

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395373	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/08/2026
NAME OF PROVIDER OR SUPPLIER Greenwood Center for Rehabilitation and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 276 Green Ave Extended Lewistown, PA 17044	
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on review of select facility policy and procedures, observation, and staff interview, it was determined that the facility failed to store food items in a safe and sanitary manner, maintain equipment in a sanitary condition, and prepare food items in accordance with professional standards in the main kitchen (Main Kitchen of Facility) and maintain equipment in a safe and sanitary condition on one of five nursing units reviewed (400 Nursing Unit). Findings include: Initial tour of the facility's main kitchen with Employee 3, Dietary Manager, on January 5, 2026, at 10:00 AM revealed the following: The parts per million (PPM) test strips used to test for appropriate dishwasher sanitizer concentration that were included in a clean, plastic sheet protector with the dishwasher temperature documentation log had expired on August 1, 2025. An appliance identified by Employee 1 as a cooler where food trays are placed during tray line had an accumulation of dust on top of it. The bottom front vents had numerous dried food stains. The commercial coffee maker located on a stainless steel table had an accumulation of dried stains and a clear liquid accumulating on the stainless steel table at the rear of the machine. A rodent glue trap was located behind the coffee machine and was noted to be wet. There were dried drip stains observed on the walls behind the coffee maker. Two ceiling vents had a black colored, dust-like substance accumulating on the vents and surrounding ceiling. A container labeled antimicrobial fruit and vegetable wash was located on a wall above a sink. The wash had expired on May 13, 2022. The black colored hose coming from the fruit and vegetable wash was sticky to the touch. Chemical test strips located adjacent to a red colored, wall-mounted, cleaning bucket expired on August 30, 2022. The walk-in cooler contained the following: Extensive debris on the floor. This included food debris, dust/dirt, and an unopened single-use butter packet. A container of peas and carrots labeled as an alternative vegetable had a facility use by date of January 4, 2026. There was a substantial build-up of dust on the ceiling and adjacent light that was located in front of the compressor fans of the cooler. A container of fine ground sage had a facility use by date of November 24, 2025. A container of basil leaves had a facility use by date of October 31, 2025. A container of iodized salt was open and partially used. Instructions on the box noted to use within three years. There were no dates on the container of iodized salt to determine when the box was opened. A storage shelf under a stainless steel table contained several stacked baking pans. The pans were stored upside down and the borders of multiple pans had debris in them. The front border of the storage shelf was sticky with debris and a hair stuck to it. The dry goods storage area had a wall mounted air conditioning unit. The vents located in the front of the unit had a black-colored substance accumulating in multiple areas. A vent located in the ceiling in the dry goods storage area had a black colored, dust-like substance accumulating on the vents. The walk-in freezer contained the following: Extensive debris on the floor. This included food debris, box tape, and dust/dirt. A stainless steel pan with a foil lid had a non-discernible food label. The facility use by date was December 28, 2025. A shepherd's pie had a facility past the use by date of December 2025. A container of hot dogs had a facility use by date of 12/26. A roll of corned beef being stored on a stainless steel baking rack had no labels or dates to indicate how long the item was in the freezer or when it expired. A sliced loaf of bread had no labels or dates on it. Further observation of the facility's main kitchen revealed (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the following: The chemical test strips to test the PPM of the sanitizer located above the three-basin sink had expired on November 15, 2023. There was a significant build-up of dust on the corner wall adjacent to the three-basin sink. A large container that contained thickener per Employee 3 had no label or dates on it. A large container that contained flour had a facility use by date of 6/25. A large ceiling vent adjacent to the kitchen office area had a significant accumulation of dust on it. Observation of the trash disposal area revealed the following: On the ground surrounding the dumpsters there was a discarded spoon, a medical glove, plastic debris, a candy wrapper, a plastic cup, cut wood pieces, cardboard pieces, and a tea wrapper. The adjacent wooden fence was broken and partially collapsed. Observation on January 5, 2026, at 1:02 PM on the 400 Nursing Unit, revealed an ice cart. The plastic of the ice cart was broken and jagged in several areas. There was scotch tape covering multiple broken areas of the cart. Review of the facility policy titled, Food Temperatures, last reviewed on January 29, 2025, revealed