was red that morning. Resident #114 was unable to recall if the nurse put cream or ointment on his bottom. Interview on 05/21/26 at 12:30 P.M. with CNA #186 revealed that Resident #114 was not incontinent and would put his call light on for the bed pan if he needed to use the restroom. CNA #186 further reported that Resident #114's skin to his peri area was red and irritated this morning and she reported it to the nurse.Further review of the medical record for Resident #114 revealed a nursing progress note for wound evaluation dated 03/10/26 identified the resident had a reddened, raised rash with fungal appearance to his bilateral buttocks that resolved (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with treatment on 04/07/26.3.Review of the closed medical record for Resident #184 revealed admission to the facility on [DATE] for a planned short skilled stay. The resident had diagnoses including shingles, chronic lung disease, heart failure, high blood pressure, pain to right and left legs, and generalized weakness.Review of the medical record for Resident #184 revealed a comprehensive MDS assessment completed on 09/03/26 indicating a BIMS score of 15/15, cognitively intact. Further review of the MDS revealed Resident #184 required substantial/maximum assistance with toileting, dressing, and bathing/showering and required the use of a wheelchair for mobility.Review of the shower schedule for Resident #184 revealed she was to have assistance with showers on Monday and Thursday during the afternoon shift.Review of the facility self-reported incident (SRI) #265296 related to Resident #184 not receiving showers revealed Resident #184's daughter reported on 09/12/25 that the resident had not received a shower or bath since her admission to the facility and the daughter was not leaving the facility until her mother had a shower. The SRI revealed no documentation in the electronic medical record confirming that Resident #184 was provided with baths or showers from 08/29/25 through 09/11/25.Interview on 05/21/26 at 2:30 PM with the facility Administrator confirmed that the facility did not have evidence documented that Resident #184 had received baths or showers prior to the daughter's complaint on 09/12/25. Review of the facility policy titled Activities of Daily Living, undated revealed appropriate care and services will be provided to residents who are unable to independently perform their own care including hygiene (bathing/dressing), mobility (transfers and walking), elimination (toileting), dining (meals/snacks, and communication methods in accordance with resident care plans. This deficiency represents non-compliance investigated under Complaint Numbers #2742642, #2686119, and #2681301.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and interviews, the facility failed to maintain sufficient levels of staff to meet the total care needs of all residents. This affected five residents (#109, #113, #114, and #184) of five residents reviewed for personal care services and had the potential to affect all 93 residents residing in the facility. The facility census was 93. Findings include: Observation and interview on 05/18/26 at 10:10 A.M. during the facility entry conference with Administrator and Licensed Practical Nurse (LPN) #213 revealed the facility Director of Nursing (DON) was on vacation this week and the facility did not currently have the assistant director of nursing (ADON) position filled. Continued observation during the survey from 05/18/26 through 05/21/26 revealed no DON and no ADON present at the facility. Review of the DON personnel file revealed she was hired as the previous ADON on 04/16/26. Further review revealed that on 05/03/26 she was transferred to the DON position.Interview on 05/19/26 at 10:36 A.M. with licensed practical nurse (LPN) #213 revealed she was the new infection preventionist nurse and started that position 13 days ago. LPN #213 reported she was the wound nurse prior and will continue that role in conjunction with the infection preventionist role. LPN #213 confirmed she just completed her certification for her role as infection preventionist the day before on 05/18/26 (date of entry of the survey). LPN #213 reported she had been receiving training from the corporate office.Interview on 05/19/26 at 10:40 A.M. with the minimum data set (MDS) coordinator, LPN #206 revealed she had been managing the infection control program for about one month until the position could be filled and that she did have a certification from previous employment at another facility. LPN #206 had been with the facility for less than one year and reported that the facility had three different DONs prior to the current DON in that time. The previous DON took a regional nursing position within the company, and the ADON had moved to the DON position. Review of the annual facility assessment updated 02/02/26 revealed the facility average daily census to be 87-100 residents residing in the facility. Further review of the facility assessment revealed a section titled Acuity: Special Treatments and Conditions based upon 08-06-24 Center for Medicare and Medicaid 672 