STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366038	A. Building B. Wing	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenfield Skilled Nursing and Rehabilitation	238 South Washington Street Greenfield, OH 45123

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 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. (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 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, review of resident fund account documentation, review of self reported incident, staff interviews, and facility policy review, the facility failed to ensure appropriate handling of resident funds. This affected four Residents (#6, #24, #42, #46) of four reviewed for resident funds. Facility identified 19 Residents (#2, #3, #6, #7, #8, #15, #19, #21, #24, #25, #26, #29, #37, #42, #43, #44, #45, #46, #47) potentially affected by the accounting practice. Facility census was 41. Findings include 1.Review of the medical record for Resident #42 revealed an admission date of 02/21/21 and discharge date of 08/06/25. Diagnoses included displaced fracture of the right leg, chronic obstructive pulmonary disease (COPD), muscle weakness, and unspecified dementia without behaviors. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #42 was cognitively impaired with a Brief Interview of Mental Status (BIMS) score of five. Review of fund authorization form dated 04/10/18 revealed Resident #42 opened a personal fund account at the facility. Review of facility withdrawal receipts and store receipts from 01/01/25 to 06/10/25 for Resident #42 revealed:On 01/09/25 a withdrawal of $50.00 was documented for personal items and snacks by Social Services #210, no receipts were provided and the facility had no documentation of where the money/change went.On 03/03/25 a withdrawal of $500.00 was documented for clothing and personal items by Social Services #210, no receipts were provided and the facility had no documentation of where the money/change went.On 05/07/25 a withdrawal of $200.00 was documented for personal items and snacks by Social Services #210, no receipts were provided and the facility had no documentation of where the money/change went.On 06/04/25 a withdrawal of $10.00 was documented the beautician by Social Services #210, no receipts were provided and the facility had no documentation of where the money/change went. 2. Review of the medical record for Resident #46 revealed an admission date of 07/20/20 to 06/23/25. Diagnoses included kidney failure, muscle weakness, heart failure, vascular dementia and edema.Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #46 was cognitively impaired with a BIMS of seven.Review of fund authorization form dated 04/01/22 revealed Resident #46 opened an personal fund account at the facility.Review of facility withdrawal receipts and store receipts from 01/01/25 to 06/10/25 for Resident #46 revealed:On 03/03/25 a withdrawal of $500.00 was documented for clothing and personal items by Social Services #210, no receipts were provided and the facility had no documentation of where the money/change went.On 05/27/25 a withdrawal of $150.00 was documented for personal items and snacks by Social Services #210, no receipts were provided and the facility had no documentation of where the money/change went.On 06/04/25 a withdrawal of $10.00 was documented for the beautician by Social Services #210, no receipts were provided and the facility had no documentation of where the money/change went. 3. Review of the medical record for Resident #24 revealed an admission date of 11/23/22. Diagnoses included non ST elevation myocardial infarction (NSTEMI), respiratory failure, edema, heart failure, diabetes and pulmonary hypertension. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #24 was cognitively intact with a BIMS of 15. Review of fund authorization form dated 06/27/24 revealed Resident #24 opened an personal fund account at the facility. Review of facility withdrawal receipts and store receipts from 01/01/25 to 06/10/25 for Resident #24 found:On 02/24/25 a withdrawal of $50.00 was documented for clothing and personal items by Social Services #210, no receipts were provided and the facility had no documentation of where the money/change went.On 03/03/25 a withdrawal of $60.00 was documented for Walmart by Social Services #210, a receipt was provided dated 03/11/25 for $26.50. The facility had no documentation of where the money/change went after the purchase. On 05/08/25 a withdrawal of $30.00 was documented for Walmart by Social Services #210, a receipt was provided dated 05/09/25 for $17.04. The facility had no documentation of where the money/change went after the purchase. On 06/04/25 a withdrawal of $10.00 was documented for the beautician by Social Services #210, no receipts were provided and the facility had no documentation of where the money/change went. 4. Review of the medical record for Resident #06 revealed an admission date of 03/29/24. Diagnoses included heart failure, unspecified dementia, malnutrition, and muscle weakness. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #06 was cognitively impaired with a BIMS of two. Review of fund authorization form with and eligible date revealed Resident #06 opened an personal fund account at the facility. Review of facility withdrawal receipts and store receipts from 01/01/25 to 06/10/25 for Resident #06 found: On 03/03/25 a withdrawal of $150.00 was documented for