that foods will be maintained at proper temperature to ensure food safety. Further review of this policy revealed a section titled, Procedures, that noted (in part) that the cook is responsible to see that all food is at the proper temperature, and the temperature will be taken and recorded for all items at all meals. Observation of the lunch service tray line on January 7, 2026, at 11:35 AM revealed three staff members preparing resident trays and loading them onto delivery carts to take to the nursing units. A request for the food temperatures that should have been taken prior to plating the resident food items revealed the temperatures were not readily available. Employee 5, cook, revealed that the temperatures were not written down yet. The surveyor requested that Employee 1 provide the meal temperatures documented for the last three weeks for each meal service. Food temperature logs provided by Employee 1 reviewed from December 14, 2025, revealed the following missing temperatures: December 15, 2025: breakfast December 16, 2025: breakfast December 17, 2025: lunch and dinner December 20, 2025: breakfast and lunch December 21, 2025: breakfast and lunch December 22, 2025: lunch December 23, 2025: breakfast December 24, 2025: breakfast December 26, 2025: breakfast and lunch December 28, 2025: breakfast and lunch December 29, 2025: breakfast and lunch December 30, 2025: breakfast and lunch January 1, 2026: breakfast January 3, 2026: breakfast January 4-7, 2026: no temperature documentation provided A follow-up interview with Employee 1 on January 7, 2026, at 11:45 AM revealed that no further food temperatures could be provided. The above information was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on January 7, 2026, at 2:15 PM. 483.60(i)(1)-(2) Food safety requirements Previously cited deficiency 3/31/25 28 Pa. Code 201.14(a) Responsibility of licensee		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on clinical record review and staff interview, it was determined that the facility failed to provide the highest practicable care regarding physician ordered medications for one of 27 sampled residents, and skin integrity for one of 27 sampled residents (Residents 38 and 122). Findings include: Interview with Resident 122 on November 5, 2026, at 2:10 PM revealed concerns regarding very dry skin. Resident 122 stated that her arms, hands, and feet were very dry and itchy, especially on her elbows, and that no lotions or creams were ever applied to these areas. Concurrent observations revealed that Resident 122's hands, arms, and feet had flakey white skin that seemed to be peeling and flaking off. Clinical record review revealed Resident 122 had no documented assessments related to her dry skin or any interventions. Interview with the Nursing Home Administrator and the Director of Nursing on January 7 at 2:30 PM confirmed that the resident did not have a treatment for dry skin in place at the time of the above interview. Clinical record review for Resident 38 revealed the facility admitted her on October 18, 2024, with diagnosis including Type 2 Diabetes Mellitus. A physician's order dated October 21, 2024, revealed nursing staff were to perform accuchecks (measures blood sugar levels) four times a day, and to notify Resident 38's physician if the blood sugar is less than 400 mg/dL (milligrams per deciliter). Interview with the Director of Nursing on January 7, 2026, at 2:04 PM revealed that Resident 38's accucheck physician order was wrong, and it should have read that nursing staff were to notify Resident 38's physician if her blood sugars were greater than 400 mg/dL. Review of Resident 38's Medication Administration Record (MAR, a form utilized by the facility to document the administration of medications) dated December 2025, revealed the following documentation of Resident 38's accucheck above 400 mg/dL: December 1, 2025, 467December 4, 2025, 471December 7, 2025, 478December 9, 2025, 466December 12, 2025, 487December 13, 2025, 440December 15, 2025, 444December 16, 2025, 425December 22, 2025, 467December 26, 2025, 423December 28, 2025, 420 Review of Resident 38's MAR, from January 1 to 7, 2026, revealed the following documentation of Resident 38's accuchecks above 400: January 2, 2026, 428 January 3, 2026, 440January 4, 2026, 464January 5, 2026, 426 Interview with the Director of Nursing on January 8, 2026, at 10:45 AM confirmed these findings and was unable to provide any documentation that Resident 38's physician was notified when her blood sugars were greater than 400. S483.25 Quality of CarePreviously cited 3/31/25 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services		