form indicating the facility averaged 0-2 bedfast residents, 68-72 residents who are in their chair most or all of the time. There was no acuity section that indicated resident's level of dependance or function for personal care such as bathing and mobility for transferring. Further review of the facility assessment revealed the staffing plan, to include direct care staff based on resident acuity, preference, competencies of staff, and needs of residents. The average staffing pattern was 4-5 licensed nurses per shift depending on acuity and 2-4 certified nursing assistants (CNA)'s per unit per shift depending on resident acuity. Review of the facility provided resident information included a list of 37 residents requiring two person assisted mechanical lifts (residents who cannot safely transfer themselves or stand and pivot form bed to chair and are dependent to get out of bed or chair), 56 residents who were incontinent of urine or bowel and required being checked for incontinency and changed as required by staff every two hours, and a list of 13 residents who required feeding assistance for all meals (meaning supervision/queuing, or feeding). Review of both the licensed nursing and CNA schedules for the week of 05/18/26 through 05/22/26 revealed one (1) licensed nurse scheduled to each unit (4 total) each shift (6:00 A.M. to 6:00 P.M. and 6:00 P.M. to 6:00 A.M) and two (2) to three (3) CNA's per unit per shift (day 7:00 A.M. to 3:00 P.M., afternoon 3:00 P.M. to 11:00 P.M., and nights11:00 P.M. to 7:00 A.M.). More detailed review of the staffing schedule for the week of 05/18/26 to 05/22/26 revealed Unit A (long term residents) and Unit F (residents receiving skilled services) were scheduled with 1-2 CNA's on day shift, afternoons, and night shift. There was an additional transport aide scheduled daily from 6:00 A.M. to 4:30 P.M. to assist with dialysis and for resident transportation to and from appointments outside of the facility.Interview on 05/19/26 at 11:54 A.M. with LPN #210 revealed Unit E had seven residents who (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	needed eating assistance (Resident #108, Resident #24, Resident #87, Resident #34, Resident #41, Resident #88, and occasionally Resident #65). During the observation of the afternoon meal, only four of the identified residents were present in the dining room. LPN #210 reported all the residents were normally up and in the dining room for meal assistance, however on this day the staff had all been really busy and ran out of time to get them up. Staff would have to assist Resident #41, Resident #34, and Resident #88 with eating in their room, and make sure the residents were all up for the dinner meal.Interview on 05/19/26 at 2:00 P.M. with CNA #192 revealed she has worked at facility since January 2026. CNA #186 reported that when the B Unit was scheduled with three CNA's, things go more smoothly and all residents were up and dressed by 10:30 A.M. If only two CNAs were working then it took longer due to some many mechanical lifts on the unit that required two persons to get them up, especially if one of the CNA's was an agency staff person and did not know where things were and did not know the residents. CNA #192 further reported there was always at least one agency CNA or Nurse working on the unit every shift. Interview on 05/19/26 at 2:38 P.M. with CNA #186 revealed she had worked at the facility since February 2023. CNA #186 confirmed she generally worked the B Unit but was pulled to the F Unit (skilled unit) for the day due to a report off of staff. CNA #186 reported there were a lot of residents requiring mechanical lift (for transfers) on the B Unit and if three CNAs were staffed residents were up and dressed for the day by 10:30 A.M. CNA #186 reported that if only two CNA were scheduled it was hard to get all the residents up in chairs and dressed for the noon meal especially if agency staff were working and did not know the residents. CNA #186 reported there were frequent call offs by the agency staff so everyday an aide was getting pulled to another unit to help.Interview on 05/20/26 at 12:50 P.M. with CNA #220 revealed he had worked at the facility for about one year and usually worked the A Unit. CNA #220 reported that it was difficult when only two CNAs were scheduled to work the unit because of the number of residents requiring mechanical lifts on the unit. CNA #220 reported the aides tried to get Resident #109 up and in chair for lunch like he liked but they don't always get to him in time. CNA #220 reported that the aides tried to make sure all the residents who wanted to eat in lunch in the dining room were dressed and up and taken down to the dining room by 11:00 A.M. and when only two aides were working it was difficult to get everyone done before lunch. Interview on 05/20/26 at 1:30 P.M. with the facility scheduler (SC) #323 revealed she was hired toward the end of November 2025. SC #323 reports the facility is trying to use less agency staff and agency staff sometimes are no call and no shows. SC #323 reported if a CNA reported off then they would pull a CNA from one of the units