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	01/27/2026

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, review of clinical and facility records, review of the Long Term Care Facility Resident Assessment Instrument 3.0 User's Manual 2025 (RAI-assessment guide used to plan the provision of care for residents), and resident and staff interviews, it was determined that the facility failed to ensure Resident R6 was free of neglect during care, which resulted in actual harm of a laceration to the left posterior head, fracture of left pubic bone with a two part fracture that extended into the pubic symphysis (the front and lower part of left hip bone which separated and fractured), left scapholunate ligament tear (a wrist injury involving bones of wrist that separate due to a tear in the connecting ligament), and shock (a life-threatening medical emergency caused by inadequate blood flow to tissues resulting in oxygen not getting to organs of body resulting in potential organ failure and death) for one of 17 residents reviewed (Resident R6). Findings include: A facility policy entitled, Abuse, Neglect and Exploitation, dated 11/01/25, revealed, It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Neglect means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Willful means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. A facility policy entitled, Safe Resident Handling/Transfers, dated 11/01/25, revealed, It is the policy of this facility to ensure that residents are handled and transferred safely to prevent or minimize risks for injury and provide and promote a safe, secure, and comfortable experience for the resident while keeping the employees safe in accordance with current standards and guidelines. Two staff members must be utilized when transferring residents with a mechanical lift. Resident R6's clinical record revealed an admission date of 2/08/25, with diagnoses that included shock, closed head injury (occurs when a sudden, violent impact to the head damages the brain without breaking the skull), fall, left scapho-lunate dissociation (a wrist injury involving bones of wrist that separate due to a tear in the connecting ligament), and closed fracture dislocation of left pubis symphysis with diastasis (the front and lower part of left hip bone which separated and fractured creating a diastasis [a widened gap]). Resident's R6's Minimum Data Set (MDS - periodic assessment of resident care needs), Section GG0170 Functional abilities Mobility dated 9/29/25, revealed Resident R6 was dependent for transfers (helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of two or more helpers is required for the resident to complete the activity). Resident R6's task order summary (a program used by nursing staff to verify transfer orders) revealed task order reviews dated 9/24/25, 9/25/26, and 9/26/25, all indicating Resident R6 was dependent for transfers. Facility provided documentation of an incident report for Resident R6 dated 9/29/25, at 6:50 a.m. revealed nursing description - Entered resident room, observed resident on floor. Resident stated he/she hit his/her head. Skin assessment done on resident, observed laceration to back of head, and abrasions to right arm. Bruising to left hand. Resident bleeding from laceration on back of head and on right arm. (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

