

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366042	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2025
NAME OF PROVIDER OR SUPPLIER Spring Meadows Nursing, A Villa Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1125 Clarion Ave Holland, OH 43528	
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 - 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, staff interviews, review of the guidelines from the National Pressure Ulcer Advisory Panel (NPUAP), and review of facility policy, the facility failed to timely identify the resident's pressure until it reached an advanced stage and failed to ensure pressure ulcer preventions consistent with professional standards of practice were in place. This resulted in Actual Harm to Resident #55 who was at risk for pressure ulcers and the facility found Resident #55's avoidable pressure ulcer as a stage three pressure ulcer (Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed). This affected one (Resident #55) of two residents reviewed for pressure ulcers. The facility census was 80. Findings include: Review of the medical record for Resident #55 revealed he was admitted on [DATE]. Diagnoses included metabolic encephalopathy, epilepsy, right-sided hemiplegia, and type II diabetes mellitus. Review of the admission Minimum Data Set 3.0 (MDS) assessment dated [DATE] revealed Resident #55 was dependent upon staff for all transfers and bed mobility. Resident #55 did not refuse care, was at risk for pressure ulcers, and did not have a pressure ulcer on admission. There were no skin and ulcer/injury treatments in place, including a turning and reposition program. Resident #55 was always incontinent of bowel and bladder. Review of the Braden Score assessment dated [DATE], revealed Resident #55 was at a high risk for acquiring pressure wounds. Review of the care plan dated 07/10/25 revealed Resident #55 was at a potential risk for impairment to skin integrity rule out bowel and bladder incontinence, diabetes mellitus, hemiplegia and weakness. Interventions included apply barrier cream per facility protocol to help protect skin from excess moisture, monitor skin when providing care, notify nurse of any changes in skin appearance, pressure reduction mattress, and wheelchair pressure reduction cushion. There was no intervention to turn and reposition Resident #55 every two hours as an intervention consistent with professional standards of practice for pressure ulcer prevention. Resident #55 had care plans in place for incontinence of bowel and bladder. Interventions included to provide skin care after each incontinent episode. There were no interventions for routine checks and changes for incontinence care in the care plan. There was no documentation in Resident #55's medical record to support Resident #55 had been turned and repositioned every two hours. Review of the weekly skin observations dated 07/22/25, 07/29/25, and 08/02/25 revealed Resident #55 did not have any new skin issues observed. The weekly skin assessment dated [DATE] for Resident #55 revealed a new stage three pressure wound to the resident's left buttock and coccyx. Review of the wound measurements for Resident #55 revealed on 08/05/25, the stage three pressure wound to his left buttock and coccyx measured 3.20 centimeters (cm) long by 2.50 cm wide by 0.10 cm deep. On 08/21/25, the pressure wound measured 5.0 cm long by 4.5 cm wide by 0.2 cm deep. Interview on 08/26/25 at 4:45 P.M. with Licensed Practical Nurse (LPN) #401 confirmed Resident #55 was immobile, at risk for pressure ulcers, and did not have the intervention consistent with professional standards of practice to turn and reposition every two hours. Interview on 08/26/25 at 5:03 P.M. with Wound Care Nurse #347 confirmed attempts to turn Resident #55 every two hours should have happened as an intervention to aid with the prevention of pressure wounds. Interview on 08/28/25 at 8:10 A.M. with LPN #401 revealed turning and (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 - Actual harm Residents Affected - Few	repositioning was not a standard intervention in the facilities care planned interventions to prevent pressure ulcers. Interview on 08/28/25 at 8:40 A.M. with the Director of Nursing confirmed professional standards of practice for pressure ulcer prevention include turning and repositioning residents every two hours. Continued interview confirmed turning and repositioning every two hours is not in Resident #55's care plan, nor was there documentation to support this standard of practice occurring. Review of the facility policy titled Pressure Ulcer Treatment dated November 2013 revealed the facility would redistribute pressure as one intervention to help prevent pressure ulcers. Review of the NPUAP guidelines dated 2014 revealed facilities should educate health professionals on how to undertake a comprehensive skin assessment that includes the techniques for identifying blanching response, localized heat, edema, and induration. Ongoing assessment of the skin was necessary to detect early signs of pressure damage. Visual assessment for erythema (redness of the skin) was the first component of every skin inspection. Skin redness and tissue edema resulting from capillary occlusion was a response to pressure, especially over bony prominences. Staff should conduct a head-to-toe assessment with particular focus on skin overlying bony prominences including the sacrum, ischial tuberosities, greater trochanters and heels and each time the patient was repositioned was an opportunity to conduct a brief skin assessment. The NPUAP further instructed to offload the pressure injury and to turn and reposition the individual.