

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: 395067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2025
NAME OF PROVIDER OR SUPPLIER Green Ridge Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2741 Boulevard Avenue Scranton, PA 18509	
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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, the facility's abuse prohibition policy and information provided by the facility it was determined the facility failed to conduct an investigation into an injury of an unknown source to rule out abuse and/or neglect and failed to implement corrective actions, and submit the results of the completed investigation to the State Survey Agency within five working days of the incident as evidenced by one of 18 residents reviewed (Resident 44). Findings included: A review of the facility's Pennsylvania Resident Abuse Policy last reviewed by the facility on October 21, 2025, indicated that it was the facility's policy to investigate all allegations, suspicions, and incidents of abuse, neglect, involuntary seclusion, intimidation, exploitation of residents, misappropriation of resident property and injuries of unknown source. The facility classified an injury as an injury of an unknown source when the source of the injury was not observed by any person, or the source of the injury could not be explained by the resident and if the injury was suspicious because of the extent of the injury, the location of the injury, the number of injuries observed at one particular point in time, or the incidence over time. Further review of the facility's abuse policy indicated all allegations of abuse, neglect, injuries of an unknown source, etc. must be reported immediately to the Nursing Home Administrator (NHA), Director of Nursing (DON), and to the applicable State Agency. If the event that caused the allegation involves an allegation of abuse or serious bodily injury, it should be reported to the Department of Health (DOH) immediately, but not later than two hours after the allegation is made. All serious incidents involving a resident will be reported to the DOH field office within twenty-four hours. Once the NHA and DON are notified, an investigation of the allegation or suspicion will be conducted, and the investigation must be completed within five working days from the alleged occurrence. Investigating injuries of an unknown source should include talking with both the shift on duty when the injury was discovered and prior shifts. Additionally, the investigation should include witness statements, obtain all medical reports and statements from physician and/or hospitals, and review the resident's record. Evidence of the investigation should be documented, and the final report will be submitted to the applicable State agency, after the investigation is completed, but no later than five working days from the occurrence. A review of Resident 44's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses that included unspecified dementia (a term that encompasses various neurological disorders characterized by cognitive decline, memory loss, and changes in behavior and mental health), unspecified fracture (a break in a bone) of lower end of left femur (thigh bone) with routine healing, left acute impact to left distal femur fracture, and presence of unspecified artificial knee joint. A review of Resident 44's Quarterly Minimum Data Set Assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated March 26, 2025, the resident could not complete the BIMS (Brief Interview for Mental Status). The BIMS is a standardized interview used to assess memory and thinking skills. Because the resident was unable to participate in the interview, the BIMS was coded as 99, meaning the assessment could not be conducted. The MDS documented severe cognitive impairment and a need for total assistance of two or more staff for bed mobility and transfers. A progress note completed by Employee 1 (LPN) on April 8, 2025, at 6:45 AM, documented that the resident's left knee (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 395067	If continuation sheet Page 1 of 5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2025
NAME OF PROVIDER OR SUPPLIER Green Ridge Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2741 Boulevard Avenue Scranton, PA 18509	
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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was noted to be swollen and painful during routine foot care. Vital signs were within normal limits, and the supervisor was notified. A progress note completed by Employee 2 (LPN) on April 8, 2025, at 12:35 PM, documented that the Certified Registered Nurse Practitioner (CRNP) assessed the resident and ordered an x-ray (medical imaging using radiation to create internal images) of the left knee. New orders included acetaminophen (a non-opioid pain reliever) 1000 mg orally every eight hours as needed for mild pain, and tramadol (an opioid pain reliever for moderate to severe pain) 50 mg orally twice daily for pain rated 7-10. The responsible party was notified. A progress note completed by Employee 2 (LPN) on April 8, 2025, at 12:35 PM, indicated that the Certified Registered Nurse Practitioner (CRNP) assessed the resident and ordered an x-ray (medical imaging using radiation to create internal images) of the left knee. New orders included acetaminophen (a non-opioid pain reliever) 1000 mg orally every eight hours as needed for mild pain, and tramadol (an opioid pain reliever for moderate to severe pain) 50 mg orally twice daily for pain rated 7-10 (pain scale ratings indicate 0 least amount of pain and 10 being worst amount of pain). The responsible party was notified. A review of the April 8, 2025, x-ray report, timed 10:19 AM, revealed a new but subacute angulated fracture (a bone break where it comes out of alignment, and tilts at an angle) of the distal left femur with partial healing. The report noted possible insufficiency fracture (a stress-related fracture occurring in weakened bone), moderate osteopenia (medical definition for bone density loss), degenerative joint disease (osteoarthritis most common type of arthritis and can occur in any joint, it usually affects the hands, knees, hips or spine), mild soft tissue swelling, and no significant joint effusion (joint swelling). Clinical correlation was suggested and follow up radiographs to confirm healing. The facility was unable to provide documentation that an investigation into this injury of unknown source was conducted, including interviews, review of shifts prior to discovery, or completion of the required investigation report. The facility was also unable to provide evidence that investigation results were submitted to the State Survey Agency within five working days as required by the facility's abuse policy. During an interview with the Director of Nursing on November 13, 2025, at 1:30 PM, it was stated that an investigation was not initiated because the facility's CRNP determined the swelling was related to an old fracture. During an interview with the Nursing Home Administrator on November 14, 2025, at 10:10 AM, the above information was reviewed. The Nursing Home Administrator indicated that an investigation should have been completed due to the presence of an injury of unknown source, in accordance with the facility's policy to rule out potential abuse or neglect. 28 Pa. Code 201.14 (a) Responsibility of licensee. 28 Pa. Code 201.18(e)(1) Management. 28 Pa. Code 201.29(a)(c) Resident Rights. 28 Pa. Code 211.10(d) Resident care policies. 28 Pa. Code 211.12(c)(d)(5) Nursing Services		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2025
NAME OF PROVIDER OR SUPPLIER Green Ridge Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2741 Boulevard Avenue Scranton, PA 18509	
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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on a review of select facility policy. controlled sub stance shift to shift count records, and staff interview, it was determined the facility failed to implement procedures to promote accurate controlled medication records on three of three medication carts observed. Findings include: A review of facility policy entitled Inventory Control of Controlled Substances (a controlled substance is a medication regulated by federal or state law because it has a risk for abuse, diversion which is misuse for non-medical purposes, or addiction).last reviewed by the facility on October 21, 2025, revealed the facility is to maintain separate individual controlled substance records on all Schedule II medications and any medication with a potential for abuse or diversion in the form of a declining inventory using the Controlled Substances Declining Inventory Record. The policy further revealed that the facility should ensure the incoming and outgoing nurse count all Schedule II controlled substances and other medications with a risk of abuse or diversion at the change of each shift. A review of the facility Shift Verification of Controlled Substances Count record from the 500-unit medication cart revealed the following:August 27, 2025, the second shift on coming nurse failed to sign that the narcotic count was completed and correct.August 31, 2025, the first shift off going nurse failed to sign that the narcotic count was completed and correct.August 31, 2025, the third shift off going nurse failed to sign that the narcotic count was completed and correct.September 1, 2025, the first shift off going nurse failed to sign that the narcotic count was completed and correct.September 1, 2025, the second shift on coming nurse failed to sign that the narcotic count was completed and correct.September 1, 2025, the second shift off going nurse failed to sign that the narcotic count was completed and correct.September 2, 2025, the second shift on coming nurse failed to sign that the narcotic count was completed and correct.September 2,2025, the second shift off going nurse failed to sign that the narcotic count was completed and correct.September 2, 2025, the third shift on coming nurse failed to sign that the narcotic count was completed and correct.September 4, 2025, the second shift on coming nurse failed to sign that the narcotic count was completed and correct.September 4, 2025, the second shift off going nurse failed to sign that the narcotic count was completed and correct.September 9, 2025, the night shift on coming nurse