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	01/27/2026

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 0600 Level of Harm - Actual harm Residents Affected - Few	Resident R6's clinical record revealed a nutritional progress note dated 9/29/25, at 12:02 p.m. which stated, Resident sent out to ER [emergency room] today after fall. Resident R6's clinical record lacked evidence of further progress notes related to a fall on 9/29/25. Facility provided documentation, Corrective Action Form, dated 10/03/25, revealed Nursing Assistant (NA) Employee E6 with a Final Written/Discharge warning for Nature of Infraction - Any deviation from a resident's course of treatment that creates the risk of/or results in serious or substantial harm to resident. Willful or reckless in attention to the needs of a resident. Description: Description of Incident - [NA Employee E6] did not follow transfer order for a resident as evidenced by using Hoyer lift [mechanical lift utilized in lifting a person who is dependent for assistance with transfers]to transfer resident by [herself/himself] instead of using assist of two. Resident R6's clinical documentation dated 10/02/25, (hospital admission date 9/29/25, and discharge date [DATE]), revealed progress notes from his/her hospitalization which indicated Resident R6 remained critically ill at this time after being dropped from a Hoyer lift approximately five feet. Progress notes stated, Currently treating this patient for fall from Hoyer lift on anticoagulants [blood thinning medication], scalp laceration with bleeding, left pubic symphysis fracture, left scapholunate ligament tear, hypotension [low blood pressure] and shock requiring vasopressors [medications used to raise low blood pressure] and fluid. V. tach [ventricular tachycardia - life-threatening heart rhythm disorder], hypokalemia [low potassium in blood]. Interview with Resident R6 on 1/25/26, at 9:55 a.m. revealed that he/she was dropped from a Hoyer lift a few months ago and received a laceration to his/her head. Resident R6 stated, I was lifted up and fell out of the lift. I hit the floor hard (rubbing the back of his/her head) and got a terrible gash to the back of my head. Resident R6 further indicated that only one NA assisted him/her during the time of fall from the Hoyer lift, and he/she was transferred to the hospital and stayed several days related to the fall. Interview with the Nursing Home Administrator (NHA) on 1/26/26, at 2:55 p.m. confirmed that Resident R6 was transferred via a Hoyer lift on 9/29/25, by NA Employee E6, which resulted in a fall with substantial harm of a laceration to his/her posterior head, fracture of pelvis, and injury to his/her wrist. The NHA further confirmed that Resident R6 was dependent for transfers and required a Hoyer lift and a two person assist for all transfers, however on 9/29/25 Resident R6 was transferred with only one person and Hoyer lift which resulted in Resident R6's fall and substantial harm of laceration and fractures. The facility failed to ensure that Resident R6 was free from neglect which resulted in actual harm of a laceration to his/her posterior head, fracture of pelvis, and injury to his/her wrist from a fall from a Hoyer lift. 28 Pa. Code 201.14(a) Responsibility of licensee28 Pa. Code 201.18(b)(1)(e)(1) Management 28 Pa. Code 211.12(c) Nursing services 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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	01/27/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, review of facility documentation and clinical records, review of the Long Term Care Facility Resident Assessment Instrument 3.0 User's Manual 2025 (RAI-assessment guide used to plan the provision of care for residents), and resident and staff interviews, it was determined that the facility failed to ensure essential resident safety measures were followed to prevent a fall for one of 17 residents (Resident R6), which resulted in actual harm of a laceration to the left posterior head, fracture of left pubic bone with a two part fracture that extended into the pubic symphysis (the front and lower part of left hip bone which separated and fractured), left scapholunate ligament tear (a wrist injury involving bones of wrist that separate due to a tear in the connecting ligament), and shock (a life-threatening medical emergency caused by inadequate blood flow to tissues resulting in oxygen not getting to organs of body resulting in potential organ failure and death). Findings include: A facility policy entitled, Safe Resident Handling/Transfers dated 11/01/25, revealed, It is the policy of this facility to ensure that residents are handled and transferred safely to prevent or minimize risks for injury and provide and promote a safe, secure, and comfortable experience for the resident while keeping the employees safe in accordance with current standards and guidelines. Two staff members must be utilized when transferring residents with a mechanical lift. Resident R6's clinical record revealed an admission date of 2/08/25, with diagnoses that included shock, closed head injury (occurs when a sudden, violent impact to the head damages the brain without breaking the skull), fall, left scapho-lunate dissociation (a wrist injury involving bones of wrist that separate due to a tear in the connecting ligament), and closed fracture dislocation of left pubis symphysis with diastasis (the front and lower part of left hip bone which separated and fractured creating a diastasis [a widened gap]). Resident's R6's Minimum Data Set (MDS - periodic assessment of resident care needs), Section GG0170 Functional abilities Mobility dated 9/29/25, revealed Resident R6 was dependent for transfers (helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of two or more helpers is required for the resident to complete the activity). Resident R6's task order summary (a program used by nursing staff to verify transfer orders) revealed task order reviews dated 9/24/25, 9/25/26, and 9/26/25, all indicating Resident R6 was dependent for transfers. Facility provided documentation of an incident report for Resident R6 dated 9/29/25, at 6:50 a.m. revealed nursing description - Entered resident room, observed resident on floor. Resident stated he/she hit his/her head. Skin assessment done on resident, observed laceration to back of head, and abrasions to right arm. Bruising to left hand. Resident bleeding from laceration on back of head and on right arm. Resident R6's clinical record revealed a nutritional progress note dated 9/29/25, at 12:02 p.m. which stated, Resident sent out to ER [emergency room] today after fall. Resident R6's clinical record lacked evidence of further progress notes related to a fall on 9/29/25. Facility provided documentation, Corrective Action Form, dated 10/03/25, revealed Nursing Assistant (NA) Employee E6 with a Final Written/Discharge warning for Nature of Infraction - Any deviation from a resident's course of treatment that creates the risk of/or results in serious or substantial harm to resident. Willful or reckless in attention to the needs of a resident. Description: Description of Incident - [NA Employee E6] did not follow transfer order for a resident as evidenced by using Hoyer lift [a mechanical lift utilized in lifting a person who is dependent for assistance with transfers] to transfer resident by [herself/himself] instead of using assist of two. Resident R6's clinical documentation dated 10/02/25, (hospital admission date 9/29/25, and discharge date [DATE]), revealed progress notes from his/her hospitalization which indicated Resident R6 remained critically ill at this time after being dropped from a Hoyer lift approximately five feet. Progress notes stated, Currently treating this patient for fall from Hoyer lift on anticoagulants [blood thinning medication], scalp laceration with bleeding, left pubic symphysis fracture, left scapholunate ligament tear, (continued on next page)

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	01/27/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few	hypotension [low blood pressure] and shock requiring vasopressors [medications used to raise low blood pressure] and fluid. V. tach [ventricular tachycardia - life-threatening heart rhythm disorder], hypokalemia [low potassium in blood]. Interview with Resident R6 on 1/25/26, at 9:55 a.m. revealed that he/she was dropped from a Hoyer lift a few months ago and received a laceration to his/her head. Resident R6 stated, I was lifted up and fell out of the lift. I hit the floor hard (rubbing the back of his/her head) and got a terrible gash to the back of my head. Resident R6 further indicated that only one NA assisted him/her during the time of fall from the Hoyer lift, and he/she was transferred to the hospital and stayed several days related to the fall. Interview with the Nursing Home Administrator (NHA) on 1/26/26, at 2:55 p.m. confirmed that Resident R6 was transferred via a Hoyer lift on 9/29/25, by a single staff member, NA Employee E6, which resulted in a fall with substantial harm of a laceration to his/her posterior head, fracture of pelvis, and injury to his/her wrist. The NHA further confirmed that Resident R6 was dependent for transfers and required a Hoyer lift and a two person assist for transfers, however on 9/29/25 Resident R6 was transferred with only one person via a Hoyer lift, which resulted in Resident R6's fall and substantial harm of laceration and fractures. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(e)(1) Management 28 Pa. Code 211.12(c) Nursing services 28 Pa. Code 211.12(d)(1)(3)(5)

