

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395604	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/15/2024
NAME OF PROVIDER OR SUPPLIER Greene Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 119 Industrial Park Road Greensburg, PA 15601	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>31760</p> <p>Based on review of policies, clinical records, and grievance/complaint investigation documents, as well as staff interviews, it was determined that the facility failed to ensure that residents were free from abuse for one of four residents reviewed (Resident 1).</p> <p>Findings include:</p> <p>The facility's policy regarding abuse, dated August 29, 2023, indicated that the facility would not tolerate abuse, neglect, mistreatment, exploitation of residents, and misappropriation of resident property. The facility would investigate all alleged, suspicions, and incidents of abuse, neglect, involuntary seclusion, intimidation, exploitation of residents, misappropriation of resident property, and injuries of unknown source. Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Mental abuse includes, but is not limited to, humiliation, harassment, and threats of punishment or deprivation.</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated December 20, 2023, revealed that the resident could understand and was understood. A care plan for an Activities of Daily Living (ADL) self-care deficit, dated February 12, 2024, indicated that staff was to encourage the resident to use the call bell to call for assistance as needed. That the resident was at risk for falls and staff was to always keep the call light in reach and to keep personal items and frequently used items within reach.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview with Resident 1, completed by Registered Nurse 1, dated January 24, 2024, revealed that on January 24, 2024, at shift change, Agency Nurse Aide 2 (on the 400-unit) asked the registered nurse to go speak with Resident 1 regarding an incident that happened in the evening, and she did not want to be inadvertently associated with it. Agency Nurse Aide 3 from an unknown agency was working the first assignment on the 400 unit. Per Resident 1's report, Agency Nurse Aide 3 was rough with him during evening care, which he did not think too much of. Afterwards, Nurse Aide 3 did not place the bed remote and call light within his reach, to which Resident 1 asked her for these items. Resident 1 claims that Nurse Aide 3 stated she would give him back the call bell only if he agrees to not ring out until 10:00 p.m. Resident 1 stated he does not utilize the call bell except for emergencies and continued to ask for the call light back. At this time, Resident 1 stated that Nurse Aide 3 began to offer and retract the call light to him in a game-like manner that was upsetting to him. Resident 1 stated he then told Nurse Aide 3 to give him his damn call light, to which Nurse Aide 3 then refused because the resident was swearing. Nurse Aide 3 then dropped the call light in the resident's trash can and left the room, closing the door behind her. Resident 1 stated that the heat was turned on in the room, making it very hot, and that he was unable to utilize the call bell, and that his door was closed. Resident 1 stated that he does not want to be at this facility and spends too much money to be here and to be treated in this manner. Resident 1 asked the writer to have Nurse Aide 3 terminated. The writer explained that Nurse Aide 3 was an outside agency staff, but that this matter would be addressed in a formal grievance to be handled by the appropriate management. Resident 1 seemed pleased with this outcome.</p> <p>Interview with the Resident 1 on March 13, 2024, at 2:45 p.m. revealed that he had asked Nurse Aide 3 to do something for him but he could not recall what it was. He indicated that she became rude, so he became rude right back. That is when she took his call light off him and placed it in the garbage can where he could not reach it. He indicated that she then left the room and shut the door. He indicated that it was concerning to him because he was not able to reach the call bell if needed, and since the door was closed, he would not be able to yell out for assistance because no one would be able to hear him. He indicated that even his roommate at the time was ringing his call bell and no one would come. He indicated that it was not until the next shift when they finally came into his room.</p> <p>Interview with Registered Nurse 1 on March 13, 2024, at 4:19 p.m. revealed that Resident 1 stated that Nurse Aide 3 came into his room and was rude. He had asked her for his call bell and Nurse Aide 3 would act as if she was going to give the call bell to him and then she would pull the call bell away, so he swore at her. Nurse Aide 3 made the resident mad by placing the call bell away from him, so that he could not use it. She indicated that at the time of her interview with the resident, she was not thinking it was abuse.</p> <p>Interview with the Nursing Home Administrator on March 15, 2024, at 11:08 a.m. confirmed that the incident between Resident 1 and Nurse Aide 3 was considered abuse per their policy.</p> <p>28 Pa. Code 201.14(a) Responsibility of Licensee.</p> <p>28 Pa. Code 201.18(b)(1)(e)(1) Management.</p> <p>28 Pa. Code 201.29(a)(j) Resident Rights.</p> <p>28 Pa. Code 211.12(d)(5) Nursing Services.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>31760</p> <p>Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to thoroughly investigate potential abuse for one of four residents reviewed (Resident 1).