STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395344	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edenbrook of Greenwood Hill	420 Pulaski Drive Pottsville, PA 17901

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on a review of select facility policy, minutes from the facility Resident Council meetings, grievances filed with the facility, and resident and staff interviews, it was determined the facility failed to put forth sufficient efforts to resolve continued resident complaints expressed during Resident Council meetings, including those voiced by nine out of 9 residents attending a resident group meeting (Residents 5, 51, 68, 87, 48, 98, 95, 10, and 114). Findings include: A review of the facility's policy titled Grievance/Concerns, last reviewed by the facility on March 18, 2026, indicated that all residents have the right to voice grievances to the facility or other agency or entity that hears grievances without reprisal and without fear of discrimination, interference, coercion, or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns of their stay at the facility. The facility will make prompt efforts to resolve all grievances. The residents have the right to file grievances orally or in writing; and they have the right to file grievances anonymously. At any time, comments, suggestions, or complaints by the residents are encouraged to direct their concerns to; the Administrator, Social Services Director, Director of Nursing or designee, or any appropriate manager. A review of Resident Council meeting minutes from March 2026 through May 2026 revealed residents raised concerns regarding facility staff failing to respond timely to residents' requests for assistance, facility staff conducting unprofessional conversations at the nursing stations, and concerns regarding the behavior of other residents. A review of the Resident Council meeting minutes dated March 18, 2026, revealed that during the February 2026 meeting, residents voiced ongoing concern regarding staff engaging in personal conversations in the common areas, poor call bell response times, and concerns with another resident walking the halls without pants on. There was no indication in the meeting minutes that a grievance was filed regarding the concerns voiced during the February 2026 meeting. The March 2026 meeting minutes indicated that the residents continue to express frustration with staff conducting personal and unprofessional conversations at the nurses station, nurses not knowing what specific medications are used for, and staff use of cell phones on the floor. There was no indication in the March 2026 meeting minutes that a grievance was filed from the ongoing and newly reported concerns voiced during the March 2026 meeting. A review of Resident Council meeting minutes dated April 1, 2026, revealed the residents in attendance expressed concern regarding facility staff failing to respond timely to residents' requests for assistance. There was no documentation in the meeting minutes indicating a grievance was filed on behalf of the residents in attendance that expressed these concerns. A review of Resident Council meeting minutes dated May 6, 2026, revealed that residents in attendance continued to express concerns regarding facility staff conducting personal conversations at the nursing stations and concern regarding the behavior of another resident yelling at night. There was no documentation in the meeting minutes indicating a grievance was filed related to these concerns. A review of grievances provided by the facility from January 2026 through June 1, 2026, revealed no record that grievances were filed on behalf of the Resident Council meeting members as a result of the concerns voiced during the February, March, April and May 2026 meetings. During a resident group interview on June 3, 2026, at 10:00 AM, four out of 9 residents (Residents 51, (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5, 87, and 68) reported that the behaviors of a resident reported during the May 2026 Resident Council meeting was still a significant concern, impacting their quality of life and ability to rest. The residents described frequent episodes of yelling and screaming that they reported could be heard throughout the unit and during various times of the day and night. Five out of the 9 residents (Residents 48, 98, 95, 10, and 114) reported that staff continue to conduct unprofessional conversations in common areas and at the nursing station, despite continually bringing up this issue at Resident Council meetings. All residents in attendance expressed frustration that the issues have not been resolved. During an interview on June 3, 2026, at 11:10 AM, the Nursing Home Administrator (NHA) and Director of Activities confirmed there were no grievances filed on behalf of residents who raised concerns during Resident Council meetings. The NHA was unable to provide documented evidence regarding actions the facility had taken to implement effective changes and resolution to resident concerns voiced during the Resident Council meetings.Refer F74028 Pa. Code 201.18 (e)(1)(4) Management. 28 Pa. Code 201.29(a) Resident rights. 28 Pa. Code 211.10(d) Resident care policies. 28 Pa. Code 211.12(d)(3)(5) Nursing services.