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	01/27/2026

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, and staff interview, it was determined that the facility failed to ensure physician's orders and residents Physician Order for Life Sustaining Treatment (POLST- a legal document specifying the resident/responsible party choices regarding life-sustaining treatments) were consistent and failed to ensure that the resident/responsible party were provided with written information on advanced directives or assisted with the opportunity to formulate advanced directives regarding life sustaining treatment for six of 20 residents reviewed (Residents R1, R5, R7, R30, R50 and R62).Findings include: Review of facility policy entitled Communication of Code Status dated [DATE], indicated It is the policy of this facility to adhere to residents' rights to formulate advance directives. The facility will follow facility policy regarding a resident's right to request. to formulate an Advance Directive/POLST. Review of Resident R1's clinical record revealed an admission date of [DATE], with diagnoses that included chronic obstructive pulmonary disease (COPD-when your lungs do not have adequate air flow), bipolar disorder (a mental illness that causes extreme mood swings with emotional highs and emotional lows), and general anxiety disorder (a condition that causes a person to be nervous, uneasy, or worried about something or someone). Review of Resident R1's clinical record revealed a physician's order for Full Code (CPR-emergency life-saving procedure that is done when breathing or a heartbeat has stopped and when performed immediately can double or triple chances of survival after cardiac arrest) dated [DATE]. Review of resident R1's POLST revealed DNR (do not resuscitate allow natural death). Review of Resident R5's clinical record revealed an admission date of [DATE], with diagnoses that included surgical care following surgery on the digestive system, enterocolitis due to clostridium difficile (an intestinal inflammation caused by toxins from a bacteria usually after antibiotics that change the normal gut bacteria), convulsions (involuntary, rapid muscle contractions causing violent, uncontrollable shaking of the body), and atrial fibrillation (a rapid, irregular heartbeat caused by disorganized electrical signals of the atria, heart's upper chambers). Review of Resident R5's clinical record lacked evidence that he/she and/or his/her representative were provided with written information on advanced directives or assisted with the opportunity to formulate advanced directives regarding life sustaining treatment. Review of Resident R7's clinical record revealed an admission date of [DATE], with diagnoses that included hypertension (high blood pressure), COPD, and cerebral infraction (also known as a stroke it occurs when blood flow to part of the brain is blocked). Review of Resident R7's clinical record lacked evidence that he/she and/or his/her representative were provided with written information on advanced directives or assisted with the opportunity to formulate advanced directives regarding life sustaining treatment. Review of Resident R30's clinical record revealed an admission date of [DATE], with diagnoses that included hypertension, weakness, and hyperlipidemia (high cholesterol). Review of Resident R30's clinical record revealed a physician's order for DNR dated [DATE]. Review of Resident R30's POLST revealed Full Code. Review of Resident R50's clinical record revealed an admission date of [DATE], with diagnoses that included protein calorie malnutrition, iron deficiency, and major depressive disorder. Review of Resident R50's clinical record lacked evidence that he/she and/or his/her representative were provided with written information on advanced directives or assisted with the opportunity to formulate advanced directives regarding life sustaining treatment. Review of Resident R62's clinical record revealed an admission date of [DATE], with diagnoses that included gastro esophageal reflux disease (a condition when stomach acid repeatedly flows back up into your throat), hypertension, and hyperlipidemia. Review of Resident R62's clinical record revealed a physician's order for Full Code dated [DATE], the clinical record lacked evidence he/she and/or his/her representative were provided with written information on advance directives or assisted with the opportunity to formulate advance directives regarding life (continued on next page)

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	01/27/2026

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	sustaining treatment. During an interview on [DATE], at 2:20 p.m. Registered Nurse Employee E1, revealed that during an emergent situation the staff refer to the POLST book to determine resident life sustaining wishes. He/she confirmed that Residents' R1 and R30's physician's orders and POLST were not consistent with one another and that Residents R5, R7, R50, and R62's clinical records lacked evidence reflecting their and/or their representative's wishes for advanced directives and that the clinical records should reflect resident's current wishes. 28 Pa. Code 201.18 (b)(1) Management 28 Pa. Code 201.29(a) Resident rights 28 Pa. Code 211.5(f) Medical records 28 Pa. Code 211.10(c) Resident care policies

