

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/18/2025
NAME OF PROVIDER OR SUPPLIER Greenfield Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1521 West 54th Street Erie, PA 16509	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48496</p> <p>Based on review of facility policy and clinical records, observations, and resident and staff interviews, it was determined that the facility failed to maintain resident privacy and dignity related to the resident's room environment for one of 11 residents reviewed (Resident R2).</p> <p>Findings include:</p> <p>Review of facility policy entitled, Promoting/Maintaining Resident Dignity dated 11/1/24, revealed It is the practice . treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances residents' quality of life . and All staff members are involved in providing care to residents to promote and maintain resident dignity and respect .</p> <p>Review of Resident R2's clinical record revealed an admitted [DATE], with diagnoses that included anxiety (a condition that causes a person to be nervous, uneasy, or worried about something or someone), difficulty walking, and hypertension (high blood pressure).</p> <p>Review of Resident R2's physician orders revealed an order dated 1/6/24, for bedside commode at all times.</p> <p>Review of Resident R2's care plan for ADL (activities of daily living) self-care performance revealed an intervention for bedside commode at all times.</p> <p>Observations on 3/13/25, at 10:25 a.m. in Resident R2's room revealed a strong foul odor upon entering the room. Observation in the room revealed a bedside commode positioned against the wall and was approximately a quarter of the way full of a yellow and brown substance. The lid of the bedside commode was laying on the floor. Further observations on 3/13/25, at 12:00 p.m. revealed the bedside commode had not been emptied and remained with the same contents and the lid remained laying on the floor. Observation on 3/13/25, at 12:25 p.m. revealed the bedside commode and lid remained in the same conditions.</p> <p>(continued on next page)</p>

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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/13/25, at 10:25 a.m. Resident R2 expressed that his/her bedside commode needed to be emptied. He/she stated that their bedside commode had needed emptied since the previous night at 10:30 p.m. He/she stated that he/she is unable to empty the bedside commode due to his/her mobility. He/she also expressed that several staff had entered their room between 10:30 p.m. on 3/12/25, through the time of this interview being conducted.</p> <p>Further interview with Resident R2 on 3/13/25, at 12:00 p.m. revealed that he/she expressed that the bedside commode had still not been emptied. He/she then expressed that his/her lunch was getting ready to be delivered and stated Now I get to eat my lunch expressing this while he/she was looking at the bedside commode.</p> <p>During an interview on 3/13/25, at 12:25 p.m. and observations in Resident R2's room with the Nursing Home Administrator, he/she confirmed the contents in Resident R2's bedside commode and the lid of the bedside commode was laying on the floor. He/she also confirmed that Resident R2's bedside commode should be emptied after every use.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services</p>

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<p>F 0711</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48496</p> <p>Based on review of facility policy and clinical records, and staff interview, it was determined that the facility failed to ensure that the physician sign and date all orders and write, date, and sign a progress note during each of his/her visits for six of seven residents reviewed (Residents R1, R3, R4, R5, R6 and R7).</p> <p>Findings include:</p> <p>Review of facility policy entitled Physician Visits and Physician Delegation dated 11/1/24, indicated The physician should: See resident within 30 days of initial admission to the facility. The resident must be seen at least once every 30 calendar days for the first 90 calendar days after admission and at least every 60 days thereafter by physician or physician delegate as appropriate by state law. Date, write and sign a progress note for each visit. Sign and date all orders .</p> <p>Resident R1's clinical record revealed an admitted [DATE], with diagnoses that included fibromyalgia (a disorder that causes widespread muscle pain, tiredness, sleep problems and thought difficulties), and diabetes (a health condition that caused by the body's inability to produce enough insulin).</p> <p>Review of Resident R1's clinical record lacked evidence of the last time his/her physician wrote a progress note and reviewed, signed, and dated his/her physician orders.</p> <p>Resident R3's clinical record revealed an admitted [DATE], with diagnoses that included diabetes and hypertension (high blood pressure).</p> <p>Review of Resident R3's clinical record lacked evidence of the last time his/her physician wrote a progress note and reviewed, signed, and dated his/her physician orders.</p> <p>Resident R4's clinical record revealed an admitted [DATE], with diagnoses that included chronic obstructive pulmonary disease (when your lungs do not have adequate air flow), and hyperlipidemia (high cholesterol).</p> <p>Review of Resident R4's clinical record revealed that on 9/25/24, at 4:30 p.m. was the last time his/her physician wrote a progress note, reviewed, signed, and dated his/her physician orders.</p> <p>Resident R5's clinical record revealed an admitted [DATE], with diagnoses that included diabetes and hypertension.</p> <p>Review of Resident R5's clinical record revealed that on 10/14/24, at 1:54 p.m. was the last time his/her physician reviewed, signed, and dated his/her physician orders. Further review of Resident R5's clinical record revealed that the last physician progress note dated 8/21/24, remained as a draft note (a progress note that has not been completed or signed by the author).</p> <p>(continued on next page)</p>		

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<p>F 0711</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident R6's clinical record revealed an admitted [DATE], with diagnoses that included gastroesophageal reflux disease (a condition when stomach acid repeatedly flows back up into your throat), and hypertension.</p> <p>Review of Resident R6's clinical record lacked evidence of the last time his/her physician wrote a progress note and reviewed, signed, and dated his/her physician orders.</p> <p>Resident R7's clinical record revealed an admitted [DATE], with diagnoses that included dementia (a disease that affects short term memory and the ability to think logically), and diabetes.</p> <p>Review of Resident R7's clinical record revealed that on 10/14/24, at 2:13 p.m. was the last time his/her physician reviewed, signed, and dated his/her physician orders. Further review of Resident R7's clinical record revealed that the last physician progress note dated 6/26/24, remained as a draft note.</p> <p>During an interview on 3/13/25, at 11:30 a.m. the Director of Nursing confirmed that physician progress notes and physician orders for Residents R1, R3, R4, R5, R6 and R7 were past due for being written, reviewed, and signed by the physician. He/she also confirmed that physician progress notes and physician orders should be written and signed on admission then every 30 days for the first 90 days then every 60 days.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.18(b)(1)(3) Management</p> <p>28 Pa. Code 211.5(f)(i) Medical records</p>