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on clinical record review and staff interview, it was determined that the facility failed to offer COVID-19 immunizations to ensure residents were up to date with the most current available immunization for five of five residents reviewed (Residents 1, 2, 3, 6, and 9), failed to maintain documentation of staff COVID-19 vaccination status, and provide evidence that staff were offered the COVID-19 vaccine or information on obtaining the COVID-19 vaccine. Findings include: Clinical record review for Resident 1 revealed that his last COVID-19 vaccine was a COVID-19 booster administered on May 31, 2024. Clinical record review for Resident 2 revealed that her last COVID-19 vaccine was a COVID-19 booster administered on November 10, 2021. Clinical record review for Resident 3 revealed that her last COVID-19 vaccine was a COVID-19 booster administered on October 21, 2022. Clinical record review for Resident 6 revealed that her last COVID -19 vaccine was a COVID-19 booster administered on May 20, 2024. Clinical record review for Resident 9 revealed that she had no documentation indicating that she received any of the COVID-19 vaccines and no evidence that she refused the vaccinations. Interview with the Director of Nursing on January 8, 2025, at 1:30 PM confirmed the above noted findings that these residents were not up to date on their COVID-19 vaccinations and there was no evidence that they were offered any further COVID-19 vaccinations. Interview with the Director of Nursing on January 8, 2025, at 1:30 PM revealed that the facility does not have evidence that they have maintained documentation related to staff COVID-19 vaccination status or that the staff were offered the COVID-19 vaccine or information on obtaining the COVID-19 vaccine. The facility failed to offer COVID-19 immunizations to ensure residents were up to date with the most current available immunization and failed to maintain documentation of staff COVID-19 vaccination status and provide evidence that staff were offered the COVID-19 vaccine or information on obtaining the COVID-19 vaccine. The surveyor reviewed the above findings during an interview with the Director of Nursing on January 8, 2026, at 1:32 PM. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services		

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observations and staff interview, it was determined that the facility failed to ensure residents' rights to secure and confidential personal and medical information in the lobby area of the facility and for one of one resident reviewed for privacy concerns (Facility Main Lobby Area; Resident 12). Findings include: Observation of the main lobby area of the facility on January 5, 2026, at 12:30 PM revealed a binder titled Department of Health Survey Results, For Public Review. The binder contained the results of recent surveys of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. Review of the contents of the binder revealed that the facility placed the full health survey and complaint survey results in the binder. Further review of the binder contents revealed a survey deficiency letter and associated Statement of Deficiencies (Form CMS-2567) for a survey completed on March 31, 2025. The letter noted the full resident's name and associated specific resident identifier for Resident 12 and 15 additional residents associated with the survey. The facility failed to ensure a resident's right to privacy of their personal and medical information. The above information was reviewed in a meeting with the Director of Nursing on January 5, 2026, at 12:40 PM. 28 Pa. Code: 201.18(e)(1) Management		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interview, it was determined that the facility failed to provide adequate housekeeping services to ensure a clean, safe, and orderly environment on one of five nursing units (Medication and Medical Supply Area located on the 400 Nursing Unit). Findings include: Observation of the house stock medication and medical supply storage room located at the end of the 400 Nursing Unit on [DATE], at 9:25 AM revealed dust and debris accumulated on the floor and under the storage shelving. There were also pieces of various paper products discarded on the floor. Further observation of the area revealed various packaged medical items discarded on the floor that included: a shower cap, toothbrush, a nutritional drink that expired in [DATE], a catheter protector cap, and rolled gauze. The above information was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on [DATE], at 2:15 PM. 483.10(i)(1)-(7) Safe/clean/comfortable/homelike Environment Previously cited deficiency [DATE] 28 Pa. Code 201.18(b)(3)(e)(2.1) Management		

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. Based on clinical record review, and resident and staff interview, it was determined that the facility failed to ensure that a resident received proper treatment for vision services for one of two residents reviewed for vision concerns (Resident 9). Findings include: Interview with Resident 9 on January 5, 2026, at 1:43 PM revealed that she had concerns with receiving timely vision services. Resident 9 stated they keep cancelling my cataract surgery and now they do not know when I can have it done. Clinical record review revealed the facility admitted Resident 9 on December 20, 2022. Review of Resident 9's clinical record revealed an ophthalmology consult dated November 27, 2024, noting Resident 9 had cataracts and needed surgery in both eyes. Review of the ophthalmology consult dated June 3, 2025, revealed the procedure was not performed due to Resident 9 eating breakfast. Further review of Resident 9's clinical record revealed no documentation that Resident 9's cataract procedure was rescheduled. The surveyor reviewed the above concerns with Resident 9's vision services during an interview with the Director of Nursing on January 8, 2026, at 10:04 AM. She confirmed Resident 9's cataract procedure has not been rescheduled. The Director of Nursing verified the facility was aware Resident 9 was to receive the cataract surgery on June 9, 2025, and did not obtain an order from her physician to be NPO (nothing by mouth) prior to the procedure. The facility failed to provide timely vision services for Resident 9. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services		