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	01/27/2026

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 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 signed and dated all orders during visits for seven of 20 residents reviewed (Residents R1, R7, R8, R10, R11, R30, and R62). Findings include: Review of facility policy entitled Physician Visits and Physician Delegation dated 11/1/25, 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. Review of Resident R1's clinical record revealed an admission date of 8/11/23, with diagnoses that included chronic obstructive pulmonary disease (COPD-when your lungs do not have adequate air flow), bipolar disorder (a mental illness that causes extreme mood swings with emotional highs and emotional lows), and general anxiety disorder (a condition that causes a person to be nervous, uneasy, or worried about something or someone). Review of Resident R1's clinical record revealed that his/her physician orders were signed and dated 10/30/25, and not again until 1/26/26, which is beyond the required 60 days. Review of Resident R7's clinical record revealed an admission date of 3/26/25, with diagnoses that included hypertension (high blood pressure), COPD, and cerebral infraction (also known as a stroke it occurs when blood flow to part of the brain is blocked). Review of Resident R7's clinical record revealed that his/her physician orders were signed and dated 10/30/25, and not again until 1/26/26, which is beyond the required 60 days. Review of Resident R8's clinical record revealed an admission date of 1/14/22, with diagnoses that included chronic kidney disease (a disease that affects the kidney's ability to filter waste products and extra fluid from the body), diabetes (a health condition that is caused by the body's inability to produce enough insulin), and hypertension. Review of Resident R8's clinical record revealed that his/her physician orders were signed and dated 10/30/25, and not again until 1/26/26, which is beyond the required 60 days. Review of Resident R10's clinical record revealed an admission date of 5/10/23, with diagnoses that included diabetes, hyperlipidemia (high cholesterol), and hypertension. Review of Resident R10's clinical record revealed that his/her physician orders were signed and dated 10/30/25, and not again until 1/26/26, which is beyond the required 60 days. Review of Resident R11's clinical record revealed an admission date of 8/30/24, with diagnosis that included chronic respiratory failure (a condition where your lungs don't exchange air properly), obstructive sleep apnea (a condition when a person repeatedly stops and starts breathing when they are sleeping), and hyperlipidemia. Review of Resident R11's clinical record revealed that his/her physician orders were signed and dated 10/30/25, and not again until 1/26/26, which is beyond the required 60 days. Review of Resident R30's clinical record revealed an admission date of 7/6/24, with diagnoses that included hypertension, weakness, and hyperlipidemia. Review of Resident R30's clinical record revealed that his/her physician orders were signed and dated 10/30/25, and not again until 1/26/26, which is beyond the required 60 days. Review of resident R62's clinical record revealed an admission date of 10/17/25, with diagnoses that included gastro esophageal reflux disease (a condition when stomach acid repeatedly flows back up into your throat), hypertension, and hyperlipidemia. Review of Resident R62's clinical record revealed that his/her physician orders were signed and dated 10/30/25, and not again until 1/26/26, which is beyond the required 60 days. During an interview on 1/26/26, at 2:35 p.m. Registered Nurse Employee E2 confirmed that physician orders for Residents R1, R7, R8, R10, R11, R30, and R62 were not reviewed and signed by the physician in the required 60 days and 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

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	01/27/2026

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 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the resident and his/her doctor meet face-to-face at all required visits. Based on review of clinical records, resident interviews and staff interviews, it was determined that the facility failed to ensure that physician visits were conducted at least once every 30 days for the first 90 days after admission and at least 60 days thereafter for three of 17 residents reviewed (R8, R11, and R62). Findings include: Review of facility policy entitled Physician Visits and Physician Delegation dated 11/1/25, 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. During an interview on 1/25/26, at approximately 10:30 a.m. Resident R8 expressed that he/she has not seen his/her physician face to face since he/she was admitted to the facility. Review of Resident R8's clinical record revealed an admission date of 1/14/22, with diagnoses that included chronic kidney disease (a disease that affects the kidney's ability to filter waste products and extra fluid from the body), diabetes (a health condition that is caused by the body's inability to produce enough insulin), and hypertension (high blood pressure). Review of Resident R8's clinical record lacked evidence that Resident R8 was seen by his/her physician every 60 days as required. Resident R11's clinical record revealed an admission date of 8/30/24, with diagnoses that included chronic respiratory failure (a long term condition where the lungs cannot exchange oxygen and carbon dioxide adequately), hypertensive heart disease with heart failure (a condition resulting from chronic uncontrolled blood pressure), chronic obstructive pulmonary disease (COPD - a lung disease caused by airway damage and inflammation causing breathing issues), and protein calorie malnutrition (a deficiency of protein intake leading to impaired growth, muscle wasting and weakened immunity). Resident R11's clinical record revealed a progress note dated 1/09/26, at 3:51 p.m. related to refusal of medications, . you say the doctor ordered it but I want to know WHAT doctor. Review of Resident R11's clinical record lacked evidence that Resident R11 was seen by his/her physician every 60 days as required. During an interview on 1/25/26, at 9:40 a.m. Resident R11 indicated that he/she has not seen their physician, and no physician has assessed him/her while being a resident at the facility. Review of resident R62's clinical record revealed an admission date of 10/17/25, with diagnosis that included gastro esophageal reflux disease (a condition when stomach acid repeatedly flows back up into your throat), hypertension (high blood pressure), and hyperlipidemia (high cholesterol). Review of Resident R62's clinical record lacked evidence that he/she was seen by his/her physician every 30 days for the first 90 days after admission as required. During an interview on 1/26/26, at 2:35 p.m. Registered Nurse Employee E2 confirmed that the clinical records lacked evidence that Resident's R8, R11, and R62 were seen by their physician as required. He/she also confirmed that all residents should be seen by their physician every 30 days for the first 90 days then every 60 days thereafter. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(3) Management 28 Pa. Code 211.5(f)(ii)(vii) Medical records