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. Based on a review of facility policy, clinical records, resident council documentation, resident interviews, staff interviews, and observation, it was determined that the facility failed to implement and evaluate effective interventions to address persistent behavioral symptoms for one of 27 sampled residents reviewed for behavioral health services (Resident 94).Findings include: A review of the facility's Behavior Management Policy, reviewed by the facility on March 18, 2026, revealed that the purpose of this policy was to identify residents who exhibit behaviors that decrease their physical and psychosocial well-being. The facility will evaluate resident progress of behavioral goals as identified on the plan of care. A clinical record review revealed Resident 94 had diagnoses that included major depressive disorder (a mental health condition characterized by persistent feelings of sadness and loss of interest), traumatic brain injury (damage to the brain caused by an external force), bipolar disorder (a mental health disorder characterized by episodes of mood elevation and depression), and disruptive behaviors. A review of Resident 94's quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated March 6, 2026, revealed that Resident 94 was moderately cognitively impaired with a BIMS score of 8 (Brief Interview for Mental Status, a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 8 through 12 indicates moderate cognitive impairment). This assessment also indicated that the resident exhibited behavioral symptoms including screaming, cursing, and threatening others up to three days during the seven-day assessment period. During a resident group interview conducted on June 3, 2026, at 10:00 AM, multiple residents residing on the same nursing unit reported that Resident 94's yelling, screaming, and calling out behaviors had persisted for an extended period and significantly affected their quality of life, ability to rest, and ability to sleep through the night. Residents described frequent episodes of yelling and screaming that could be heard throughout the unit and during various times of the day and night. The resident council members indicated that this has been going on for a long time, but they were trying to be understanding and patient with the situation, but there has been no evidence that things are improving. Resident 87 stated that Resident 94's yelling and screaming was ongoing and disruptive. He reported, I was in the shower last night around 7:00 PM and I could hear the resident yelling. Resident 5 reported that Resident 94's behavior significantly affected her ability to sleep. She stated, You wake up in the morning, and it feels like you never slept. Staff put her at the nursing station at night, and she screams and yells for hours. Resident 51 reported being awakened repeatedly by Resident 94's vocalizations during the night. She stated, I don't even get out of bed some days because I've been kept up all night long. Resident 68 reported that despite residing across the hall, she could still hear Resident 94's yelling and stated, I'm across the hall, and I'm hearing her. How can I sleep? Residents 87, 5, 51, and 68 indicated that they had consistently reported that the yelling and screaming continued to disrupt sleep, rest, and daily activities for multiple residents residing on the first-floor nursing unit. Review of the May 6, 2026, Resident Council Meeting minutes revealed that the facility received a verbal grievance from Resident 51 related to Resident 94 yelling for help during nighttime hours. A review of nursing documentation revealed repeated episodes of behavioral symptoms, including yelling, screaming, calling out, cursing at staff, cursing at other residents, whining, and inability to be redirected. Documentation further revealed the behaviors occurred primarily during evening and nighttime hours and continued despite staff interventions. April 16, 2026, at 3:57 AM, the resident was in the hallway yelling and cursing at staff. April 19, 2026, at 5:36 AM, the resident was calling out, yelling, and cursing and could not be redirected. April 20, 2026, at 2:30 AM, the resident continuously called out and cursed at staff and could not be redirected. April 22, 2026, at 11:49 PM, the resident was yelling and calling out and could not be redirected. April 25, 2026, at 10:27 (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PM, the resident had been yelling on and off since 7:30 PM and redirection was unsuccessful. May 2, 2026, at 6:47 AM revealed that the resident slept till 5:00 AM and was yelling on and off; redirection was unsuccessful. May 4, 2026, at 3:28 AM, staff documented attempts to redirect the resident at the nurses' station were only slightly effective. May 4, 2026, at 11:07 PM, the resident was occasionally yelling out despite staff efforts. May 5, 2026, at 1:41 AM, attempts to redirect the resident at the nurses' station were unsuccessful. May 5, 2026, at 5:02 AM, staff documented the yelling escalated as the shift progressed. May 12, 2026, at 1:16 AM, the resident had been yelling since 10:50 PM when the nightshift nurse arrived on the unit. May 17, 2026, at 1:59 AM, the resident was calling out, yelling, cursing at staff, and unable to be redirected. May 17, 2026, at 4:02 AM, the resident continued yelling and cursing in the hallway. May 19, 2026, at 1:39 AM, the resident was yelling and cursing at the nurses' station and could not be redirected. May 23, 2026, at 2:07 AM, the resident was yelling and cursing at the nurses' station. May 28, 2026, at 7:37 AM, the resident yelled on and