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	01/08/2026

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on review of facility policies, clinical records, and staff interviews, it was determined that the facility failed to provide the resident and/or resident representative with a written notice of the facility bed-hold policy (explanation of how long a bed can be held during a leave of absence and the cost per day) and failed to make certain that the necessary resident information was communicated to the receiving health care provider upon transfer to the hospital for four of four residents reviewed for hospitalization (Residents R2, R5, R6, and R7).Findings include: Facility policy entitled Bed-Hold Notice dated 1/7/26, indicated that It is the policy of this facility to provide written information to the resident and/or the resident representative regarding bed hold practices both well in advance, and at the time of, a transfer for hospitalization or therapeutic leave. The policy further states In the event of an emergency transfer of a resident, the facility will provide written notice of the facility's bed-hold policies to the resident and/or the resident representative within 24 hours. The facility will document multiple attempts to reach the resident's representative in cases where the facility was unable to notify the representative., The facility will keep a signed and dated copy of the bed-hold notice information given to the resident and/or representative in the resident's file and/or medical record. and The facility will provide this information to all facility residents, regardless of their payment source. Facility policy entitled Transfer and Discharge (including AMA [against medical advice]) dated 1/7/26, indicated that for a transfer to another provider, for any reason, the following information must be provided to the receiving provider: contact information for the practitioner responsible for care of resident, resident representative information, advanced directive, information necessary to meet the resident's needs, special instructions and/or precautions for ongoing care, and care plan goals. Resident R2's clinical record revealed an admission date of 3/26/25, with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD - a condition that prevents airflow to the lungs resulting in difficulty breathing), Epilepsy (a chronic brain disorder which a group of nerve cells or neurons will sometimes send wrong signals and cause a seizure which temporarily affects your consciousness, muscle control, and behavior), and Stroke (occurs when blood flow to the brain is blocked or a blood vessel inside or on the surface of the brain bursts causing brain cells to die often times, but not always leading to permanent disabilities). Resident R2's clinical record revealed a progress note dated 12/8/25, indicating a transfer to the hospital. The clinical record lacked evidence that the resident's necessary clinical information was communicated to the receiving health care provider. Resident R2's clinical record also lacked evidence indicating that Resident R2 and/or his/her representative were provided with a copy of the facility bed-hold policy upon transfer or within twenty-four hours of transfer. Resident R5's clinical record revealed an admission date of 6/22/16, with diagnoses that included Epilepsy, Gastroesophageal reflux disease (GERD - happens when stomach acid flows back up into the esophagus and causes heartburn), and Paraplegia (the loss of the ability to move, and sometimes to feel (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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	anything in the legs or lower body, typically caused by a spinal injury or disease). Resident R5's clinical record revealed a progress note dated 12/26/25, indicating a transfer to the hospital. The clinical record lacked evidence that the resident's necessary clinical information was communicated to the receiving health care provider. Resident R5's clinical record also lacked evidence indicating that Resident R5 and/or his/her representative were provided with a copy of the facility bed-hold policy upon transfer or within twenty-four hours of transfer. Resident R6's clinical record revealed an admission date of 12/2/24, with diagnoses that included Encephalopathy (a group of conditions that cause problems with the brain that can appear as confusion, memory loss, and personality changes), High Blood Pressure and Anxiety (a condition that causes a person to be nervous, uneasy, or worried about something or someone). Resident R6's clinical record revealed a progress note dated 11/24/25, indicating a transfer to the hospital. The clinical record lacked evidence that the resident's necessary clinical information was communicated to the receiving health care provider. Resident R6's clinical record also lacked evidence indicating that Resident R6 and/or his/her representative were provided with a copy of the facility bed-hold policy upon transfer or within twenty-four hours of transfer. Resident R7's clinical record revealed an admission date of 6/15/24, with diagnoses that included Schizoaffective Disorder (a mental health condition that can be a mix of symptoms such as hallucinations [seeing things or hearing voices that other don't], delusions [believing things that are not real or true], and depression [persistent feeling of sadness loss of interest in activities once enjoyed]), Epilepsy, and GERD. Resident R7's clinical record revealed a progress note dated 11/5/25, 11/17/25, and 12/29/25, indicating transfers to the hospital. The clinical record lacked evidence that the resident's necessary clinical information was communicated to the receiving health care provider. Resident R7's clinical record also lacked evidence indicating that Resident R7 and/or his/her representative were provided with a copy of the facility bed-hold policy upon transfer or within twenty-four hours of transfer. During a telephone interview on 1/8/25, at approximately 11:09 a.m. the Nursing Home Administrator and Director of Nursing confirmed that Residents R2, R5, R6, and R7's clinical records lacked evidence that necessary clinical information was communicated to the receiving health care provider and lacked evidence that the resident and/or their representative were provided with a copy of the facility bed-hold policy upon transfer or within twenty-four hours of transfer. 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 201.29(c.3)(2) Resident rights