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. Based on clinical record review, observation, and resident and staff interview, it was determined that the facility failed to arrange for the necessary foot care for one of 27 residents reviewed (Resident 122). Findings include: Interview with Resident 122 on January 5, 2026, at 2:10 PM revealed that she had not seen the podiatrist in a very long time, and she thought her toenails were very long and in need of clipping. Resident 122 indicated that the left foot was worse than the right foot. Concurrent observation of Resident 122's toenails revealed that her right foot had multiple elongated toenails including the large toe and the middle toe, with toenails grown over the tip of the toe by 1 cm (centimeter). The left foot toenails were all noted to be overgrown with 1 cm of growth noted over the tips of the toes. All toenails appeared to have jagged edges. Review of Resident 122's clinical record revealed that the resident was last seen by podiatry on May 23, 2025. The progress note located on the podiatry consult stated, Non-professional treatment is hazardous to the patient. Interviews with the Nursing Home Administrator and the Director of Nursing on January 7, 2026, at 2:30 PM, and with the Director of Nursing on January 9, 2026, at 12:37 PM, confirmed that the facility had no evidence of any further podiatry services provided for Resident 122. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, it was determined that the facility failed to identify triggers related to a resident's diagnosis of Post-Traumatic Stress Disorder, to provide culturally, competent, trauma-informed care, and to eliminate or mitigate re-traumatization for one of six residents reviewed for mood/behavior (Resident 4). Findings include: Clinical record review for Resident 4 revealed the facility admitted him on June 2, 2025. A diagnosis of Post Traumatic Stress Disorder (PTSD, a mental and behavioral disorder that develops related to a terrifying event) was added to his diagnosis list on July 11, 2025. A review of Resident 4's quarterly Minimum Data Set (MDS, an assessment completed by the facility at specific intervals to determine care needs) assessment dated [DATE], indicated a diagnosis of PTSD for Resident 4. Review of Resident 4's care plan identified that he had a diagnosis of PTSD. There were no identified triggers (everyday situations that cause a person to re-experience the traumatic event as if it was reoccurring). Review of Resident 4's psych visit notes dated September 3, 2025, and November 11, 2025, revealed no mention of his diagnosis of PTSD. An interview with the Director of Nursing on January 8, 2026, at 11:39 AM confirmed the above noted findings related to Resident 4's diagnosis of PTSD. The facility failed to identify and care plan triggers that may retraumatize Residents 4 related to his diagnosis of PTSD. 28 Pa Code 211.12 (d)(3)(5) Nursing services		

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. Based on clinical record review and staff interview, it was determined that the facility failed to develop and implement an individualized person-centered care plan to address dementia and cognitive loss displayed by one of three residents reviewed (Residents 4). Findings include: Clinical record review for Resident 4 revealed the facility admitted him on June 2, 2025. A diagnosis of Dementia (loss of memory, language, problem-solving, and other thinking abilities that interfere with daily life) was added to his diagnosis list on June 26, 2025. A review of Resident 4's quarterly Minimum Data Set Assessment (MDS, a form completed at specific intervals to determine care needs) dated, October 18, 2025, indicated that Resident 4 had a diagnosis dementia. A review of Resident 4's care plan revealed that the facility failed to develop a person center care plan with individualized interventions related to his diagnosis of dementia. An Interview with the Director of Nursing on January 8, 2026, at 11:39 AM confirmed that the facility failed to develop a person-centered care plan related to dementia for Resident 4. The facility failed to develop a person-centered care plan for Resident 4 related to his diagnosis of dementia. 