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from the wrongful use of the resident's belongings or money. (continued on next page)

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, review of resident fund account documentation, review of self reported incident investigation, staff interviews, and policy review, facility failed to ensure residents were free from the potential of misappropriation. This affected three Residents (#7 #42 and #46) of three reviewed for misappropriation. Facility census was 41. Findings include 1.Review of the medical record for Resident # 42 revealed an admission date of 02/21/21 and discharge date of 08/06/25. Diagnoses included displaced fracture of the right leg, chronic obstructive pulmonary disease (COPD), muscle weakness, and unspecified dementia without behaviors. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #42 was cognitively impaired with a brief interview of mental status (BIMS) score of five. Review of facility Self Reported Incident (SRI) #261495 investigation dated 06/10/25 to 06/13/25 revealed Social Services (SS) #210 had asked an Activity Aide (AA) #185 to have a resident sign a blank receipt for resident funds. When questioned, SS #210 informed AA #185 she would fill in the amount later. AA #185 had concerns of mishandling of funds and reported an allegation of misappropriation to management who began an SRI investigation. The investigation found when the facility was taking money out of the resident accounts to shop for the resident, staff were not consistently providing a receipt to account for the disposition of the funds removed and did not keep documentation whether the change was returned and if so how (cash back to the resident, or returned to the fund account). Review of a staff statement from SRI #261495 investigation from Social Services (SS) #210 revealed she was asked if she had any additional money or receipts due to money being unaccounted for during the SRI investigation audit. SS #210 reported she had $500.00 in her car for several months for Resident #42. At the time of this interview statement, SS #210 had been suspended since 06/10/25 for an allegation of mishandling funds. 2. Review of the medical record for Resident #46 revealed an admission date of 07/20/20 to 06/23/25. Diagnoses included kidney failure, muscle weakness, heart failure, vascular dementia and edema. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #46 was cognitively impaired with a BIMS of seven. Review of a staff statement from SRI #261495 investigation from Social Services (SS) #210 revealed she was asked if she had any additional money or receipts due to money being unaccounted for during the SRI investigation audit. SS reported she had $92.41 in her car for Resident #46. At the time of this interview statement, SS #210 had been suspended since 06/10/25 for an allegation of mishandling funds. Review of Resident fund account from 06/01/25 to 08/14/25 revealed no evidence the $92.41 was returned to resident fund account for Resident #46. Interview on 08/18/25 at 2:35 P.M. with Regional Nurse #200, Regional Account Manager (RAM) #205 and Administrator confirmed Resident #46 did not have the cash money found in Social Service #210's personal vehicle return to his personal fund account. 3. Review of the medical record for Resident #07 revealed an admission date of 09/27/16. Diagnoses included dysphagia, intellectual disabilities, contracture of upper extremities, and anxiety. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #07 was cognitively impaired with a BIMS of six. Review of a staff statement from SRI #261495 investigation from Social Services (SS) #210 revealed she was asked if she had any additional money or receipts due to money being unaccounted for during the SRI investigation audit. SS reported she had $30.00 in her car for Resident #7. At the time of this interview statement, SS #210 had been suspended since 06/10/25 for an allegation of mishandling funds. Interview on 08/18/25 at 10:20 A.M. with Director of Nursing (DON), Administrator and Business office Manager (BOM) #55 and Regional Account Manager (RAM) #205 confirmed facility had investigated the allegation of misappropriation. They confirmed Social Serivces (SS) #210 was suspended pending investigation. They confirmed SS had taken resident fund money home with her. Interview on 08/18/25 at 3:00 with Administrator and Regional Account Manager #205 confirmed Social Services (SS) #210 took resident money to her home. They confirmed staff regularly shop for residents and they did not have a standard procedure for staff taking resident money and how long they could keep the money before returning it, or returning the resident's change. They acknowledged SS #210's statement included a report she had $500.00 for Resident #42 for several months in her personal vehicle. They acknowledged the risk of theft with no checks and balances and no one making sure staff followed any guidelines when taking residents money out of the building. Review of facility policy titled, Abuse Neglect, Exploitation and Misappropriation Prevention Program, dated 04/2021 revealed Residents had the right to be free from misappropriation. Facility shall protect residents from misappropriations by anyone including facility