failed to sign that the narcotic count was completed and correct.September 9, 2025, the night shift off going nurse failed to sign that the narcotic count was completed and correct.September 12, 2025, the night shift off going nurse failed to sign that the narcotic count was completed and correct.September 14, 2025, the second shift on coming nurse failed to sign that the narcotic count was completed and correct.September 14, 2025, the second shift off going nurse failed to sign that the narcotic count was completed and correct.September 17, 2025, the second shift on coming nurse failed to sign that the narcotic count was completed and correct.September 17, 2025, the second shift off going nurse failed to sign that the narcotic count was completed and correct.September 22, 2025, the second shift off going nurse failed to sign that the narcotic count was completed and correct.September 24, 2025, the third shift on coming nurse failed to sign that the narcotic count was completed and correct.September 24, 2025, the third shift off going nurse failed to sign that the narcotic count was completed and correct.September 27, 2025, the second shift on coming nurse failed to sign that the narcotic count was completed and correct.October 1, 2025, the third shift on coming nurse failed to sign that the narcotic count was completed and correct.October 1, 2025, the third shift off going nurse failed to sign that the narcotic count was completed and correct.October 4, 2025, the first shift off going nurse failed to sign that the narcotic count was completed and correct.November 9, 2025, the third shift off going nurse failed to sign that the narcotic count was completed and correct.November 13, 2025, the first shift on coming nurse failed to sign that the narcotic count was completed and correct.An interview completed on November 13, 2025, at 08:25AM with employee 4 (Licensed Practical Nurse) revealed she did not complete the shift-to-shift narcotic count with the off going (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2025
NAME OF PROVIDER OR SUPPLIER Green Ridge Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2741 Boulevard Avenue Scranton, PA 18509	
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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	night shift nurse. Employee 6 stated she forgot to sign the book, then proceeded to sign the shift-to-shift narcotic count sheet without completing a complete count of the controlled medications stored in 500 Hall Cart. A review of the facility Shift Verification of Controlled Substances Count record from the 500 Private Hall medication cart revealed the following: August 15, 2025, the first shift off going nurse failed to sign that the narcotic count was completed and correct. August 17, 2025, the first shift off going nurse failed to sign that the narcotic count was completed and correct. August 19, 2025, the third shift off going nurse failed to sign that the narcotic count was completed and correct. August 22, 2025, the first shift off going nurse failed to sign that the narcotic count was completed and correct. August 23, 2025, the first shift off going nurse failed to sign that the narcotic count was completed and correct. August 24, 2025, the second shift on coming nurse failed to sign that the narcotic count was completed and correct. August 24, 2025, the second shift off going nurse failed to sign that the narcotic count was completed and correct. August 25, 2025, the first shift off going nurse failed to sign that the narcotic count was completed and correct. August 25, 2025, the second shift off going nurse failed to sign that the narcotic count was completed and correct. August 30, 2025, the third shift on coming nurse failed to sign that the narcotic count was completed and correct. August 30, 2025, the third shift off going nurse failed to sign that the narcotic count was completed and correct. September 2, 2025, the second shift on coming nurse failed to sign that the narcotic count was completed and correct. September 2, 2025, the second shift off going nurse failed to sign that the narcotic count was completed and correct. September 4, 2025, the second shift off going nurse failed to sign that the narcotic count was completed and correct. September 6, 2025, the first shift off going nurse failed to sign that the narcotic count was completed and correct. September 7, 2025, the first shift off going nurse failed to sign that the narcotic count was completed and correct. September 8, 2025, the second shift on coming nurse failed to sign that the narcotic count was completed and correct. September 8, 2025, the second shift off going nurse failed to sign that the narcotic count was completed and correct. September 12, 2025, the first shift on coming nurse failed to sign that the narcotic count was completed and correct. September 12, 2025, the first shift off going nurse failed to sign that the narcotic count was completed and correct. September 15, 2025, the second shift on coming nurse failed to sign that the narcotic count was completed and correct. September 15, 2025, the second shift off going nurse failed to sign that the narcotic count was completed and correct. September 16, 2025, the