off during the prior shift and could not be redirected. May 28, 2026, at 10:34 PM, the resident had multiple instances of yelling and screaming. May 30, 2026, at 7:03 AM, the resident was yelling on and off and whining throughout the morning. May 30, 2026, at 2:15 PM, the resident was yelling and screaming at staff and other residents and redirection was ineffective. June 2, 2026, at 5:54 AM, the resident exhibited behaviors throughout the night and could not be redirected. An interview with Employee 3 Licensed Practical nurse (LPN) on June 3, 2026, at 10:30 AM revealed Resident 94's behaviors routinely escalated during the 3:00 PM to 11:00 PM shift and the 11:00 PM to 7:00 AM shift due to the resident's diagnosis and declining mental ability. Employee 3 stated the resident's behaviors were generally more manageable during the day shift because staff had interventions available and the resident's daughter, who worked in the facility on the day shift, frequently assisted with behavior management. A review of the resident's care plan dated March 14, 2026, revealed interventions intended to address behavioral symptoms. However, the record contained repeated documentation over several weeks that the resident continued to yell, scream, call out, curse, and disrupt the unit despite implementation of those interventions. The facility failed to demonstrate that it evaluated the effectiveness of the interventions or revised the care plan to address the resident's consistent pattern of behavioral escalation during evening and nighttime hours. The facility failed to identify interventions specific to the resident's documented behavioral pattern, declining cognitive abilities, or the times of day when the behaviors most frequently occurred. Observations conducted on June 3, 2026, at 9:00 AM, June 4, 2026, at 9:00 AM and 11:00 AM, and June 5, 2026, at 11:45 AM revealed Resident 94 sleeping in a chair at the nurses' station. During an interview on June 5, 2026, at 9:00 AM, the Director of Nursing and Nursing Home Administrator were unable to provide evidence demonstrating the facility had evaluated the effectiveness of the resident's behavioral interventions or revised interventions in response to the persistent pattern of yelling, screaming, calling out, and cursing documented during evening and nighttime shifts. The Director of Nursing and Nursing Home Administrator further acknowledged that after surveyor inquiry, staff implemented additional interventions, including a busy box (a container of activity items intended to provide engagement and redirection) and interventions related to the resident's past smoking habits. Staff reported those interventions were successful during the evening and nighttime shifts beginning June 4, 2026, into June 5, 2026. The facility was unable to provide evidence these interventions had been considered or implemented earlier despite ongoing behavioral symptoms documented throughout April, May, and June 2026, repeated resident complaints, and a resident council grievance. Refer to F-565. 28 Pa. Code 211.12 (c)(d)(3) (5) Nursing services. 28 Pa. Code 211.10(d) Resident care policies.

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. Based on staff interviews and a review of facility training and orientation records, the facility failed to provide training to agency staff on the facility's procedures related to activities that constitute abuse, neglect, exploitation, or the misappropriation of resident property and resident abuse prevention for four of the six employees reviewed (Employees 4, 5, 6, and 7). Findings included: During an observation conducted on the third floor on June 2, 2026, at 1:25 PM, Employee 4 (Licensed Practical Nurse) was observed working on the facility's medication cart (a secure, mobile rolling workstation used by nurses to transport, organize, and administer residents' daily medications). An interview at the time of the observation revealed Employee 4 was employed by a nurse staffing agency and working at the facility for the first time on the day of this interview. Employee 4 stated the facility had not provided training on the facility's abuse prohibition policy and procedures to identify and report abuse, neglect, exploitation, or misappropriation of resident property or resident abuse prevention. There was no documentation that Employee 4 was trained on the facility's abuse prohibition policies and procedures as part of staff orientation and training on the prohibition of all forms of abuse, neglect, and exploitation prohibition. Review of three additional nurse staffing agency personnel records revealed the facility failed to provide education and training of the facility's abuse prohibition policy and procedures to identify and report abuse, neglect, exploitation, or misappropriation of resident property or resident abuse prevention to Employee 5 (Licensed Practical Nurse), Employee 6 (Registered Nurse), and Employee 7 (nurse aide). During an interview on June 4, 2026, at 2:14 PM, the Nursing Home Administrator confirmed the facility had not provided agency staff, Employees 4, 5, 6, and 7, training on the prohibition of all forms of abuse, neglect, and exploitation prohibition and the specifics of the facility's abuse prohibition policies and procedures. 28 Pa. Code 201.20(b)(d) Staff development. 28 Pa Code 201.18 (e)(1) Management. 28 Pa. Code 201.29(a)(c) Resident rights. 28 Pa. Code 201.19 (7) Personnel policies and procedures.

