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	04/22/2026

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, interviews, facility policy review, review of job descriptions, and review of information from the Ohio Board of Nursing, the facility failed to ensure pressure ulcer interventions were implemented timely and weekly assessments, including staging, were completed per the professional standards of practice for Resident #28. This affected one (Resident #28) out of six residents reviewed for pressure ulcer care. The facility census was 39.Findings Included:Review of the medical record for Resident #28, revealed an admission date of 03/11/25. Diagnoses included cerebral infarction due to embolism of right middle cerebral artery, heart failure, neuromuscular dysfunction of bladder, weakness and muscle weakness and multiple sclerosis.Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of cognitive intactness. Resident #28 was assessed to require total dependence on bed mobility, transfers, toilet hygiene, and shower/bathe self. The resident was also assessed to have an indwelling catheter and an ostomy and not rated for urinary and bowel continence and a stage IV pressure ulcer.Review of the baseline care plan dated 03/11/25 for Resident #28 revealed pressure injury/skin care related to a left buttock pressure ulcer with interventions including to follow the facility skin protocol with no preventative measures such as an air mattress, pressure reducing cushion to wheelchair and offloading the area while in wheelchair.Review of the activities of daily living plan dated 03/11/25 for Resident #28 revealed a wound to the left buttock with extensive assist with positioning and turning with no preventative measures such an air mattress, pressure reducing cushion to wheelchair and offloading the area while in wheelchair.Review of the Braden Scale for Predicting Pressure Sore Risk dated 03/11/25 for Resident #28 revealed a score of 16.0 on a scale of, 6 (high risk) to 23 (no risk), which indicated Resident #28 to be at low risk for skin breakdown.Review of the skin grid pressure assessment dated [DATE] completed by Licensed Practical Nurse (LPN) Unit Manager #183 for Resident #28 revealed a left buttock stage II pressure ulcer measured 3.5 centimeters (cm) by 4.5 cm by 0.2 cm with minimal serosanguineous drainage.Review of the Physician #300's admission assessment dated [DATE] of Resident #28 revealed no assessment of the left buttock pressure ulcer.Review of the progress note dated 03/12/25 at 12:00 P.M. for Resident #28 revealed resident maneuvering about the facility in motorized wheelchair with poor safety awareness. Resident transferred to a standard wheelchair and continued to participate in therapy for management of her motorized wheelchair.Review of the skin grid pressure assessment dated [DATE] completed by LPN Unit Manager #183 for Resident #28 revealed a left buttock stage II pressure ulcer measured 3.5 cm by 4.5 cm by 0.2 cm with minimal serosanguineous drainage.Review of the skin grid pressure assessment dated [DATE] completed by LPN Unit Manager #183 for Resident #28 revealed a left buttock stage II pressure ulcer measured 4.0 cm by 4.8 cm by 0.2 cm with moderate serosanguineous drainage.Review of the comprehensive care plan initiated 03/31/25 for Resident #28 revealed at risk for skin integrity related to impaired mobility with no interventions.Review of the skin grid pressure assessment dated [DATE] completed by LPN Unit Manager #183 for Resident #28 revealed a left buttock stage II pressure ulcer measured 4.0 cm by 4.8 cm by 0.2 cm with moderate serosanguineous drainage.Review of the physician orders dated (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	04/03/25 for Resident #28 revealed an alternating overlay air mattress to bed, to check placement and function and pressure relieving cushion to wheelchair, to check placement each shift. Review of the comprehensive care plan revised on 04/04/25 for Resident #28 revealed at risk for skin integrity related to impaired mobility with interventions including an air cushion to wheelchair and an alternating air overlay to mattress.Review of the skin grid pressure assessment dated [DATE] completed by LPN Unit Manager #183 for Resident #28 revealed a left buttock stage II pressure ulcer measured 5.0 cm by 6.0 cm by 1.8 cm with moderate serosanguineous drainage and slight odor. Physician notified of decline.Review of the medical record for Resident #28 dated 03/11/25 through 04/08/25 revealed no documentation of communication to a Registered Nurse or a physician of the assessment, description and staging of the left buttock pressure ulcer from LPN Unit Manger #183 regarding assessments, including staging on the weekly skin grid pressure ulcer assessments.Further review of the medical record for this resident during that time revealed no documented assessments, descriptions and staging from a Registered Nurse or Physician. Interview on 04/21/26 at 8:56 A.M. with the Director of Nursing (DON) revealed LPN Unit Manager #183 did complete the weekly skin grid pressure assessments from 03/11/25 through 04/08/25 with no documentation of an RN or physician assessment or communication to verify the assessment and staging of the left buttock pressure ulcer. Also verified the baseline care plan for Resident #28 did not have interventions for the pressure ulcer area as she did get transferred to a standard wheelchair from her motorized chair due to safety on 03/12/25 and had a pressure reducing cushion to her motorized wheelchair, but not her standard wheelchair. No documentation to verify when Resident #28 was able to safely use her motorized wheelchair. Verified no orders and plan of care interventions for the left buttock pressure ulcer such as a pressure reducing cushion to the standard wheelchair and the air mattress overlay until 04/03/25 and 04/04/25.Interview on 04/22/26 at 8:45 A.M. with the Regional Quality Assurance Nurse #247 verified LPN Unit Manager #183 was not wound certified but had received some facility education on wounds that included pressure ulcers.Interview on 04/22/26 at 8:47 A.M. with LPN Unit Manager #183 verified she was not wound certified and could not describe the type of education she had received from the facility for pressure ulcer assessments. Verified she was unable to stage pressure ulcers as it was not in her scope of practice but did document her assessment for Resident #28 each week on the skin grid pressure ulcer left buttock assessments dated 03/11/25 through 04/08/25 which included staging. She could not recall if she called the DON about the assessments to confirm the accuracy of the assessment and staging as there was no documentation to support that.A follow-up interview on 04/22/26 at 8:54 A.M. with the DON revealed LPN Unit Manager #183 would call with pressure ulcer assessments for residents to confirm staging, but there is no documentation of the communication for assessments completed for Resident #28's weekly skin grid pressure for the left buttock from 03/11/25 through 04/08/25. Could not recall if she assessed Resident #28's pressure ulcer to the left buttock weekly to verify staging and assessments as there was no documentation and should be. Reviewed the activities of daily living plan dated 03/11/25 and confirmed the resident was an extensive assist with positioning and turning with no preventative measures such an air mattress, pressure reducing cushion to wheelchair and offloading the area while in wheelchair.Review of the facility policy titled Resident Examination and Assessment revised February 2014 revealed the purpose of this procedure is to examine and assess the resident for any abnormalities in health status. Physical examination included skin and the presence of pressure sores with the documentation of the assessment in the residents medical record by the individuals who performed it. Report other information in accordance with facility policy and professional standards of practice.Review of the facility policy titled Charting and Documentation revised July 2017 revealed all services provided to the resident shall be documented in the resident's medical record such as objective observations. Documentation in the medical record will be objective, complete and accurate. Entries may only be recorded in the resident's clinical record by licensed personnel in accordance with the state law and facility policy.Review of the Licensed Practical Nurse job description dated (continued on next page)

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