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	01/27/2026

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on resident and staff interviews, and review of resident council minutes and grievances, and review of nursing staffing documentation, it was determined that the facility failed to provide sufficient nursing staff and services to promote the physical and mental well-being and meet the needs for six of 20 residents interviewed (Residents R6, R8, R9, R30, R53, and R57). Findings include: Interviews during the Resident Council meeting on 1/25/26, between 12:00 p.m. and 12:30 p.m., revealed Residents R8, R9, R30, R53, and R57, in attendance stated the call bells are not answered in a timely manner with all indicating they wait greater than 30 minutes. Resident R30 had concerns related to staff not responding to his/her call bell timely and it took hours for call bell response on 1/14/26, which resulted in him/her soiling his/her brief (incontinence product). Resident R9 had concerns related to staff responding timely to their call bell to close their bathroom door. Resident R9 indicated that he/she can transfer themselves to the toilet independently, however, cannot shut the bathroom door afterwards. He/She further indicated that it takes a very long time for staff to respond to his/her call bell, and he/she typically sits on toilet with door open allowing the roommate to see. Resident R9 indicated that the lengthy call bell response time is due to lack of staffing. Review of resident council minutes for November 2025, December 2025, and January 2026, revealed the following: On November 26, 2025, there were 13 residents in attendance that indicated they would like staff to answer call bells in a timely manner.On December 16, 2025, there were 10 residents in attendance that indicated call bell response times continued to be an issue.On January 20, 2026, there were 10 residents in attendance that indicated residents would like management to do an audit on call bell response times, because it continued to be an issue.Review of the Grievance Logs from June 2025, through December 2025, revealed a grievance related to call bell response time on 11/9/25.Review of facility nursing staffing documents for day of a fall incident, 9/29/25, which involved Nursing Assistant (NA) Employee E6 participating in a transfer of Resident R6 utilizing a two-person mechanical lift independently, which resulted in injury to Resident R6 falling out of the mechanical lift, it was revealed that the hours of direct resident care was below 3.2 minimum per patient per day (PPD) at 3.16 PPD, and NA staffing shortages for the dayshift where the NA ratios were not met with 6.59 NA worked and 7.0 were required for a census of 70 residents. During an interview on 1/27/26, at 9:50 a.m. the Nursing Home Administrator (NHA) confirmed that the facility does not have sufficient nursing staff and services to promote the physical and mental well-being and meet the needs of the residents. The NHA further confirmed that nursing hours for 9/29/25, day of Resident R6's fall incident, was below state mandated levels. Refer to F686 and F600. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.12(d)(4)(5) Nursing services

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	01/27/2026

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on review of facility policy, manufacturer's guidelines, observations, and staff interviews, it was determined that the facility failed to ensure expired medications were discarded in a timely manner in two of two medication carts reviewed (West North Cart and East North Cart).Findings include: A facility policy entitled, Labeling of Medications and Biologicals dated 11/01/25, revealed Labels for multi-use vials must include: All opened or accessed vials should be discarded within 28 days unless the manufacturer specifies (shorter or longer) date for that opened vial. Manufacturer's guidelines for Humalog insulin (a fast-acting insulin used to manage blood sugar levels in people with diabetes), revealed that after opened vials and pre-filled pens should be discarded after 28 days. Manufacturer's guidelines for Lantus insulin (a long-acting insulin used to manage blood sugar levels in people with diabetes), revealed that after opened vials and pre-filled pens should be discarded after 28 days. Observation on 1/24/26, at 4:15 p.m. of the [NAME] North medication cart revealed an open vial of Lantus with an open date of 12/26/25, therefore the medication was expired. This was witnessed and confirmed at that time by Licensed Practical Nurse (LPN) Employee E5. Observation on 1/24/26, at 4:29 p.m. of the East North medication cart revealed an opened Humalog vial with an open date of 12/18/25, and two open vials of Lantus, one with an open date of 12/21/25, and the other with an open date of 12/26/25, therefore the medications were expired. This was witnessed and confirmed at that time by LPN Employee E4. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(e)(1) Management 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12(d)(1)(2)(5) Nursing services