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, select facility policy, and resident and staff interviews, it was determined the facility failed to ensure that written notice, including the reason for a room change, was provided to residents and/or their resident representatives prior to a facility-initiated room change for two residents of 27 residents reviewed (Resident 51 and 93).Findings include: Review of the facility policy titled Room Change last reviewed by the facility on March 18, 2026, revealed the residents' preferences should be considered when making a room or roommate change. The policy further indicated that whenever a resident is transferred from one room to another within the facility, a written notice of transfer must be given to the resident and/or family prior to the move, according to state law. Additionally, the policy stated the resident should be provided with an opportunity to tour the new location, meet the new roommate and express any concerns regarding the move. Advanced notice was to be provided except in circumstances outside the facility's control, such as a change in level of care, change in medical or treatment program, or for the resident's welfare as documented in the medical record. At the time of the survey ending June 5, 2026, all beds in the facility were licensed and dually certified for participation in both the Medicare and Medicaid programs. Review of the clinical record revealed Resident 51 was admitted to the facility on [DATE], and resided in the same first-floor room from June 25, 2025, until February 20, 2026. On February 20, 2026, the facility initiated a room change and relocated the resident to another room on the first floor. There was no documented evidence that the resident or the resident's representative was provided with written notice or an explanation for the room change prior to the move. Additionally, there was no documented evidence that circumstances existed which would have exempted the facility from providing advance notice as outlined in the facility policy. During an interview on June 3, 2026, at 11:10 AM, Resident 51, a cognitively intact resident with a BIMS score of 14 (Brief Interview for Mental Status, a tool that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 13 through 15 indicates intact cognition) stated the room changed occurred unexpectedly. The resident reported she was not informed why the move was necessary and did not receive advance notice. She expressed frustration stating, I didn't know about the room change until the day they moved us. I didn't want to move. Resident 51 further stated she had not been informed of her right to refuse the room change, was not provided written notification explaining the reason for the room change, was not offered an opportunity to tour the new room or meet the new roommate before the move, and was not asked whether she had concerns regarding the move. Review of the clinical record revealed Resident 93 was admitted to the facility on [DATE], and resided in the same first-floor room from February 28, 2025, until February 20, 2026. On February 20, 2026, the facility initiated a room change and relocated the resident to another room on the first floor. There was no documented evidence that the resident or the resident's representative was provided with written notice or an explanation for the room change prior to the move. Additionally, there was no documented evidence that circumstances existed which would have exempted the facility from providing advance notice as outlined in the facility policy. Further review of the clinical record revealed Resident 93 was moderately cognitively impaired with a BIMS score of 10 (a score of 8 through 12 indicates moderate cognitive impairment). During an interview on June 4, 2026, at 1:15 PM, Resident 93 stated the room change was very sudden. The resident reported staff entered her room while she was lying in bed and stated, You're moving. Resident 93 stated staff packed her belongings, took her to a different room and informed her it was her new room. The resident stated she was not informed of the reason for the room change prior to the move and did not receive written notice explaining the room change. She stated she was not given an opportunity to voice concerns regarding the room change and would have objected to the move had she been given the opportunity to do so. During an interview on June 5, (continued on next page)

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2026, at 9:17 AM the Director of Nursing was unable to provide documented evidence that the facility provided any written explanation of the reasons for the facility-initiated room changes to the residents and/or their representatives. 28 Pa Code 201.29 (a) Resident Rights. 28 Pa Code 210.11 (c) Resident Care Policies.

