STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395262	A. Building B. Wing	09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenfield Healthcare and Rehabilitation Center	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)
F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. Based on review of facility policy and clinical records, and staff interviews, it was determined that the facility failed to ensure that the physician sign and date all orders during each of his/her visits for five of five residents reviewed (Residents R1, R3, R4, and R5). Findings include: 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. Sign and date all orders. Resident R1's clinical record revealed an admission date of 6/6/25, with diagnoses that included hyperlipidemia (high cholesterol), and bipolar disorder (a mental illness that causes extreme mood swings with emotional highs and emotional lows). Review of Resident R1's clinical record lacked evidence of the last time his/her physician reviewed, signed, and dated his/her physician orders. Resident R2's clinical record revealed an admission date of 9/25/22, with diagnoses that included diffuse traumatic brain injury (a head injury that has caused damage across multiple areas of the brain), and hypertension (high blood pressure). Review of Resident R2's clinical record revealed the last time his/her physician reviewed, signed, and dated his/her physician orders was on 3/14/25. Resident R3's clinical record revealed an admission date of 5/2/24, with diagnoses that included chronic obstructive pulmonary disease (COPD-condiiton when your lungs do not have adequate air flow), and diabetes (a health condition that is caused by the body's inability to produce enough insulin) Review of Resident R3's clinical record revealed the last time his/her physician reviewed, signed, and dated his/her physician orders was on 3/14/25. Resident R4's clinical record revealed an admission date of 6/18/25, with diagnoses that included diabetes and hyperlipidemia. Review of Resident R4's clinical record lacked evidence of the last time his/her physician reviewed, signed, and dated his/her physician orders. Resident R5's clinical record revealed an admission date of 2/26/25, with diagnosis that included diabetes and COPD. Review of Resident R5's clinical record revealed the last time his/her physician reviewed, signed, and dated his/her physician orders was on 3/14/25. During an interview on 9/5/25, at 11:05 a.m. the Nursing Home Administrator (NHA) confirmed that physician orders for Residents R1, R2, R3, R4, and R5 were past due to be reviewed and signed by the physician. The NHA also confirmed that physician orders should be reviewed and signed with every physician visit on admission then every 30 days for the first 90 days then every 60 days. 28 Pa. Code 201. 14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(3) Management 28 Pa. Code 211.5(f)(i) Medical records

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
	395262	A. Building B. Wing	09/05/2025

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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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on review of the facility's plan of correction for previous survey, and the results of the current survey, it was determined that the facility's Quality Assurance Performance Improvement (QAPI) committee failed to correct quality deficiency and ensure that the plan to improve the delivery of care and services effectively addressed recurring deficiencies.Findings include: Review of facility policy entitled Quality Assurance and Performance Improvement (QAPI) dated 11/1/24, indicated Program systematic analysis and systemic action to ensure improvements are sustained. The facility's deficiency and plan of correction for a complaint survey ending March 18, 2025, revealed that the facility developed plans of correction that included quality assurance systems to ensure that the facility maintained compliance with cited nursing home regulation. The results of the current survey, ending September 5, 2025, identified repeated deficiency related to a failure to ensure that the physician sign and date all orders during each of his/her visits. The facility's plan of correction for the deficiency regarding the physician sign and date all orders during each of his/her visits ending 4/4/25, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey revealed that the facility's QAPI committee failed to successfully implement their plan to ensure that the physician signed and dated all orders during each of his/her visits. During an interview on 9/5/25, at 2:37 p.m. the Nursing Home Administrator confirmed that the results of the current survey, cited under F711, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding physician orders being reviewed and signed by the physician as required. Refer to F711 28 Pa. Code 201.14(a) Responsibility of Licensee 28 Pa. Code 201.18(e)(1) Management