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	01/27/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on review of facility policy, observations, and staff interviews, it was determined that the facility failed to follow acceptable infection control practices regarding enhanced barrier precautions (EBP) for two of two resident units (East and [NAME] Unit). Findings include: Facility policy, Enhanced Barrier Precautions, dated 11/01/25, revealed it is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities. Implementation of Enhanced Barrier Precautions - Make gowns and gloves available immediately near or outside of the resident's room. Note: face protection may also be needed if performing activity with risk of splash or spray (i.e., wound protection may also be needed if performing activity with risk of splash or spray (i.e., wound protection may also be needed if performing activity with risk of splash or spray (i.e., wound protection may also be needed if performing activity with risk of splash or spray (i.e., wound irrigation, tracheostomy care). Personal Protective Equipment (PPE) for enhanced barrier precautions is only necessary when performing high-contact care activities and may not need to be donned prior to entering the resident's room. Ensure access to alcohol-based hand rub in every resident room (ideally both inside and outside of the room). Position a trash can inside the resident room and near the exit for discarding PPE after removal, prior to exit of the room or before providing care for another resident in the same room. High contact resident care activities include: Dressing-Bathing-Transferring-Providing hygiene-Changing linens-Changing briefs or assisting with toileting-Device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, peripheral inserted central catheter (PICC) lines-midline catheters-Wound care: any skin opening requiring a dressing. Observations on 1/23/26, and 1/24/26, revealed no educational signage or PPE maintained for EBP for residents with indwelling devices, wounds, or infections throughout the facility. During an interview on 1/25/26, at 12:00 p.m. Registered Nurse (RN) Employee E1 confirmed that no EBPs are maintained throughout the facility for residents with indwelling devices, chronic wounds, or infections, and staff does not utilize PPE during high contact care for these residents. RN Employee E1 further indicated that the facility did have EBPs maintained, but the facility no longer has the EBPs in place. During an interview on 1/25/26, at 12:00 p.m. Licensed Practical Nurse (LPN) Employee E4 confirmed that no EBPs are maintained for residents on the East Unit with indwelling devices, chronic wounds, or infections, and staff does not utilize PPE during high contact care for these residents. During an interview on 1/25/26, at 2:10 p.m. LPN Employee E3 confirmed that no EBPs are maintained for residents on the [NAME] Unit with indwelling devices, chronic wounds, or infections, and staff does not utilize PPE during high contact care for these residents. During an interview on 1/25/26, at 2:15 p.m. the Nursing Home Administrator confirmed the facility lacked signage and PPE readily available when providing care for residents with indwelling devices, chronic wounds, or infections, who should have EBP maintained. 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services

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	01/27/2026

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on a review of facility policy, clinical records, resident and staff interviews, it was determined that the facility failed to provide a bath/shower as resident preference for two of 20 residents reviewed (Residents R8 and R62).Findings include: Review of facility policy entitled Resident Showers dated 11/1/25, indicated Residents will be provided showers as per request or as per facility schedule. and Document resident shower in point of care if refused, given, or bed bath given. Review of Resident R8's clinical record revealed an admission date of 1/14/22, with diagnoses that included chronic kidney disease (a disease that affects the kidney's ability to filter waste products and extra fluid from the body), diabetes (a health condition that is caused by the body's inability to produce enough insulin), and hypertension (high blood pressure). Interview with Resident R8 on 1/26/26, at approximately 10:30 a.m. revealed that he/she stated, I have not received a shower in weeks, it would be nice to get a shower and not just washed up in the bathroom. Review of resident R8's bath/shower documentation for 1/1/26, through 1/25/26, revealed he/she was scheduled for a bath/shower on Tuesday/Friday on the daylight shift. Further review revealed on 1/6/26 no shower was documented, on 1/9/26, 1/13/26, 1/16/26, 1/20/26, and 1/23/26, N/A (not applicable) was documented. Review of Resident R62's clinical record revealed an admission date of 10/17/25, with diagnoses that included gastro esophageal reflux disease (a condition when stomach acid repeatedly flows back up into your throat), hypertension, and hyperlipidemia (high cholesterol). Interview with Resident R62 on 1/25/26, at approximately 3:15 p.m. revealed that he/she stated, I have not taken a shower in a long time, I wash up in the bathroom in the morning, but I would really like to get a shower every other day if not every day. Review of Resident R62's clinical record for bath/shower documentation lacked evidence of a bath/shower schedule for Resident R62. During an interview on 1/26/26, at 3:00 p.m. the Nursing Home Administrator confirmed that Residents R8 and R62's clinical records lacked evidence of showers/baths being given as residents' preferences. He/she also confirmed that shower/baths should be given per resident request/schedule. 28 Pa. Code 211.10 (d) Resident care policies 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services