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, staff interviews, and review of facility policies, the facility failed to serve food in a manner that prevented contamination. This affected seven (Residents #13, #19, #35, #45, #54, #86, and #87) observed for room tray service and had the potential to affect all residents in the facility except Residents #4, #9, #12, and #88 who do not receive food from the kitchen. The facility census was 80. Findings include:1. Observation on 08/26/25 at 8:05 A.M. of tray service on the 400-hall revealed Certified Nurse Assistant (CNA) #306 began passing breakfast trays and did not perform hand hygiene before he started. CNA #306 began with serving a breakfast tray to Resident #86 by setting the tray on her bedside table in her room. CNA #306 came out of her room, did not perform hand hygiene, then obtained another breakfast tray. CNA #306 took the tray to Resident #54's room, put the tray down on the bedside table, adjusted the resident's blanket, then prepared the breakfast tray by opening the milk, arranging beverages, removing lids from food containers, adding brown sugar to the oatmeal, and stirring the oatmeal with the resident's silverware. CNA #306 returned to the tray cart and obtained the next breakfast tray without performing hand hygiene. CNA #306 delivered the tray to Resident #19's bedside table, turned the overbed light on by pulling the cord and prepared the tray for the resident. CNA #306 returned to the tray cart and obtained the next breakfast tray without performing hand hygiene. CNA #306 delivered the tray to Resident #13 and cut up the food using the silverware on the tray. CNA #306 returned to the tray cart and obtained the next breakfast tray without performing hand hygiene. CNA #306 delivered the tray to Resident #35's bedside table then assisted Resident #87 with positioning. CNA #306 touched buttons on the bed, boosted Resident #87 up in bed, and touched the pullcord for the overbed light. CNA #306 returned to the tray cart and obtained the next breakfast tray without performing hand hygiene. CNA #306 delivered the tray to Resident #45's bedside table, went in the soiled workroom, then went in another resident's room, and returned with a folding chair. CNA #306 did not perform hand hygiene, unfolded the chair, and sat next to Resident #45 to feed him. Interview on 08/26/25 at 8:25 A.M. with CNA #306 confirmed he did not perform hand hygiene throughout the above noted observation of tray service that started at 8:05 A.M. Review of the facility policy titled Hand Hygiene Guideline dated 04/16/25 revealed hand hygiene would occur before and after the care of all residents, after touching a patient, and before assisting a resident with meals.2. Observation on 08/27/25 at approximately 11:30 A.M. of lunch service revealed [NAME] #374 touching pan lids, steam table surfaces, serving utensils, plates, spatulas, and a frying pan handle then touching a grilled cheese sandwich with the same contaminated gloved hand. The grilled cheese sandwich was placed on a plate and transferred to a tray cabinet to be served to a resident. Concurrent interview with Regional Food Services Director #500 revealed the grilled cheese should not have been touched with contaminated gloved hands. Observation on 08/27/25 at approximately 11:35 A.M. of lunch service revealed Dietary Aides #372 and #391 returned to the tray line and applied clean gloves without washing their hands. Concurrent interview with Regional Food Services Director #500 revealed hand washing should have occurred before putting gloves on. The facility identified Residents #4, #9, #12, and #88 who do not receive food from the kitchen. Review of the facility policy from the Food and Nutrition Manual titled Quick Resource Tool: QRT Hand Washing dated 09/01/21 revealed hands would be washed before putting on gloves, after handling soiled utensils and equipment, and as often as needed during food preparation.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, resident and staff interview, observation, and review of facility policy, the facility failed to ensure Minimum Data Set (MDS) assessments accurately reflected the resident's care needs. This affected two resident (#2 and #27) of 18 residents reviewed for MDS accuracy. The facility census was 80. Findings include: 1. Review of the medical record for Resident #27 revealed an admission date of 07/11/25. Diagnoses included chronic respiratory failure with hypoxia (lack of oxygen), chronic obstructive pulmonary disease (COPD), and obstructive sleep apnea. Review of Resident #27's hospital referral records dated 07/11/25 revealed there were Bilevel Positive Airway Pressure (BIPAP) orders to continue at night and during naps with settings for inspiratory pressure of nine and expiratory pressure of five. Review of Resident #27's physician orders for 07/11/25 to 07/13/25 revealed there were no orders for a BIPAP machine. Review of the admission MDS assessment dated [DATE] revealed Resident #27 was cognitively intact and Resident #27 did not utilize a BIPAP machine. Observation on 08/25/25 at 1:11 P.M. revealed Resident #27 was lying in bed with BIPAP sitting on her nightstand. Observation and interview on 08/26/25 at 8:12 A.M. revealed Resident #27 was resting in bed with her BIPAP on. Resident #27 stated she was on BIPAP at home and she did bring her BIPAP machine from home and has had it since she arrived at the facility. Interview on 08/26/25 at 12:30 P.M. with Licensed Practical Nurse (LPN) #401 stated Resident #27 required the use of a BIPAP machine while residing in the facility. LPN #401 verified the admission MDS assessment for Resident #27 had no indication she required the use of a BIPAP machine and the MDS should have reflected the use of BIPAP machine. 