that has three assigned that day and then each unit would have at least two CNA for the shift. SC #323 reported that if the transportation aide was available between her duties she would help the units also. SC #323 verified that the facility utilized four different staffing agencies to cover both CNA and nursing needs.Interview on 05/20/26 at 2:10 P.M. with a family member of Resident #51 revealed concerns regarding the facility using agency staffing. She reported a few weeks before many of the routine staff had the flu, and most of the staffing was covered by agency staffers. During that time, her mother was not getting clean. She had the same socks on for the entire week. One Certified Nurse Aide (CNA) came into the room to deliver her lunch, and the smell of body odor was so bad it lingered in the room. She made sure to take all her trays out of the room herself, so the staff member did not return to the room. Review of the medical record for Resident #109 revealed admission to facility on 08/31/1992 with most recent reentry on 08/29/2013. The resident's diagnoses included stroke with hemiplegia, aphonia (difficulty speaking), heart failure, chronic lung disease, dysphagia (difficulty swallowing), major depression, bilateral retinopathy (affects vision to both eyes).Further review of the medical record for Resident #109 revealed his most recent quarterly minimum data set (MDS) assessment completed on 04/14/26 indicated a brief interview for mental status score of 15/15 indicating full cognition without deficit. The MDS 3.0 assessment further revealed that Resident #109 was dependent on staff for eating and oral hygiene, dependent on staff for bathing and dressing, and dependent on staff for transferring and mobility. Resident #109 required the use of a mechanical lift (continued on next page)

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	365604	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Green Meadows Skilled Nursing and Rehab	7770 Columbus Road NE Louisville, OH 44641

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	and two staff to transfer from bed to wheelchair and had both bowel and bladder incontinence.Observation on 05/19/26 at 12:45 P.M. of Resident #109 revealed he was lying in bed with his head elevated and no meal tray present. This was verified by licensed practical nurse (LPN) #217.Interview on 05/19/26 at 12:46 P.M. with LPN #217 revealed that Resident #109 had just ate his lunch and was fed by a nursing aide. LPN #217 further reported that Resident #109 preferred to get up in his wheelchair for meals, but the staff did not have time to get him up for lunch and were going to get him up in his wheelchair soon.Observation and interview on 05/20/26 at 12:52 P.M. with Resident #109 revealed he was dressed and groomed with no odor present and sitting up in his tilt wheelchair. The certified nurse aide (CNA) had just taken the tray from the room and Resident #109 was noted to have a clothing protector present. Resident #109 verified he liked to be up in his chair for lunch and dinner but sometimes ate his breakfast in bed. Resident #109 verified that the staff doesn't always get him up for lunch and when asked why he shrugged his shoulders.Review of the medical record for Resident #114 revealed admission to facility on 08/25/23 with most recent re-entry on 07/07/25. The resident had diagnoses including end stage renal disease, chronic respiratory failure, atrial fibrillation (irregular heartbeat), downs syndrome, morbid obesity, depression, mild intellectual disabilities, anemia (low blood count), kidney dialysis, and high blood pressure. Review of the medical record revealed Resident #114's BIMS score was15/15 revealing he was cognitively intact. Further review revealed Resident #114 was continent of urine and bowel. Resident #114 was dependent on staff for transferring from bed to wheelchair and dependent on staff to assist with bathing and dressing. Further review of the medical record for Resident #114 revealed a nursing progress note for wound evaluation dated 03/10/26 that the resident had a reddened, raised rash with fungal appearance to his bilateral buttocks that resolved with treatment on 04/07/26.Interview on 05/21/26 at 12:22 P.M. with Resident #114 revealed he was able to control his bowels and bladder and would put his call light on for the staff to help him get on the bed pan to urinate or move his bowels. Resident #114 further reported that he sometimes had to wait too long and that he would have accidents with his bowels/bladder in his bed. Resident #114 reported that his bottom was sore that day and the nurse told him that his bottom was red that morning. Resident #114 was unable to recall if the nurse put cream or ointment on his bottom. Interview on 05/21/26 at 12:30 P.M. with CNA #186 revealed that Resident #114 was not incontinent and would put his call light on for the bed pan if he needed to use the restroom. CNA #186 further reported that Resident #114 skin to his peri area was red and irritated this morning and she reported it to the nurse. CNA #186 further reported that she also had concerns with Resident #113 