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	01/27/2026

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 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 review of facility policy, review of clinical and facility records, and resident and staff interviews, it was determined that the facility failed to complete a thorough investigation related to falls for one of 17 residents reviewed (Resident R6). Findings include: Review of facility policy, Fall Prevention Program dated 11/01/25, revealed Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. When any resident experiences a fall, the facility will a. Assess the resident. b. Complete a post-fall assessment. c. Complete an incident report. d. Notify physician and family. e. Review the resident's care plan and update as indicated. f. Document all assessments and actions. g. Obtain witness statements in the case of injury. Resident R6's clinical record revealed an admission date of 2/08/25, with diagnoses that included shock, closed head injury (occurs when a sudden, violent impact to the head damages the brain without breaking the skull), fall, left scapho-lunate dissociation (a wrist injury involving bones of wrist that separate due to a tear in the connecting ligament), and closed fracture dislocation of left pubis symphysis with diastasis (the front and lower part of left hip bone which separated and fractured creating a diastasis [a widened gap]). Facility provided documentation of an incident report for Resident R6 dated 9/29/25, at 6:50 a.m. revealed nursing description dated 9/29/25 5:54 p.m. - Entered resident room, observed resident on floor. Resident stated he/she hit his/her head. Skin assessment done on resident, observed laceration to back of head, and abrasions to right arm. Bruising to left hand. Resident bleeding from laceration on back of head and on right arm. Assisted to resident to bed using mechanical lift. Vital signs obtained, within normal limits. Wound care done on laceration on abrasions. Resident stated he hit his head during fall. Resident R6's clinical record revealed a nutritional progress note dated 9/29/25, at 12:02 p.m. which stated, Resident sent out to ER [emergency room] today after fall. Resident R6's clinical record lacked evidence of further progress notes related to a fall on 9/29/25. Facility provided documentation, Corrective Action Form, dated 10/03/25, revealed Nursing Assistant (NA) Employee E6 with a Final Written/Discharge warning for Nature of Infraction - Any deviation from a resident's course of treatment that creates the risk of/or results in serious or substantial harm to resident. Willful or reckless in attention to the needs of a resident. Description: Description of Incident - NA [NA Employee E6] did not follow transfer order for a resident as evidenced by using Hoyer lift [mechanical lift utilized in lifting a person who is dependent for assistance with transfers] to transfer resident by [herself/himself] instead of using assist of two. Resident R6's clinical documentation dated 10/02/25, (hospital admission date 9/29/25, and discharge date [DATE]), revealed progress notes from his/her hospitalization which indicated Resident R6 remained critically ill at this time after being dropped from a Hoyer lift approximately five feet. Progress notes stated, Currently treating this patient for fall from Hoyer lift on anticoagulants [blood thinning medication], scalp laceration with bleeding, left pubic symphysis fracture, left scapholunate ligament tear, hypotension [low blood pressure] and shock requiring vasopressors [medications used to raise low blood pressure] and fluid. V. tach [ventricular tachycardia - life-threatening heart rhythm disorder], hypokalemia [low potassium in blood]. Interview with Resident R6 on 1/25/26, at 9:55 a.m. revealed that he/she was dropped from a Hoyer lift a few months ago and received a laceration to his/her head. Resident R6 stated, I was lifted up and fell out of the lift. I hit the floor hard (rubbing the back of his/her head) and got a terrible gash to the back of my head. Resident R6 further indicated that only one NA assisted him/her during the time of fall from the Hoyer lift, and he/she was transferred to the hospital and stayed several days related to the fall. Interview on 1/27/26, at 11:00 a.m. the Nursing Home Administrator (NHA) confirmed that the incident report and investigation of Resident R6's fall from a Hoyer lift on 9/29/25, was incomplete and lacked evidence of a complete timely investigation which included, but not limited to, witness statements, nursing response to a resident falling from a Hoyer (continued on next page)

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	01/27/2026

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	lift including response to a staff member utilizing a Hoyer lift independently resulting in a resident's fall from the Hoyer lift, fall assessment, and notification of physician and family at time of fall. The NHA further confirmed it is the responsibility of the facility to ensure all incidents, including falls, are investigated and documented thoroughly in a timely manner. There was no evidence that the facility thoroughly investigated the fall incident involving Resident R6 falling out of a Hoyer lift on 9/29/25. 28 Pa. Code 201.14(a)(c) Responsibility of licensee 28 Pa. Code 211.5(f)(ii)(iii) Medical records 28 Pa. Code 211.12(d)(1)(5) Nursing services

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	01/27/2026

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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observations and interviews, it was determined that the facility did not ensure the garbage and refuse was disposed of properly for one dumpster. Findings include: No facility policy provided. Observations on 1/24/26, at 5:15 p.m. revealed the dumpster open, without a full lid to secure the top of the dumpster, allowing garbage to be freely exposed. During an interview on 1/24/26, at 5:15 p.m. the Dietary Manager confirmed that the top of the dumpster was open without a lid, allowing the garbage to be freely exposed. He/She further confirmed that the dumpster lids should always be closed and tightly fitted when not in use to prevent insect/rodents to be attracted to area. 28 Pa. Code 201.18(b)(3) Management