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Respond appropriately to all alleged violations. (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, self-reported incident (SRI) review, review of the facility investigation, resident interview, staff interview, and policy review, the facility failed to ensure a thorough investigation was completed for Resident #51 who had an allegation of abuse and for Residents #7, #42, and #46 who were involved with an allegation of misappropriation. This affected four residents (#7, #42, #46, and #51) out of four reviewed for abuse, neglect, and misappropriation. The facility identified 19 residents (#2, #3, #6, #7, #8, #15, #19, #21, #24, #25, #26, #29, #37, #42, #43, #44, #45, #46, #47) who were potentially affected by the accounting practices related to the misappropriation SRI #261495 and one resident (#51) identified in the abuse SRI #262018. The facility census was 41.Findings Include: 1. Review of the medical record for Resident #51 revealed an admission date of 03/18/25 and a discharge date of 07/25/25. Diagnoses included chronic pulmonary disease, fracture of the left femur, and bipolar disorder. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #51 was cognitively intact.Review of Self Reported Incident (SRI) #262018 revealed Resident #51 reported Registered Nurse (RN) #72 had pushed him. No suspected perpetrator was listed on the intake and no witnesses were listed on the intake. RN #72 was interviewed and named two witnesses who observed the entirety of the interaction, one was an aide and the other was a hospice nurse. No statements were provided from those two staff members stating their observations of the incident. Interview on 08/14/25 at 4:00 P.M. with the Administrator confirmed the suspected perpetrator was not reported appropriately for tracking purposes to the Health Department for SRI #262018. The Administrator also confirmed two witnesses were mentioned in the suspected perpetrators statement, noting those two people were at the nurses station and saw the whole event. The Administrator confirmed those staff were not listed in the report intake either and neither witness had a signed statement of what they observed during the incident in question.2. Review of facility Self Reported Incident (SRI) #261495 investigation dated 06/10/25 to 06/13/25 revealed Social Services (SS) #210 had asked an Activity Aide (AA) #185 to have a resident sign a blank receipt for resident funds. When questioned, SS #210 informed AA #185 she would fill in the amount later. AA #185 had concerns of mishandling of funds and reported an allegation of misappropriation to management who began an SRI investigation. The facility also identified Activity Aide (AA) #70 as the staff who reported the allegation. The investigation found when the facility was taking money out of the resident accounts to shop for the residents, staff were not consistently providing a receipt to account for the disposition of the funds removed and did not keep documentation whether the change was returned and if so, how (cash back to the resident or returned to the fund account). Further review of the investigation revealed Resident #42 was the only resident assigned as a victim through the system (which tracks perpetrators, victims and witnesses), though 19 total residents were included in the investigation (#2, #3, #6, #7, #8, #15, #19, #21, #24, #25, #26, #29, #37, #42, #43, #44, #45, #46, and #47). The investigation stated the residents/responsible parties were immediately advised they would be refunded for any transactions in question. The investigation revealed Activity Aide (AA) #70 was not listed on the SRI intake as a witness and no other witnesses were listed. Staff statements were unclear due to having several statements from the same staff on the same day including AA #70 having three interviews that provided slightly different information, including one statement naming Registered Nurse #95 as a witness. No interviews were included for Activity Aide #185 or Registered Nurse #95, who were named as additional potential witnesses. Staff statements were also written by facility management as an interview without providing interview questions of what was asked. It was unknown if additional information was known by staff, but not specifically asked about. Social Services #210 also had documented two interviews/statements on 06/10/25 that varied in information.Review of the facility investigation revealed audits for 2025. The audits revealed 12 residents (#2, #3, #6, #7, #19, #21, #24, #26, #42, #44, #45, and #46) had withdrawals without receipts. The reimbursement report for 2025 stated a total $3,223.55 was refunded to 11 residents (#2, #3, #6, #19, #21, #24, #26, #42, #44, #45, and #46). It did not include any evidence of Resident #7 being reimbursed the unaccounted for withdrawal from 05/15/25 and 06/04/25 equaling a total of $40.00. Additionally, the accounting for Resident #46 revealed the resident was not reimbursed the accurate amount and was shorted $96.38.Interview on 08/14/25 at 1:35 P.M. with Resident #24 found the facility had informed her of potential missing money a few months ago and reported the money had been returned. She did not remember if she was asked to sign a blank receipt for staff, but revealed she had never really looked and she stated, I just