first shift off going nurse failed to sign that the narcotic count was completed and correct. September 16, 2025, the second shift on coming nurse failed to sign that the narcotic count was completed and correct. September 16, 2025, the second shift off going nurse failed to sign that the narcotic count was completed and correct. September 23, 2025, the first shift on coming nurse failed to sign that the narcotic count was completed and correct. September 23, 2025, the first shift off going nurse failed to sign that the narcotic count was completed and correct. September 23, 2025, the second shift on coming nurse failed to sign that the narcotic count was completed and correct. September 23, 2025, the second shift off going nurse failed to sign that the narcotic count was completed and correct. September 24, 2025, the second shift on coming nurse failed to sign that the narcotic count was completed and correct. September 24, 2025, the second shift off going nurse failed to sign that the narcotic count was completed and correct. September 24, 2025, the third shift on coming nurse failed to sign that the narcotic count was completed and correct. September 24, 2025, the third shift off going nurse failed to sign that the narcotic count was completed and correct. October 2, 2025, the second shift on coming nurse failed to sign that the narcotic count was completed and correct. October 2, 2025, the second shift off going nurse failed to sign that the narcotic count was completed and correct. October 3, 2025, the second shift on coming nurse failed to sign that the narcotic count was completed and correct. October 3, 2025, the second shift off going nurse failed to sign that the narcotic count was completed and correct. October 13, 2025, the second shift on coming nurse failed to sign that the narcotic count was completed and correct. October 13, 2025, the second shift off going nurse failed to sign that the (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2025
NAME OF PROVIDER OR SUPPLIER Green Ridge Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2741 Boulevard Avenue Scranton, PA 18509	
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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	narcotic count was completed and correct.October 15, 2025, the second shift on coming nurse failed to sign that the narcotic count was completed and correct.October 15, 2025, the second shift off going nurse failed to sign that the narcotic count was completed and correct.October 17, 2025, the second shift on coming nurse failed to sign that the narcotic count was completed and correct.October 17, 2025, the second shift off going nurse failed to sign that the narcotic count was completed and correct.October 22, 2025, the first shift off going nurse failed to sign that the narcotic count was completed and correct.October 22, 2025, the second shift off going nurse failed to sign that the narcotic count was completed and correct.October 23, 2025, the first shift off going nurse failed to sign that the narcotic count was completed and correct.October 23, 2025, the second shift off going nurse failed to sign that the narcotic count was completed and correct.October 24, 2025, the first shift on coming nurse the second shift off going nurse failed to sign that the narcotic count was completed and correct.October 25, 2025, the second shift on coming nurse failed to sign that the narcotic count was completed and correct.October 25, 2025, the second shift off going nurse failed to sign that the narcotic count was completed and correct.October 28, 2025, the second shift off going nurse failed to sign that the narcotic count was completed and correct.October 28, 2025, the third shift on coming nurse failed to sign that the narcotic count was completed and correct.October 29, 2025, the second shift on coming nurse failed to sign that the narcotic count was completed and correct.October 29, 2025, the second shift off going nurse failed to sign that the narcotic count was completed and correct.November 3, 2025, the second shift on coming nurse failed to sign that the narcotic count was completed and correct.November 3, 2025, the second shift off going nurse failed to sign that the narcotic count was completed and correct.November 7, 2025, the second shift on coming nurse failed to sign that the narcotic count was completed and correct.November 7, 2025, the second shift off going nurse failed to sign that the narcotic count was completed and correct. A review of the facility Shift Verification of Controlled Substances Count record from the 200-unit medication cart revealed the following:November 12, 2025, the first shift off going nurse failed to sign that the narcotic count was completed and correct.During an interview on November 13, 2025, at 08:05 AM, Employee 3 (Licensed Practical Nurse) confirmed that the count on the 200-unit cart for the above date was incomplete. On November 13, 2025, at 12:45 PM, the surveyor reviewed the above findings with the Nursing Home Administrator and the Director of Nursing.28 Pa Code 211.9 (c)(k) Pharmacy services28 Pa Code 211.12 (c)(d)(1)(3)(5) Nursing service28 Pa Code 211.10 (c) Resident care policies.28 Pa Code 211.5(f)(x) Clinical records		