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	01/27/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy and review of clinical and facility records and resident and staff interview, it was determined that the facility failed to maintain accurate and complete documentation related to falls for one of 17 residents reviewed (Resident R6). Findings include: Review of facility policy entitled, Fall Prevention Program dated 11/01/25, revealed Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. When any resident experiences a fall, the facility will a. Assess the resident. b. Complete a post-fall assessment. c. Complete an incident report. d. Notify physician and family. e. Review the resident's care plan and update as indicated. f. Document all assessments and actions. g. Obtain witness statements in the case of injury. Resident R6's clinical record revealed an admission date of 2/08/25, with diagnoses that included shock, closed head injury (occurs when a sudden, violent impact to the head damages the brain without breaking the skull), fall, left scapho-lunate dissociation (a wrist injury involving bones of wrist that separate due to a tear in the connecting ligament), and closed fracture dislocation of left pubis symphysis with diastasis (the front and lower part of left hip bone which separated and fractured creating a diastasis [a widened gap]). Resident R6's clinical record revealed a nutritional progress note dated 9/29/25, at 12:02 p.m. which stated, Resident sent out to ER [emergency room] today after fall. Resident R6's clinical record lacked evidence of further progress notes related to a fall on 9/29/25. Facility provided documentation, Corrective Action Form, dated 10/03/25, revealed Nursing Assistant (NA) Employee E6 with a Final Written/Discharge warning for Nature of Infraction - Any deviation from a resident's course of treatment that creates the risk of/or results in serious or substantial harm to resident. Willful or reckless in attention to the needs of a resident. Description: Description of Incident - NA [NA Employee E6] did not follow transfer order for a resident as evidenced by using Hoyer lift [mechanical lift utilized in lifting a person who is dependent for assistance with transfers] to transfer resident by [herself/himself] instead of using assist of two. Resident R6's clinical documentation dated 10/02/25, (hospital admission date 9/29/25, and discharge date [DATE]), revealed progress notes from his/her hospitalization which indicated Resident R6 remained critically ill at this time after being dropped from a Hoyer lift approximately five feet. Progress notes stated, Currently treating this patient for fall from Hoyer lift on anticoagulants [blood thinning medication], scalp laceration with bleeding, left pubic symphysis fracture, left scapholunate ligament tear, hypotension [low blood pressure] and shock requiring vasopressors [medications used to raise low blood pressure] and fluid. V. tach [ventricular tachycardia - life-threatening heart rhythm disorder], hypokalemia [low potassium in blood]. Interview with Resident R6 on 1/25/26, at 9:55 a.m. revealed that he/she was dropped from a Hoyer lift a few months ago and received a laceration to his/her head. Resident R6 stated, I was lifted up and fell out of the lift. I hit the floor hard (rubbing the back of his/her head) and got a terrible gash to the back of my head. Resident R6 further indicated that only one NA assisted him/her during the time of fall from the Hoyer lift, and he/she was transferred to the hospital and stayed several days related to the fall. During an interview on 1/26/26, at 2:55 p.m. the Nursing Home Administrator (NHA) confirmed that Resident R6's clinical record lacked evidence of the nursing response to Resident R6's fall from a Hoyer lift on 9/29/25, including nursing assessment of resident and actions, fall assessment, and notification of physician and family. The NHA further confirmed it is the responsibility of the facility to ensure all documentation of resident care, including falls, is accurate and complete in each resident's clinical record. 28 Pa. Code 211.5(f)(ii)(iii) Medical records 28 Pa. Code 211.12(d)(1)(5) Nursing services

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	01/27/2026

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 0881 Level of Harm - Potential for minimal harm Residents Affected - Many	Implement a program that monitors antibiotic use. Based on review of facility policy and infection control documentation, and staff interview, it was determined that the facility failed to develop and implement an antibiotic stewardship program. Findings include: Review of the facility policy Antibiotic Stewardship Program, dated 11/01/25, revealed it is the policy of this facility to implement an Antibiotic Stewardship Program as part of the facility's overall infection prevention and control program. The purpose of the program is to optimize the treatment of infections while reducing the adverse events associated with antibiotic use. The Medical Director, Director of Nursing, and Consultant Pharmacist serve as the leaders of the Antibiotic Stewardship Program and receives support from the Administrator and other governing officials of the facility. The Antibiotic Stewardship Program leaders utilize existing resources to support antibiotic stewards' efforts by working with the following partners: Infection Preventionist-Consultant Laboratory-State and Local Health Departments. Licensed nurses participate in the program through assessment of residents and following protocols as established by the program. The program includes antibiotic use protocols and a system to monitor antibiotic use. Nursing will monitor the initiation of antibiotics on residents and conduct an antibiotic timeout within 48-72 of antibiotic therapy to monitor response to the antibiotic and review laboratory results and will consult with the practitioner to determine if the antibiotic is to continue or if adjustments need to be made based on the findings. New or changed orders for antibiotics based on the antibiotic timeout recommendations will be obtained from the practitioner. At least annually or per facility policy, feedback shall be provided on the facility's antibiotic use data in the form of a written report shared with administration, medical, and nursing staff, resident and family council, and the Quality Assessment and Assurance (QAA) Committee. At least annually or per facility policy, each attending physician shall be provided feedback on his/her antibiotic use data in the form of a written report (i.e antibiotic report card) to improve prescribing practices and resident outcomes. Education regarding antibiotic stewardship shall be provided at least annually to facility staff, prescribing practitioners, residents, and families. The elements of the program and associated protocols are reviewed on an annual basis and as needed as part of the facility's review of the overall infection prevention and control program. Documentation related to the program is maintained by the Infection Preventionist, including, but not limited to Action plans and/or work plans associated with the program-Assessment forms-Antibiotic use protocols/algorithms-Data collection forms for antibiotic use, process, and outcome measures-Antibiotic stewardship meeting minutes-Feedback reports-Records related to education of physicians, staff, residents, and families-Annuals reports. Data obtained from antibiotic stewardship monitoring activities is discussed in the facility's Quality Assurance and Performance Improvement (QAPI) meetings. From 1/24/26, through 1/27/26, no evidence of the above noted facility Antibiotic Stewardship program was provided for review. During an interview on 1/26/26, at 3:30 p.m. the Nursing Home Administrator confirmed that the facility failed to implement an Antibiotic Stewardship Program as part of the facility's overall infection prevention and control program. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(3) Management 28 Pa. Code 211.12(c)(d)(3) Nursing services