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on review of facility policy and clinical records, and staff interview, it was determined that the facility failed to initiate a baseline care plan and provide a written summary of the baseline care plan and order summary to the resident and/or representative for three of 29 residents reviewed (Closed Record Residents CR1, CR2, and CR3). Findings include:A facility policy entitled Baseline Care Plan dated 11/01 /25, revealed the facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of care. The baseline care plan will be developed within 48 hours of a resident ' s admission. Include the minimum healthcare information necessary to properly care for a resident including, but not limited to: Initial goals based on admission orders, Physician orders, Dietary orders, Therapy services, Social services, Preadmission Screening and Resident Review (PASARR) recommendation, if applicable. A written summary of the baseline care plan shall be provided to the resident and representative in a language that the resident/resident representative can understand. The summary shall include, at a minimum, the following: The initial goals of the resident, A summary of the resident ' s medications and dietary instructions, Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.Resident CR1's clinical record revealed an admission date of 9/18/25, with diagnoses that included chronic kidney disease (a condition where the kidneys cannot remove waste and balance fluids), hemiplegia and hemiparesis following cerebral infarction (paralysis, muscle weakness affecting one side of the body after a stroke), and diabetes mellitus (a condition when your blood sugar is too high), and chronic obstructive pulmonary disease (COPD - a group of respiratory conditions that involve shortness of breath, a persistent cough, and excess mucus).Resident CR2 ' s clinical record revealed an admission date of 9/19/25, with diagnoses that included morbid obesity (a person who is severely overweight), diabetes mellitus, hyperlipidemia (high levels of fat, including cholesterol and triglycerides, in the blood), and obstructive sleep apnea (a sleep disorder where the airway at times collapses during sleep causes disruption in the breathing pattern of a person).Resident CR3 ' s clinical record revealed an admission date of 10/23/25, with diagnoses that included severe protein-calorie malnutrition (a condition when a person does not consume enough protein and calories to meet their body ' s needs), dysphagia (difficulty swallowing), gastroparesis (a delay in the movement of food from the stomach to the small intestine), and diverticulitis of intestine (inflammation or infection of small pouches that form in the wall of the intestine).Review of the clinical records for Residents CR1, CR2, and CR3 lacked evidence that a baseline care plan was initiated, or a copy of the baseline care plan including physician orders with medications, dietary orders, therapy services, were provided to Residents CR1, CR2, and CR3 and/or their representative.During an interview on 11/03/25, at approximately 3:40 p.m. the Nursing Home Administrator confirmed there was no evidence that a baseline care plan was initiated, or a copy of the baseline care plan including physician orders with medications, dietary orders, therapy services, were provided to Resident CR1, CR2, and CR3 and/or their representative.28 Pa. Code 211.10(c) Resident care plan28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. Based on review of facility policy and clinical records and staff interview, it was determined that the facility failed to transcribe and act upon physician orders for medications ordered at time of admission for one of six residents reviewed (Resident R2) and failed to follow physician's orders regarding the administration of seizure medications for one of five residents reviewed (Resident R2).Findings include: Facility policy entitled Medication Orders dated 1/7/26, indicated for written transfer orders sent with a resident by a hospital or other health care facility the facility will Implement a transfer order without further validation, if it is signed and dated by the resident's current attending physician, unless the order is unclear or incomplete, or the date signed is different from the date or admission. If the order is unsigned, or signed by another physician, or the date is other than the date of admission, the receiving nurse should verify the order with the current attending physician before medications are administered. The nurse should document verification on the admission order record, by entering the time, date, and signature. Resident R2's clinical record revealed an admission date of 3/26/25, with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD - a condition that prevents airflow to the lungs resulting in difficulty breathing), Epilepsy (a chronic brain disorder which a group of nerve cells or neurons will sometimes send wrong signals and cause a seizure which temporarily affects your consciousness, muscle control, and behavior), and Stroke (occurs when blood flow to the brain is blocked or a blood vessel inside or on the surface of the brain bursts causing brain cells to die often times, but not always leading to permanent disabilities). Resident R2's clinical record revealed discharge instructions dated 3/26/25, from a local hospital that included Aspirin 81 milligrams (mg) by mouth every morning and Cholecalciferol (Vitamin D3) 50 micrograms (mcg) by mouth daily. Facility physician orders between 3/26/25, and 1/7/26, lacked evidence of Aspirin 81 mg and Cholecalciferol 50 mcg being ordered per the hospital discharge instructions. Medication Administration Records (MAR) between 3/26/25, and 1/7/26, lacked evidence of Aspirin 81 mg and Cholecalciferol 50 mcg being administered per hospital discharge instructions. Clinical record progress notes completed at time of admission lacked evidence that Resident R2's physician was notified and/or made any changes to the hospital discharge instructions. Resident R2's clinical record revealed discharge instructions dated 3/26/25, from a local hospital that included Clonazepam (medication used to treat seizures) 0.5 mg every twenty-four hours as needed (prn) for seizures. Facility physician orders indicated Clonazepam 0.5 mg every twenty-four prn for seizures. Clinical record progress notes dated 12/8/25, at 8:06 a.m. indicated that the nurse was called to residents' room at approximately 6:20 a.m. due to resident being found on the floor. Resident R2 stated he/she had a headache and later also complained of lightheadedness and stated he/she got dizzy. Resident R2 was assisted to bed and placed on a bedpan. When aide returned to room to assist Resident R2 off the bedpan, Resident R2 was having seizure like activity and upon observation resident was noted to have had a 13-minute (approximate) seizure At approximately 7:05 a.m. Resident R2 was starting to have another seizure that lasted approximately one minute. Clinical record progress notes and MAR lacked evidence that Clonazepam 0.5 mg every 24 hours prn for seizures was administered per physician orders. Findings of the facility not following physician orders and not administering Aspirin 81mg by mouth every morning and Cholecalciferol 50 mcg by mouth daily since time of admission and not following physician orders related to not administering Clonazepam 0.5 mg every twenty-four hours prn for seizures on 12/8/2025 when Resident R2 was having a seizure were reviewed with the Nursing Home Administrator and Director of Nursing on 1/08/2026 at 11:05 a.m. 28 Pa. Code 211.5(f)(i)(x) Medical records 28 Pa. Code 211.12(d)(1)(5) Nursing services