having a wet adult incontinence brief and bed this morning with skin irritation to buttocks that she reported to the nurse.Review of the medical record for Resident #113 revealed admission to facility on 05/30/24 with diagnoses including stroke, diabetes, dysarthria (difficulty finding words), anxiety, depression, impaired left eye, left side weakness from stroke, and high blood pressure.Further review of the medical record for Resident #113 revealed she required a two person transfer with a mechanical lift. Resident #113 was noted to be incontinent of urine and bowel and had a BIMS score of 11/15, indicating moderate cognitive impairment. Observation on 05/21/26 at 12:40 P.M. of incontinence care provided to Resident #113 revealed CNA #186 and CNA #192 gathered supplies and performed hand hygiene and put on clean gloves then transferred Resident #113 from her wheelchair to her bed using the mechanical lift. CNA #186 and #192 then removed Resident #113 pants and soiled adult brief and provided incontinence care using clean wash cloths with soap and water appropriately. Further observation noted that Resident #113 skin on her buttocks was red and irritated around her peri area and appeared to have moisture associated skin damage (MASD) to the area. LPN #223 was present and verified the area was red and irritated and applied Triad cream (a skin protectant cream) to the area after Resident #113 was clean and prior to placing a new incontinence brief.Interview on 05/21/26 at 12:45 P.M. with LPN # 223 revealed the skin protectant cream (Triad Cream) that was ordered for incontinent residents every shift and as need with incontinent episodes were kept locked at the nurses' station and could only be applied by the nursing (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	staff. LPN #223 reports she was not always available when the CNAs were doing rounds to check and change residents and that if she was not available the cream was not applied. Interview with on 05/21/26 at 12:48 P.M. with CNA #186 revealed that the CNA must ask the nurse to use the skin protectant cream and it was not left at the bedside for the CNAs to use with check and changes. CNA #186 reported that LPN #223 was the best at trying to make sure to apply cream to the incontinent residents, but the agency nurses were not that good at getting to it.Review of the closed medical record for Resident #184 revealed admission to the facility on [DATE] for a planned short skilled stay for diagnoses including shingles, chronic lung disease, heart failure, high blood pressure, pain to right and left legs, and generalized weakness.Review of the medical record for Resident #184 revealed a comprehensive MDS assessment completed on 09/03/26 indicating a BIMS score of 15/15, cognitively intact. Further review of the MDS revealed Resident #184 required substantial/maximum assistance with toileting, dressing, and bathing/showering and required the use of a wheelchair for mobility.Review of the shower schedule for Resident #184 revealed she was to have assistance with showers on Monday and Thursday during the afternoon shift.Review of the facility self-reported incident (SRI) #265296 related to Resident #184 not receiving showers revealed Resident #184's daughter reported on 09/12/25 that the resident had not received a shower or bath since her admission to the facility and the daughter was not leaving the facility until her mother had a shower. The SRI revealed no documentation in the electronic medical record confirming that Resident #184 was provided with baths or showers from 08/29/25 through 09/11/25.Interview on 05/21/26 at 3:15 PM with the facility Administrator confirmed that the facility did not have evidence documented that Resident #184 had received baths or showers prior to the daughter's complaint on 09/12/26. This deficiency represents non-compliance investigated under Complaint Number #2742642, #2686119, and #2681301.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on review of the medical record and facility policy, observations, and staff interview, the facility failed to ensure appropriate hand hygiene to stop the spread of infection. This affected one resident (#113) of two residents observed for incontinence care. The facility census was 93.Findings include: Review of the medical record for Resident #113 revealed admission to facility on 05/30/24 for diagnoses including stroke, diabetes, dysarthria (difficulty finding words), anxiety, depression, impaired left eye, left side weakness from stroke, and high blood pressure.Further review of the medical record for Resident #113 revealed an annual comprehensive minimum data set (MDS) 3.0 was completed on 05/14/26. The MDS revealed Resident #113 required a two person transfer with a mechanical lift. Resident #113 was noted to be incontinent of urine and bowel and had a BIMS score of 11/15, indicating moderate cognitive impairment. Observation on 05/21/26 at 12:40 P.M. of incontinence care provided to Resident #113 revealed certified nurse aides (CNA) #186 and CNA #192 gathered supplies and performed hand hygiene and put on clean gloves then transferred Resident #113 from her wheelchair to her bed using the mechanical lift. CNA #186 and #192 then removed Resident #113's pants and soiled adult incontinence brief and provided incontinence care using clean wash cloths with soap and water appropriately. Further observation noted that Resident #113's skin on her buttocks was red and irritated around her peri area and appeared to have moisture associated skin damage (MASD) to the area. Licensed Practical Nurse (LPN) #223 was present and verified the area was red and irritated and applied Triad cream (a skin protectant cream) to the area after Resident #113 was clean and prior to placing a new brief. Continued observation revealed CNA #192 did not remove her gloves after cleaning the resident and proceeded to touch Resident #113's items such as her call light, bed rails, and pulled her blankets up. Further observation revealed CNA #192 removed her gloves prior to leaving the room and did not perform hand hygiene before walking into the next room to remove a lunch tray from the other resident's room. Interview on 05/21/26 at 12:55 P.M. with CNA #192 revealed verification that she did not perform hand hygiene after removing gloves and prior to entering the next resident's room to pick up and remove lunch tray and place on meal cart.Review of the facility Hand Hygiene, policy dated 09/01/2022 revealed hand hygiene will be properly performed to assist in the spread of infection. This deficiency represents an incidental finding of non-compliance investigated under Complaint Number 2681301.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This had the potential to affect all 93 residents of the facility. The facility census was 93.Findings include:On 05/18/26 at 12:48 P.M., an observation of the Men's Restroom in the main lobby revealed a sign stating the restroom was temporarily out of order. The inside of the restroom revealed a hole in the ceiling over the toilet with honeycomb-like rusted metal exposed. On 05/18/26 at 12:50 P.M., an interview with the Administrator confirmed the restroom off the main lobby was closed because the roof had a leak and was causing the ceiling to fall down. The Administrator could not confirm when the restroom had been closed for public use. She reported it was a process to get the problem corrected and roofers were supposed to start repair of the roof of the entire facility in the coming week. On 05/18/26 at 1:08 P.M., an observation of the solarium of E Wing revealed 13 tiles with brown stains on them. On 05/18/26 at 1:08 P.M., an interview with Licensed Practical Nurse (LPN) #210 confirmed there were 13 ceiling tiles with brown stains in the E Wing Solarium. She reported the tiles would get replaced by maintenance, and then the roof would continue to leak and the staining would come back. On 05/18/26 at 3:29 P.M., an observation of the lobby area of the facility revealed multiple areas of ceiling tiles that were covered with a black, gray, or orange, mold-like substance, around hanging lights, and ceiling fans and scattered throughout the common areas of the facility. This was confirmed by the Maintenance Director at the time of the observation. On 05/18/26 at 3:40 P.M., interview with the Maintenance Director revealed the ceilings were probably not mold, just rust, and should not affect the residents' health conditions. He reported since he started at the facility, the ceiling had been leaking because the roof needed repaired, and he would just change the tiles when they got bad, since the roof had not been repaired. The metal tiles in the lobby would be taken down, cleaned or painted, then put back up. He reported the tiles were all stained and there was now a bucket under the tiles in the E-Wing solarium since the ceiling was leaking. On 05/18/26 at 4:00 P.M., an interview with Owner #400 revealed [named company] purchased the building two years ago. At the time of the purchase, the company was aware the roof needed repair. He indicated the repair had not been done because it took a lot of money, however roofers were coming the next day. On 05/19/26 from 9:10 A.M.to 9:22 A.M., a walk-through observation of F-Wing revealed the carpeting between room [ROOM NUMBER] and 112 as well as the carpeting outside of room [ROOM NUMBER] had multiple black stains. Observation of the shower room revealed a stained and dirty shower bed. The solarium of the F-Wing had three ceiling tiles with brown staining on them. Directly across from the nurses' station was the soiled linen and trash room. This room had a profound odor which emanated into the hallway of the resident care areas. This was confirmed by Housekeeper (HK) #150 during interview on 05/19/26 at 9:22 A.M. On 05/19/26 at 9:22 A.M., an interview with HK #150 revealed she did not know if the carpeting of F-Wing ever was cleaned. She did not think the facility had a carpet shampooer and did not know if anyone had come in to try to clean the carpets. She reported the soiled linen room had an odor which grosses me out. She thought the trash was taken out twice daily by the aides, however the smell never went away and it was not pleasant at all. She indicated any time