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (continued on next page)

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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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure a safe discharge plan was implemented. This affected one resident (#48) of three reviewed for discharge planning. The facility census was 41. Findings Include: Review of the medical record for Resident #48 revealed an admission date of 02/19/25 and a discharge date of 05/22/25. Diagnoses included pulmonary disease, respiratory failure, embolism of thoracic aorta, cerebral infarct, bipolar disorder, schizophreniform disorder, skin picking disorder and neuropathy. Review of the plan of care dated 03/05/25 revealed Resident #48 would possibly require discharge planning with interventions to provide information on community resources and utilize resources (for example: home health care) and participate in therapy.Review of the communication in the insurance portal with [NAME] on 05/14/25 revealed Resident #48 had seven benefit days remaining before benefits ran out. The message instructed facility to begin discharge planning.Review of the physical therapy notes dated 05/20/25 revealed Resident #48 required 50 percent (%) verbal instruction for transfer training with 75% physical assistance of two staff due to compromised balance, coordination and safety awareness. The resident transferred to the wheelchair with pivot transfer with two person moderate assistance. When using the slide board Resident #48 required minimum assistance of two staff. Resident #48 continued to need stabilization of lower extremities to keep feet from lifting off the floor during sit to stand transfers.Review of the occupational therapy note dated 05/20/25 revealed Resident #48 had transfer training of stand pivot transfers from the wheelchair to the mat table with maximum assistance of one to moderate assistance of two staff. Resident #48 had increased anxiety with fear of falling requiring increased time to allow the resident to rest.Review of the physical therapy notes dated 05/21/25 revealed Resident #48 and her son were educated on bilateral upper and lower extremity exercises. Skilled interventions focused on transfer training to increase functional task performance. The resident's son was educated on wheelchair mat transfers and the resident's son completed a return demonstration. He stated he felt confident with these transfers at home.Review of the occupational therapy note dated 05/21/25 revealed Resident #48 was educated on compensatory strategies for activities of daily living (ADLs) including wearing a gown for ease, elastic shoe laces to improve the ability to slide shoes on, they discussed recommendations for toileting, encouraged bed level verses one person assistance (with son having to stand and manage clothing items and bed/rails), performed basin bath due to second story shower, and easy open containers and light meals if her family was out for short periods of time. Resident #48 stated her son was taking a leave of absence from work to be a full time caregiver and provide meals and ADL care. Resident #48's family also planned to hire a part-time caregiver in addition to the recommended home healthcare for therapy and nursing.Review of the physical therapy Discharge summary dated [DATE] revealed Resident #48 had requested to return home. It stated the resident had only met one of six goals and required maximum assistance of one to two people for functional transfers and minimum to moderate assistance with the use of a bed rail for bed mobility.Review of the occupational therapy Discharge summary dated [DATE] revealed Resident #48 exhausted her benefits days and declined treatment (private pay). It stated Resident #48 had only met one of seven goals and required substantial maximum assistance for toileting and partial to moderate assistance for activities of daily living.Review of the progress notes dated 05/21/25 from the Director of Nursing revealed Resident #48 was scheduled to discharge home 05/22/25 with referrals to home health services for physical therapy, occupational therapy, nursing and state tested nursing aides (STNA). Resident #48 and her son were aware. The note dated 05/22/25 from Licensed Practical Nurse (LPN) #58 revealed the nurse signed discharge paperwork with Resident #48's son (Power of Attorney (POA)). Resident #48 discharged with her POA. The note dated 05/22/25 from Social Services #210 revealed Resident #48 was discharging home with her son and home health and appointments were set up.Review of Resident #48's discharge Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) of 06 indicating impaired cognition. It stated Resident #48 required set up assistance for eating, substantial maximum assistance for oral hygiene, shower/bathing, upper body dressing, personal hygiene, rolling, sitting up in bed and sitting at the edge of the bed and she was dependent upon staff with toileting assistance, lower body dressing, placing footwear, mobility from sit to stand, chair to bed transfers, toilet transfers, and shower transfers. Car transfers and walking 10 feet were not attempted due to medical or safety concerns.Review of the discharge summary/discharge plan of care dated 05/22/25 revealed Resident #48 was discharged due to meeting