</p> <p>Findings include:</p> <p>The facility's policy regarding abuse, dated August 29, 2023, indicated that the facility would not tolerate abuse, neglect, mistreatment, exploitation of residents, and misappropriation of resident property. The facility would investigate all alleged, suspicions, and incidents of abuse, neglect, involuntary seclusion, intimidation, exploitation of residents, misappropriation of resident property, and injuries of unknown source. Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Mental abuse includes, but is not limited to, humiliation, harassment, and threats of punishment or deprivation.</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated December 20, 2023, revealed that the resident could understand and was understood. A care plan for an Activities of Daily Living (ADL) self-care deficit, dated February 12, 2024, indicated that staff was to encourage the resident to use the call bell to call for assistance as needed. The resident was at risk for falls, and staff was to always keep the call light in reach and to keep personal items and frequently used items within reach.</p> <p>An interview with Resident 1, completed by Registered Nurse 1, dated January 24, 2024, revealed that on January 24, 2024, at shift change, Agency Nurse Aide 2 (on the 400-unit) asked the registered nurse to go speak with Resident 1 regarding an incident that happened in the evening, and she did not want to be inadvertently associated with it. Agency Nurse Aide 3 from an unknown agency was working the first assignment on the 400 unit. Per Resident 1's report, Agency Nurse Aide 3 was rough with him during evening care, which he did not think too much of. Afterwards, Nurse Aide 3 did not place the bed remote and call light within his reach, to which Resident 1 asked her for these items. Resident 1 claims that Nurse Aide 3 stated she would give him back the call bell only if he agrees to not ring out until 10:00 p.m. Resident 1 stated he does not utilize the call bell except for emergencies and continued to ask for the call light back. At this time, Resident 1 stated that Nurse Aide 3 began to offer and retract the call light to him in a game-like manner that was upsetting to him. Resident 1 stated he then told Nurse Aide 3 to give him his damn call light, to which Nurse Aide 3 then refused because the resident was swearing. Nurse Aide 3 then dropped the call light in the resident's trash can and left the room, closing the door behind her. Resident 1 stated that the heat was turned on in the room, making it very hot, and that he was unable to utilize the call bell and that his door was closed. Resident 1 stated that he does not want to be at this facility and spends too much money to be here and to be treated in this manner. Resident 1 asked the writer to have Nurse Aide 3 terminated. This writer explained that Nurse Aide 3 was an outside agency staff, but that this matter would be addressed in a formal grievance to be handled by the appropriate management. Resident 1 seemed pleased with this outcome.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with the Assistant Director of Nursing on March 13, 2024, at 2:35 p.m. revealed that when she came in to work the next morning, she was advised of the situation between Resident 1 and Nurse Aide 3. She went back to speak with Resident 1 and at that time the resident did not feel it was abuse because the other nurse aide had gotten him his call light, and that he did not want Nurse Aide 3 caring for him again. She indicated that is when the facility called Nurse Aide 3's agency and told them that she was not allowed to come back to the facility.</p> <p>There was no documented evidence of the interaction between the Assistant Director of Nursing and Resident 1 on the morning following the incident on January 24, 2024. There was no documented evidence that statements were obtained from Nurse Aide 2, Nurse Aide 3, and/or Resident 1's roommate.</p> <p>Interview with the Resident 1 on March 13, 2024, at 2:45 p.m. revealed that he had asked Nurse Aide 3 to do something for him but he could not recall what it was. He indicated that she became rude, so he became rude right back. That is when she took his call light off him and placed it in the garbage can where he could not reach it. He indicated that she then left the room and shut the door. He indicated that it was concerning to him because he was not able to reach the call bell if needed, and since the door was closed, he would not be able to yell out for assistance because no one would be able to hear him. He indicated that even his roommate at the time was ringing his call bell and no one would come. He indicated that it was not until the next shift when they finally came into his room.</p> <p>Interview with the Director of Nursing on March 13, 2024, at 3:35 p.m. confirmed that there was no documented evidence of the interaction between the Assistant Director of Nursing and Resident 1 the following morning after the incident on January 24, 2024.</p> <p>Interview with Registered Nurse 1 on March 13, 2024, at 4:19 p.m. revealed that Resident 1 stated that Nurse Aide 3 came into his room and was rude. He had asked her for his call bell and Nurse Aide 3 would act as if she was going to give the call bell to him and then she would pull the call bell away, so he swore at her. Nurse Aide 3 made the resident mad by placing the call bell away from him, so that he could not use it. She indicated that at the time of her interview with the resident, she was not thinking it was abuse and confirmed that she did not obtain statements from Nurse Aide 2, Nurse Aide 3, and/or Resident 1's roommate.</p> <p>Interview with the Nursing Home Administrator on March 15, 2024, at 11:08 a.m. confirmed that the incident between Resident 1 and Nurse Aide 3 on January 24, 2024, was not thoroughly investigated as per their policy.</p> <p>28 Pa. Code 201.18(e)(1) Management.</p> <p>28 Pa. Code 211.12(d)(5) Nursing Services.</p>