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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, staff and resident interview, and policy review, the facility failed to ensure the Interdisciplinary Team (IDT) determined whether the self-administration of a topical medication was clinically appropriate. This affected one (Resident #09) of one resident reviewed for self-administration. The facility census was 39 residents.Findings include:Review of the medical record revealed Resident #09 originally admitted to the facility on [DATE] and readmitted on [DATE]. Diagnoses included edema, cellulitis, malignant neoplasm of skin, and local infection of the skin and subcutaneous tissue.Review of Resident #09's Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact and had edema and one venous ulcer.Review of Resident #09's prescriber orders revealed an order dated 11/12/25 for triamcinolone acetonide external cream 0.1% (a steroid cream) apply to rash to bilateral arms topically every shift and an order dated 11/12/25 for triamcinolone acetonide external cream 0.1% apply to left lower extremity topically every shift. Further review of the order had no instructions that Resident #09 may self-apply.Review on 04/19/26 of the Medication Administration Records for March 2026 and April 2026 revealed nursing staff signed off as the medication was administered.Review of Resident #09's medical record on 04/19/26 revealed there was no documentation of a medication self-administration assessment and care plan.Observation on 04/19/26 at 8:52 A.M. of Resident #09's bed revealed a tube of triamcinolone acetonide 0.1% cream.Interview on 04/19/26 at 8:52 A.M. with Resident #09 revealed the resident had a biopsy site of the left hand that was not healing. Resident #09 said they were self-applying the triamcinolone to the biopsy site.Observation on 04/19/26 at 1:37 P.M. revealed Resident #09 was resting with eyes closed in a recliner, and the triamcinolone cream was present on the bed.Observation on 04/20/26 at 8:33 A.M. revealed Resident #09 was resting with eyes closed in a recliner, and the triamcinolone cream was present on the bed.Interview with Licensed Practical Nurse (LPN) #109 on 04/20/26 at 8:44 A.M., revealed the LPN was unsure why Resident #09 used the triamcinolone cream and verified the resident was self-applying the medication. Further interview with LPN #109 revealed Resident #09 had cancer removed from the left hand and does not have a treatment order to apply triamcinolone 0.1% to the location.Observation of Resident #09 on 04/20/26 at 9:35 A.M. revealed the resident was resting with eyes closed in a recliner, and the triamcinolone cream was present on the bed.Interview with the Regional Quality Assurance Nurse #247 on 04/20/26 at 11:00 A.M., revealed the resident self-administration assessments were documented in the electronic medical record under assessments. Further review of Resident #09's assessments dated 04/20/26 at 11:04 A.M. revealed no self-administration assessment.Requested documentation from the facility on 04/20/26 at 1:30 P.M. of a medication self-administration assessment for Resident #09. Observation of Resident #09's room on 04/21/26 at 9:02 A.M. revealed the door was open, the resident was not in the room, and the triamcinolone cream was no longer on the bed.Requested documentation from the Director of Nursing (DON) on 04/21/26 at 10:10 A.M. of a medication self-administration assessment for Resident #09.Interview with the Regional Director of Operations #245 on 04/21/26 at 1:15 P.M. revealed the self-administration assessment for Resident #09 was documented under the assessments. Review of Resident #09's assessments revealed a (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	self-administration skills assessment completed on 04/20/26 at 2:32 P.M. Further interview with the Regional Director of Operations #245 revealed the self-administration skills assessment was not completed until yesterday because the facility management was not aware the resident was self-administering the medication until it was brought to their attention.Review of the policy titled Self-Administration of Medications, dated December 2016 revealed as part of their overall evaluation, the staff and practitioner will assess each resident's mental and physical abilities to determine whether self-administering medications is clinically appropriate. Self-administered medications must be stored in a safe and secure place, which is not accessible by other residents. Staff shall identify and give to the Charge Nurse any medications found at the bedside that are not authorized for self-administration.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to develop a plan of care for residents with a gastrostomy tube and receiving tube feedings. This affected one (Resident #07) of two residents reviewed for enteral tube feeding care plans. The facility census was 39.Findings Included:Review of the medical record revealed Resident #07 was admitted to the facility on [DATE]. Diagnoses included metabolic encephalopathy, diabetes mellitus type II, chronic obstructive pulmonary disease, depression, atherosclerosis, protein-calorie malnutrition, morbid obesity, hyperlipidemia, chronic pain, sciatica, asthma, cerebral infarction, anxiety, depression, and epilepsy. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #07 had minimally impaired cognition.Review of Resident #07's current comprehensive care plan, last revised on 04/19/26, revealed there was no care plan in place to address Resident #07's care needs addressing tube feedings when she readmitted to the facility on [DATE] with a new gastrostomy tube in place. Review of the physician orders revealed enteral feeding for dysphagia. Provide 2 Cal (Two Cal is a high-calorie high-protein supplement) infuse 60 milliliters per hour (ml/hour) for 12 hours. Initiate at 5:00 P.M. and discontinue at 5:00 A.M. daily. Orders also included water flush, to check placement, and air bolus to check placement routinely. Clean site with soap and water and apply new dressing daily.Interview with the MDS Coordinator #239 on 04/21/26 at 2:19 P.M., verified that a care plan for tube feeding was not in place on Resident #07's nutritional care plan until 04/19/26. MDS Coordinator #239 verified the resident had been receiving feedings via tube feed since 01/12/26.