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F 0689 Level of Harm - Minimal harm or potential for 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 clinical records, select facility policy, documentation provided by the facility, and staff interviews, it was determined the facility failed to ensure the resident's environment remained free of accident hazards for one out of 27 residents reviewed (Resident 59).Findings include: Review of the facility Equipment and Supplies Policy last reviewed March 18, 2026, indicated the facility provides and maintains equipment to meet the needs of residents. Equipment provided for the general use of all residents may not be permanently assigned to any resident. A clinical record review revealed Resident 59 was admitted to the facility on [DATE], with diagnoses that include dementia (a condition characterized by the loss of cognitive functioning such as thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities) and anxiety. A review of Resident 59's annual Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated May 16, 2026, revealed that Resident 59 was severely cognitively impaired with a BIMS score of 0 (Brief Interview for Mental Status, a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 0 through 7 indicates cognition is severely impaired) and was dependent on staff for bed mobility and transfers. A physician's order dated May 9, 2026, directed staff to administer Ceftriaxone Sodium (an antibiotic used to treat bacterial infections) 1 gram intravenously (through a vein) for two days. A nursing note dated May 11, 2026, documented that the intravenous (IV) catheter was removed in accordance with the physician's order, indicating the IV treatment had been completed. A review of facility investigative documentation dated May 25, 2026, at 11:00 PM revealed that Employee 1, a nurse aide, was lowering Resident 59's bed when the bed frame became caught on the cord of an IV pole located in the resident's room. The IV pole tipped over and struck the resident in the right eyebrow area. Facility documentation revealed the resident sustained a 4 centimeter(cm) laceration (a tear or cut in the skin) to the right eyebrow area. Staff cleansed the wound and applied Steri-Strips (adhesive skin-closure strips used to hold the edges of a wound together). A small amount of bleeding was observed. Due to the resident's severe cognitive impairment, the resident was unable to describe the event. The physician and resident representative were notified. Interview with the Director of Nursing on June 4, 2026, at 1:00 PM confirmed the IV pole should have been removed from Resident 59's room when the IV therapy was discontinued on May 11, 2026. The Director of Nursing further confirmed staff are expected to ensure equipment and cords are positioned away from bed frames and other moving equipment to prevent items from becoming caught, tipping, or falling.Interview with the Nursing Home Administrator on June 4, 2026, at 1:30 PM confirmed the facility was responsible for maintaining an environment free of avoidable accident hazards for Resident 59. 28 Pa Code 201.18(b)(1) Management. 28 Pa Code 211.10 (d) Resident care policies. 28 Pa Code 211.12 (d)(3)(5) Nursing services.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, select facility policy, observation, and staff interviews, it was determined the facility failed to consistently ensure oxygen therapy was administered per a physician's orders for two residents out of 27 residents reviewed (Resident 12 and 102).Findings include: A review of the facility's policy titled Oxygen Administration and Storage, last reviewed on March 18, 2026, revealed the purpose of the policy was to provide guidelines for safe oxygen administration and storage. The policy directed staff to check the oxygen delivery system, including the mask, oxygen tank, and humidifier bottle (also known as the humidifier reservoir, the container that holds sterile or distilled water through which oxygen passes to add moisture before being delivered to the resident) to ensure they were in good working order and securely fastened. The policy required staff to verify there was an adequate water level in the humidifier bottle so that the water bubbled as oxygen flowed through and to change oxygen tubing weekly. A clinical record review revealed that Resident 12 was admitted to the facility on [DATE], with a diagnosis to include chronic obstructive pulmonary disease (COPD is a condition caused by damage to the airways or other parts of the lung that blocks airflow and makes it hard to breathe) and respiratory failure (a serious condition that makes it difficult to breathe). A review of Resident 12's Quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated May 4, 2026, revealed the resident was cognitively intact with a BIMS score of 13 (Brief Interview for Mental Status, a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 13 through 15 indicates cognition is intact). A review of the physician's orders dated April 8, 2026, directed that Resident 12 receive oxygen at 2.0 liters per minute (L/min) by nasal cannula (a flexible medical tube with two prongs that fit into the nostrils, used to deliver supplemental oxygen), change oxygen tubing weekly, and change humidification bottle every week and as needed when empty. An observation on June 2, 2026, at 11:50 AM revealed Resident 12 was in bed receiving oxygen at 3.0 liters per minute (L/min) via nasal cannula with no date on the tubing and with no humidifier bottle attached to the oxygen flowmeter. This observation was confirmed, and the tubing was replaced and the oxygen liter was corrected, and humidifier bottle was added by Employee 2, a Licensed Practical Nurse (LPN) on June 2, 2026, at 11:55 AM. A clinical record review revealed that Resident 102 was admitted to the facility on [DATE], with diagnosis to include chronic obstructive pulmonary disease and pulmonary hypertension (a type of high blood pressure that specifically affects the arteries in the lungs and the right side of the heart). A review of Resident 102's Quarterly Minimum Data Set assessment dated [DATE], revealed the resident was cognitively intact with a BIMS score of 15. A review of the physician's orders dated January 8, 2026, directed that Resident 102 receive oxygen at 2.0 liters (L/min) per minute continuously by nasal cannula. An observation on June 2, 2026, at 11:35 AM revealed Resident 102 was seated in a wheelchair in the dining room with an oxygen tank attached to the back of the wheelchair. The oxygen tank was not turned on. This observation was confirmed by Employee 2 LPN. During an interview with the Director of Nursing on June 3, 2026, at 1:05 PM, the above findings were reviewed and confirmed it is the facility's responsibility to ensure oxygen therapy is administered in accordance with the physician's orders. 28 Pa. Code 211.10 (c) Resident care policies. 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services.