

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 07/10/2025
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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>Based on review of clinical records, facility documentation, and facility policy, and staff interview, it was determined that the facility failed to maintain complete and accurate records for two of six residents reviewed (Closed Record Resident CR2 and Resident R5).</p> <p>Findings include:</p> <p>A facility policy entitled Assessing Falls and Their Cause dated 11/01/24, indicated that when a resident falls, the following information should be recorded in the resident's medical record:</p> <ol style="list-style-type: none"> 1. The condition in which the resident was found (e.g. resident found laying on the floor between bed and chair). 2. Assessment data, including vital signs and any obvious injuries. 3. Interventions, first aid, or treatment administered. 4. Notification of the physician and family, as indicated. 5. Completion of a falls risk assessment. 6. Appropriate interventions taken to prevent future falls. 7. The signature and title of the person recording the data. <p>Resident CR2's clinical record revealed an admission date of 5/03/23, with diagnoses including Parkinson's disease with dyskinesia uncontrollable (age-related degenerative brain condition with uncontrollable jerky movements), paranoid schizophrenia (a severe mental illness characterized by paranoia, delusions, and hallucinations), anxiety, and generalized muscle weakness.</p> <p>A departmental progress note dated 5/13/25, indicated that Resident CR2's family was informed that he/she was currently at the hospital. The clinical record lacked documentation of the cause for Resident CR2 being sent to the hospital.</p> <p>Review of facility documentation revealed that on 5/13/25, at 4:30 a.m. Resident CR2 was being provided personal hygiene and fell from the bed sustaining injuries to his/her face, right arm, and right foot and leg.</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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Further review of Resident CR2's clinical record revealed no evidence of documentation of his/her fall, vital signs, assessment and injuries, first aid or treatments administered, notification to the family and physician, completion of the falls risk assessment, and signature and title of the person recording the data.</p> <p>Resident R5's clinical record revealed an admission date of 6/06/25, with diagnoses including stroke with left-sided weakness, muscle weakness, unsteady on feet, abnormal gait, mobility and posture, and history of falling.</p> <p>Review of facility documentation revealed that on 6/10/25, at 7:20 p.m. Resident R5 experienced a fall in his/her room while self-ambulating.</p> <p>Departmental progress note dated 6/11/25, indicated Resident R5 experienced a fall on 6/10/25. The clinical record lacked documentation of his/her fall, vital signs, assessment and injuries, first aid or treatments administered, notification of the family and physician, completion of the falls risk assessment, and signature and title of the person recording the data.</p> <p>Review of facility documentation revealed that on 6/13/25, at 1:50 p.m. Resident R5 experienced a fall in another resident's room and sustained injuries to his/her left knee and elbow.</p> <p>Departmental progress note dated 6/13/25, indicated Resident R5 experienced a fall and was assisted back to his/her wheelchair by staff. The clinical record lacked documentation of his/her vital signs, assessment and injuries, first aid or treatments administered, notification of the family and physician, and completion of the falls risk assessment.</p> <p>A provider note dated 6/27/25, indicated the presence of skin tear on Resident R5's left upper buttock, and referenced that the clinical record lacked documentation regarding the cause of the skin tear.</p> <p>Provider note dated 7/01/25, indicated the presence of dressings to Resident R5's to the left knee and elbow, Resident R5 disclosed to the provider that he/she had fallen. There was no documentation in the clinical record of a fall since last observed on 6/27/25, and the last noted fall in the clinical record was 6/13/25.</p> <p>During an interview on 7/09/25, at 4:05 p.m. the Director of Nursing confirmed that Resident CR2's clinical record lacked the required documentation regarding his/her fall on 5/13/25, and that Resident R5's clinical record lacked the required documentation regarding his/her falls on 6/10/25, and 6/13/25.</p> <p>28 Pa. Code 201.18 (b)(1)(3) Management</p> <p>28 Pa. Code 211.5(f)(ii)(iv)(ix) Medical records</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		