483.40(b)(3) Dementia Treatment and Services Previously cited 3/31/2025 28 Pa Code 211.12 (d)(1)(3)(5) Nursing services		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interview, it was determined that the facility failed to ensure a medication error rate below five percent (100 Nursing Unit; Residents 21 and 46). Findings include: The facility's medication error rate was eight percent based on 25 medication opportunities with two medication errors. Review of Resident 46's current physician orders dated [DATE], indicated staff were to administer Centrum Silver Oral Tablet (multiple vitamin with minerals); give one tablet by mouth daily. Observation of Resident 46's medication administration pass on [DATE], at 9:12 AM revealed that Employee 1, licensed practical nurse, prepared the medications prior to administration. This preparation included a Senior Tab Multivitamin (house stock substituted for the Centrum Silver oral tablet per Employee 1). Employee 1 proceeded to administer the medication to Resident 46. Upon review, it was determined that the Senior Tab Multivitamin had expired in [DATE]. Review of Resident 21's current physician orders revealed an order dated February 17, 2024, for Biotin Oral Tablet (a part of the B-complex vitamins) give 10,000 micrograms (mcg) one tablet by mouth one time a day. Observation of Resident 21's medication administration pass on [DATE], at 9:39 AM revealed that Employee 1 prepared the medications prior to administration. This preparation included Biotin 1000 mcg. Employee 1 proceeded to administer the medication to Resident 21. A follow-up interview with Employee 1 on [DATE], at 10:37 AM regarding Resident 21's medication pass confirmed that Employee 1 administered the 1000 mcg dose of Biotin; however, the physician's order was for 10,000 mcg. Employee 1 stated she would have to check with the registered nurse to confirm the dose and proceeded to contact the registered nurse via cell phone. Clinical record review for Resident 21 revealed that the Biotin order was later changed after surveyor questioning to the following: Biotin Oral Capsule 1 milligram (mg; 1000 mcg) give one capsule by mouth in the morning to start [DATE], at 8:00 AM. The above information was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on [DATE], at 2:15 PM. 28 Pa. Code 211.9(a)(1) Pharmacy services 28 Pa. Code 211.10(a)(c) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services		

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. Based on clinical record review, and resident and staff interview, it was determined that the facility failed to obtain dental services for one of nine residents reviewed for dental concerns (Resident 122). Findings include: Interview with Resident 122 on November 5, 2026, at 2:10 PM revealed that she was concerned about her teeth chipping and breaking. Concurrent observations of the resident's teeth revealed multiple teeth that appeared chipped and broken. Clinical record review revealed that Resident 122 had last received dental services on May 13, 2025. The exam indicated five teeth that were fractured and not restorable. The consultant requested a referral to an oral surgeon for radiographic imaging (images on a sensitive plate or film by X-rays, gamma rays, or similar radiation examination) and extractions of any teeth with a less than favorable prognosis. Interview with the Nursing Home Administrator and the Director of Nursing on January 8, 2026, at 2:30 PM confirmed that there no evidence that a referral to an oral surgeon had been attempted. 28 Pa. Code 211.15 Dental 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: 395373	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/08/2026
NAME OF PROVIDER OR SUPPLIER Greenwood Center for Rehabilitation and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 276 Green Ave Extended Lewistown, PA 17044	
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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on clinical record review, observation, and staff and resident interview, it was determined that the facility failed to obtain professional dental services for three of nine residents reviewed for dental concerns (Residents 9, 28, and 125). Findings include: Interview with Resident 28 on January 6, 2026, at 11:47 AM revealed that she has decayed and broken teeth that cause her pain. She said the facility dentist has seen her and he is waiting for her to get her teeth pulled so he can start making her dentures. She said she has to see an oral surgeon that will accept her insurance. Observation of Resident 28 during the interview confirmed her statement that she has decayed and broken teeth. Interview with the Director of Nursing on January 7, 2026, at 2:21 PM revealed that Resident 28 has been seen by the dentist and by the oral surgeon and she would provide all the dental consultation notes. The facility provided the following documents related to Resident 28's dental visits: Review of dental consult documentation dated March 14, 2025, revealed that Resident 28 was seen by the dentist in facility. His documentation indicated that Resident 28 did not have her tooth extractions done yet. He then indicated that the action required by the nursing home staff was for the facility to refer Resident 28 to an oral surgeon for extraction of all remaining dentition. Review of dental consult documentation dated May 13, 2025, revealed that Resident 28 was seen by the dentist in the facility. The dentist again noted that Resident 28 has not been seen by the oral surgeon yet and that he cannot proceed with dentures until the extractions are completed. He again asked that the facility refer her to an oral surgeon. Review of the dental consult documentation dated July 11, 2025, revealed that Resident 28 was seen by the dentist in the facility. The dentist again noted that Resident 28 was not yet seen by the oral surgeon but noted that she has an appointment on July 29, 2025, and he