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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 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 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 (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 05/2009 revealed job responsibility that included to monitor resident care on assigned shift to meet standards of practice and state federal regulations and asses newly admitted residents and transcribe findings according to assessment policy and guidelines. Review of the Ohio Board of Nursing information under Section 4723.01 nurse definitions effective 04/06/23 revealed the practice of nursing as a licensed practical nurse means providing individuals and groups nursing care requiring the application of basic knowledge of the biological, physical, behavioral, social, and nursing sciences at the direction of a registered nurse. Such nursing care include: observation in a diversity of health care settings and contributions to the planning, implementation, and evaluation of nursing. This deficiency represents non-compliance investigated under Complaint Number 2971657.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and policy review, the facility failed to accurately transcribe, clarify and follow a prescriber's order for a resident who was on a voiding trial after removal of a Foley catheter. This affected one (Resident #06) of five residents with indwelling urinary catheters. The facility census was 39 residents.Findings include:Review of Resident #06's medical record revealed an initial admission date of 02/26/26 and a readmission date of 04/08/26. Diagnoses included diabetes mellitus, chronic kidney disease stage three, and obstructive and reflux uropathy. Review of the admission assessment dated [DATE] revealed Resident #06 had a urinary catheter upon admission.Review of Resident #06's Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact and had an indwelling urinary catheter in place. Review of Resident #06's care plan dated 03/17/26 revealed the resident had an alteration in elimination due to diabetes, chronic kidney disease stage three, hypertension, and an indwelling Foley catheter.Review of the prescriber order dated 02/27/26 for Resident #06 revealed an order for discontinuation of the indwelling urinary catheter on 03/02/26.Review of the prescriber order dated 03/02/26 revealed an order to remove Resident #06's indwelling catheter due to a voiding trial on 03/02/26. Additionally, an order dated 03/02/26 to straight catheterize every eight hours as needed for urinary retention; keep leg catheter in place if 2400 milliliters (mL) of urine.Review of the progress note dated 03/02/26 at 9:22 P.M. revealed Resident #06's indwelling catheter was discontinued per order, and the resident was provided a urinal and a bedside commode.Review of the progress note dated 03/03/26 at 6:37 P.M. revealed Resident #06 was straight catheterized and 850 mL of urine was obtained. Further review of the progress notes revealed a note dated 03/03/26 at 8:10 P.M. the straight catheterization procedure for Resident #06 was effective.Review of the Medication Administration Record (MAR) for March 2026 revealed Resident #06 was straight catheterized on 03/03/26. Further review revealed no other documentation of straight catheterization performed for Resident #06 for the month of March.Review of the progress notes revealed a late entry note created on 03/14/26 with an effective date of 03/05/26 at 4:58 P.M. revealed Resident #06 was complaining of abdominal pain, and the resident's abdomen was distended and tender to touch. Further review of the progress note revealed Resident #06 was straight catheterized with 1400 mL of urine obtained, and the straight catheter was left in place per prescriber order.Interview on 04/20/26 at 10:30 A.M., with the Director of Nursing (DON) verified the prescriber order reflected the catheter to be left in place if 2400 mL of urine was obtained with straight catheterization, but the progress note reflected the catheter was left in place when 1400 mL of urine was obtained with straight catheterization.Interview on 04/20/26 at 10:39 A.M., with the Nurse Practitioner #243 and the DON verified the prescriber order for straight catheterization should have reflected to leave the urinary catheter in place if 400 mL of urine was obtained with straight catheterization not 2400 mL. Further interview with the DON verified Resident #06 should have had the urinary catheter left in place sooner since previous catheterization output was greater than 400 mL and the order had not been clarified and was transcribed incorrectly.Review of the policy titled Telephone Orders revised February 2014 revealed verbal telephone orders are recorded in the resident's medical record. The entry must contain the instructions from the physician, date, time, and the signature and title of the person receiving the order. Telephone orders must be countersigned by the physician during his or her next visit.