2. Review of the medical record for Resident #2 revealed he was admitted on [DATE]. Diagnoses included multiple sclerosis and paraplegia. Review of the care plan for Resident #2 revealed interventions for the management of bowel and bladder incontinence. Review of the annual MDS assessment dated [DATE] revealed Resident #2 was frequently incontinent of bowel and bladder. The quarterly MDS assessment dated [DATE] revealed Resident #2 was always continent of bowel and bladder. Interview on 08/28/25 at 9:45 A.M. with the Director of Nursing (DON) revealed Resident #2 was always incontinent of bowel and bladder. Interview on 08/28/25 at 9:50 A.M. with Licensed Practical Nurse (LPN) #401 verified the MDS assessments for Resident #2 dated 01/14/25 and 07/10/25 reflected incorrect data regarding (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #2's continence status of frequently incontinent and always continent, respectively. LPN #401 verified Resident #2 was always incontinent of bowel and bladder. Review of the facility policy titled Villa Healthcare RAI Process Guideline (Resident Assessment Instrument) revealed the facility would conduct an accurate MDS assessment for each resident.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and review of facility policy, the facility failed to regularly monitor a resident's weight according to physician orders and facility policy. This affected one (Resident #55) of one resident reviewed for nutrition. The facility census was 80. Findings include: Review of the medical record for Resident #55 revealed he was admitted on [DATE]. Diagnoses included metabolic encephalopathy, gastroesophageal reflux disease, and type II diabetes mellitus. Review of Resident #55's physician orders, dated 07/10/25, revealed an order to obtain admission weight, weekly for four weeks and then monthly. Review of Resident #55's weights revealed on 07/10/25 his weight was 225 pounds and on 08/04/25 his weight was 180.6 pounds. There were no other weights documented in this resident's medical record. There was a weight loss of 19.7 percent (%) over 24 days. Interview on 08/26/25 at 4:45 P.M. with Licensed Practical Nurse (LPN) #401 confirmed Resident #55's weights were not obtained according to physician orders, weights were not obtained according to facility policy, and the significant weight variance of 19.7% should have resulted in a reweigh to confirm the variance. Review of the facility policy titled Weight Monitoring Guideline dated 04/06/18 revealed residents would be weighed upon admission, weekly for four weeks post-admission, then monthly to ensure the maintenance of acceptable parameters of nutritional status. Additionally, the policy indicated a weight variance less than or greater than five pounds would constitute a reweigh.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, staff interview, and review of the facility policy, the facility failed to ensure physician orders were obtained for use of oxygen therapy and Bilevel Positive Airway Pressure (BIPAP) use. This affected one (#27) of one resident reviewed for oxygen and BIPAP use. The facility identified 29 residents who require the use of oxygen and six residents who require the use of BIPAP machine. The facility census was 80. Findings include: Review of the medical record for Resident #27 revealed an admission date of 07/11/25. Diagnoses included chronic respiratory failure with hypoxia (lack of oxygen), chronic obstructive pulmonary disease (COPD), and obstructive sleep apnea. Review of the hospital referral records dated 07/11/25 for Resident #27 revealed BIPAP orders to continue at night and during naps with settings for inspiratory pressure of nine and expiratory pressure of five and oxygen therapy at two to four liters per minute (LPM). Review of the admission assessment dated [DATE] for Resident #27 revealed she was admitted to the facility via wheelchair and oxygen by way of nasal cannula. Review of the current physician orders for 08/2025 for Resident #27 revealed there were no orders for BIPAP use and oxygen administration. Observation on 08/25/25 at 1:11 P.M. revealed Resident #27 was lying in bed with BIPAP sitting on her nightstand. Interview on 08/26/25 at 8:14 A.M. with Licensed Practical Nurse (LPN) #395 verified there were no physician orders for oxygen therapy and BIPAP machine use for Resident #27. Interview on 08/28/25 at 2:08 P.M. with LPN #402 verified she updated the physician orders for Resident #27 to include the orders for oxygen therapy and BIPAP use. Review of the facility policy titled Oxygen Administration Policy, revised 10/2010, revealed the purpose of the procedure is to provide guidelines for safe oxygen administration, review the physician's orders or facility protocol for oxygen administration. Review of the facility policy titled CPAP (Continuous Positive Airway Pressure)/BIPAP Support, revised 10/2020 revealed the purpose is to provide the spontaneously breathing resident with continuous positive airway pressure with or without supplemental oxygen. Review the physician's order to determine the oxygen concentration and flow, and the positive end-expiratory pressure (PEEP), CPAP, bilevel positive airway pressure (BIPAP), and expiratory positive airway pressure (EPAP) for the machine.		