someone opened the door, the smell would go into the hallway and linger. On 05/19/26 at 9:23 A.M., an interview with Resident #86 (room adjacent to the soiled linen room of F-Wing) revealed she occasionally would notice the smell from the soiled linen room but did not know what the facility could do about it. On 05/19/26 from 9:39 A.M. to 9:43 A.M., a walk-through observation of the A-Wing revealed a dirty, stained shower head in the shower room. The wall mounted shower was rusty. In front of the nurses' station, there were two ceiling tiles with brown stains on them. This was confirmed by LPN #217 during an interview on 05/19/26 at 9:44 A.M. On 05/19/26 at 9:44 A.M., an interview with LPN #217 revealed the ceiling tile (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	staining had been there since she started at the facility a few years ago. She felt the issues in the shower were caused from hard water, however she personally would not want to shower in the shower room. On 05/19/26 from 9:55 A.M. to 10:10 A.M., a walk-through observation of the B-Wing revealed a rusted wall mounted shower in the shower room. There was a stained and dirty shower head and a dirty shower chair in the shower room. The hall in front of the nurses' station contained five ceiling tiles with brown stains. This was confirmed by the maintenance director at the time of the observations. On 05/20/26 at 1:55 P.M., an observation of the hallway on E-Wing between rooms [ROOM NUMBERS] revealed a black bucket with a yellow caution sign beside it. The ceiling was noted to be dripping from around the light fixture into the bucket. The space between the resident doorway and the bucket in the hall was small. This was confirmed by LPN #210 during an interview on 05/20/26 at 2:05 P.M. On 05/20/26 at 2:05 P.M., an interview with LPN #210 confirmed the black bucket with caution sign and leaking ceiling in the hallway between room [ROOM NUMBER] and 21. She reported the two residents in room [ROOM NUMBER] (Resident #32 and Resident #34) both required wheelchairs. Resident #32 would self-propel her wheelchair. The resident in room [ROOM NUMBER] (Resident #63) self-propelled his wheelchair. The LPN did not know if the placement of the bucket and signage in the hallway would affect the residents' ability to enter or exit their rooms. On 05/20/26 at 2:10 P.M., an interview with Resident #51 revealed she did not like to leave her room unless she had to. Left only to go to the shower room once a week. She indicated the shower never stops and it was very hot in the shower room. She said often there would be things piled up all over the room. She did not like to go to the solarium because everything was dirty and the room was just pitiful looking. On 05/20/26 at 2:25 P.M., an observation of the public hallway outside the entrance to the F-Wing revealed two brown trash cans and two yellow caution signs sitting on towels. There was noted water dripping from the ceiling. Resident #67 was observed running into the trash cans with her wheelchair as she attempted to leave the F-Wing. This observation was confirmed by Resident #67 at the time of the observation. On 05/20/26 at 2:25 P.M., an interview with Resident #67 revealed she was frustrated with the leaking roof. She stated it is about time they fixed this roof. It is terrible. People can't even get around this place without running into something. On 05/20/26 at 2:29 P.M., an observation of room [ROOM NUMBER] of the F-Wing revealed the ceiling was peeling and there was water leaking from the ceiling into a white bucket on the floor. This was confirmed at the time of the observation by Registered Nurse (RN) #309. On 05/20/26 at 2:29 P.M., an interview with RN #309 confirmed the ceiling of room [ROOM NUMBER] was peeling and there was water dripping from the ceiling into a bucket. She did not feel this was a problem because there was no resident currently residing in the room. On 05/20/26 from 2:30 P.M. to 2:38 P.M., an observation of the B-Wing hallway revealed outside room [ROOM NUMBER] there was a cracked ceiling light cover in a large X shape. Outside of room [ROOM NUMBER], the ceiling light cover had a linear crack from side to side. There was a ceiling tile in front of the nurses' station which had a large brown stain on it. These findings were confirmed at the time of the observations by Certified Nurse Aide (CNA) #404. On 05/21/26 at 11:15 A.M., an interview with Contractor #402 from [named company] revealed there had been delays in the roof being replaced. Delays included weather, scheduling and materials. The contract with the facility was originally presented on 12/20/25. The contract was signed on 03/26/26 and included repairing the roof of E and F wing and replacing the roof over the public areas that connected each wing and the roof over the multi-level portion of the building. It did not include any repairs or replacements of A-Wing, B-Wing, C-Wing, or D-Wing. The contractor provided a signed copy of the contract via electronic communication. This deficiency represents non-compliance investigated under Master Complaint 2748123 and Complaint Number 2742642.