will follow up after that. Review of the oral surgeon's documentation dated July 29, 2025, revealed that he was unable to treat Resident 28 in his office due to her complex medical problems. He indicated for the facility to refer Resident 28 to a hospital based oral surgery practice. Review of dental documentation dated November 20, 2025, revealed that Resident 28 was seen by a new contracted in-house dentist and he indicated that she needs x-rays, cleaning, extraction of all remaining teeth, and then she will need dentures. He recommended she be referred to an oral surgeon. Review of dental documentation dated December 8, 2025, revealed that Resident 28 was seen by the in-house dentist for a cleaning and that Resident 28 indicated that it was hard for her to eat related to tooth or mouth problems. He also noted that the resident is waiting for oral surgery to extract her teeth so she can get dentures. Interview with the Director of Nursing on January 7, 2026, at 2:33 PM revealed that the resident is not currently scheduled for oral surgery. She also indicated that there is no evidence that the facility attempted to schedule Resident 28 for dental services at a hospital based oral surgery practice. The facility failed to provide Resident 28 with dental services as noted above. Observation of Resident 9 on January 5, 2026, at 1:41 PM revealed that she had several broken and missing teeth. Interview with Resident 9 at this time revealed that she is not happy with the facility dental services. Resident 9 stated she has several broken teeth and cavities, but that the dentist only looks at her teeth and never fixes them. Clinical record review revealed the facility admitted Resident 9 on December 20, 2022, with payment sources that included the state Medicaid benefit. Review of Resident 9's dental documentation provided by the facility, revealed Resident 9 had an initial exam on June 12, 2023. A review of this progress notes revealed the recommended treatment for Resident 9 included prophylactic dental cleaning every six months and a fluoride varnish. Resident 9's clinical record revealed that there were no further dental visits until December 8, 2025. The facility provided a dental visit note dated May 13, 2025, indicating that Resident 9 was not treated on this date due to her not being brought to the treatment room. Observation of Resident 125 on January 6, 2026, at 10:04 AM revealed that she appeared to have her own teeth. Resident 125 was unable to be interviewed pertaining to her dental services due to her current cognitive status. Clinical record review revealed the facility admitted Resident 125 on February 25, 2016, with payment sources that included the (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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NAME OF PROVIDER OR SUPPLIER Greenwood Center for Rehabilitation and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 276 Green Ave Extended Lewistown, PA 17044	
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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medicaid benefit. Further review of Resident 125's clinical record revealed an initial exam by a dentist on November 20, 2025, and a prophylactic cleaning by a dental hygienist on December 8, 2025. Resident 125's clinical record revealed the facility was unable to provide documentation of dental care prior to November 20, 2025. Interview with the Director of Nursing on January 8, 2026, at 10:24 AM confirmed these findings and had no further information to indicate that Residents 9 and 125 received routine dental services every six months as the State plan allows. 483.55(b)(1)-(5) Routine/emergency Dental Services in NFsPreviously cited deficiency 3/31/2025 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services 28 Pa. Code 211.15 Dental services		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on a review of facility procedures, observation, and resident and staff interview, the facility failed to follow proper infection prevention practices for foot care equipment for two of 27 residents reviewed (Residents 29 and 48). Findings include: Observation of the 500 Hall on January 7, 2026, at 11:08 AM revealed Employee 1, nurse aide (NA), retrieved nail clippers from a staff member standing near a med cart and began trimming Resident 48's fingernails. At 11:12 AM, Employee 1 walked over to Resident 29 and began to trim his fingernails. Review of the facility policy and procedure entitled Care of Fingernails/Toenails under the section titled Steps in the Procedure revealed that step 20 instructs staff to clean reusable equipment and supplies, and step 25 instructs staff to wash and dry hands thoroughly. Employee 1 did not clean the fingernail clippers or wash and dry her hands between each resident's nail care. Interview with Resident 29 on January 7, 2026, at 12:35 PM revealed that he does have his own personal nail clippers in his room, but he stated that they must have used the nurses' clippers today. Resident 48 was not interviewable. The above findings were reviewed with the Nursing Home Administrator and the Director of Nursing on January 7, 2026, at 2:30 PM. 483.80 Infection ControlPreviously cited deficiency 3/31/25 28 Pa. Code 211.12(d)(1)(5) Nursing services 28 Pa. Code 201.18(b)(1)(3) Management		