STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395604	A. Building B. Wing	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greene Health & Rehab Center	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)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 48941 Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to maintain accountability for controlled medications (drugs with the potential to be abused) for three of five residents reviewed (Residents 3, 4, 5). Findings include: The facility's policy for medication administration, dated September 26, 2024, indicated to document the administration of controlled substances in accordance with applicable law and to document necessary medication administration/treatment information (e.g., when medications are given and as needed medications) on appropriate forms. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 3, dated February 4, 2025, revealed that the resident was cognitively intact, required assistance with care needs, had pain frequently rated a 10 of 10 on a pain scale of 0-10, was receiving an opioid (narcotic pain medication that can lead to addiction) for pain, and had diagnoses that included a fracture to the right lower leg. Physician's orders for Resident 3, dated November 27, 2024, included an order for the resident to receive 50 milligrams (mg) of Tramadol (a narcotic pain medication) every six hours as needed for moderate to severe pain rated a 7-10 on a pain scale. Review of the controlled drug record (a form that accounts for each tablet/pill/dose of a controlled drug) for Resident 3, dated February, March and April 2025 revealed that a 50 mg Tramadol tablet was signed out on February 15 at 11:03 a.m.; February 17 at 8:15 p.m.; March 2 at 9:05 p.m.; March 6 at 8:25 p.m.; March 10 at 8:03 p.m.; March 14 at 8:10 p.m.; March 15 at 9:01 p.m.; March 20 at 9:00 p.m.; April 7 at 2:50 p.m. and 8:20 p.m.; April 14 at 8:30 p.m.; April 17 at 7:45 p.m.; and April 23 at 12:35 a.m. However, there was no documented evidence in Resident 3's clinical record, including the Medication Administration Record (MAR), that the signed-out doses of controlled medications were administered to the resident on the above-mentioned dates and times. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An annual MDS assessment for Resident 4, dated February 4, 2025, revealed that the resident was cognitively intact, required assistance with care needs, had pain frequently rated a 4 of 10 on a pain scale of 0-10, was receiving opioid medications for pain, and had diagnoses that included osteoarthritis, chronic pain syndrome and fibromyalgia (chronic condition causing pain in muscles and joints throughout the body). Physician's orders for Resident 4, dated December 10, 2024, included an order for the resident to receive 5-325 mg of oxycodone-acetaminophen (a narcotic pain medication) three times daily for pain. Review of the controlled drug record for Resident 4, dated March 2025, revealed that a 5-325 mg oxycodone-acetaminophen tablet was signed out on March 29 at 7:30 p.m. However, there was no documented evidence in Resident 4's clinical record, including the MAR, that the signed-out dose of controlled medication was administered to the resident on the above-mentioned date and time. A quarterly MDS assessment for Resident 5, dated March 5, 2025, revealed that the resident was cognitively intact, required assistance with care needs, had pain frequently rated a 5 of 10 on a pain scale of 0-10, was receiving opioid medications for pain, and had diagnoses that include chronic pain and polyneuropathy (disease affecting peripheral nerves in the hands, feet, arms and legs). Physician's orders for Resident 5, dated December 28, 2023, included an order for the resident to receive 5-325 mg of hydrocodone-acetaminophen (a narcotic pain medication) every four hours as needed for moderate pain. Review of the controlled drug record for Resident 5, dated February 2025, revealed that a 5-325 mg hydrocodone-acetaminophen tablet was signed out on February 25, at 2:40 a.m. However, there was no documented evidence in Resident 5's clinical record, including the MAR, that the signed-out dose of controlled medication was administered to the resident on the above-mentioned date and time. Interview with the Director of Nursing on April 24, 2025, at 3:46 p.m. confirmed that there was no documented evidence in Resident 3's, 4's and 5's clinical records to indicate that the signed-out doses of controlled medications were administered on the above-mentioned dates and times. 28 Pa. Code 211.9(a)(1) Pharmacy Services. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.

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(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 - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 48941 Based on a review of clinical records, as well as resident and staff interviews, it was determined that the facility failed to maintain clinical records that were complete and accurately documented for five of five residents reviewed (Residents 1, 2, 3, 4, 5). Findings include: The facility's policy for medication administration, dated September 26, 2024, indicated to document the administration of controlled substances (drugs with the potential to be abused) in accordance with applicable law and to document necessary medication administration/treatment information (e.g., when medications are given and as needed medications) on appropriate forms. An annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated April 9, 2025, revealed that the resident was cognitively intact, required assistance with care needs, was receiving a scheduled opioid (narcotic pain medication that can lead to addiction) for pain, and had diagnoses that included multiple sclerosis (MS-chronic disease that affects nerves in the brain and spinal cord) and chronic pain. Physician's orders for Resident 1, dated September 18, 2024, included an order for the resident to receive 50 milligrams (mg) of Tramadol (a narcotic pain medication) every four hours and to hold for sedation and document. A review of the Medication Administration Record (MAR) for Resident 1, dated February and March 2025, revealed that 50 mg of Tramadol was administered to the resident on February 8 at 4:00 p.m. and 8:00 p.m.; February 9 at 12:00 a.m. and 4:00 a.m.; February 25 at 4:00 a.m.; March 28 at 8:00 p.m.; and March 29 at 12:00 a.m. However, a review of the resident's controlled medication record (a form that accounts for each tablet/pill/dose of a controlled drug), dated February and March 2025, revealed no documented evidence that 50 mg of Tramadol was signed out for administration on the above-mentioned dates and times. A quarterly MDS assessment for Resident 2, dated February 12, 2025, revealed that the resident was cognitively intact, required assistance with care needs, had pain rated a 5 of 10 on a pain scale of 0-10, was receiving opioid medications for pain, and had diagnoses that included polyneuropathy (disease affecting peripheral nerves in the hands, feet, arms and legs) and spinal stenosis (condition where the spaces within the spine narrow). Physician's orders for Resident 2, dated April 4, 2025, included an order for the resident to receive 50 mg of Tramadol every six hours. A review of the MAR for Resident 2, dated April 2025, revealed that 50 mg of Tramadol was administered to the resident on April 5, at 12:00 a.m. However, a review of the resident's controlled medication record, dated April 2025, revealed no documented evidence that 50 mg of Tramadol was signed out for administration on the above-mentioned date and time. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A quarterly MDS assessment for Resident 3, dated February 4, 2025, revealed that the resident was cognitively intact, required assistance with care needs, had pain frequently rated a 10 of 10 on a pain scale of 0-10, was receiving opioid medications for pain, and had diagnoses that included a fracture to the right lower leg. Physician's orders for Resident 3, dated November 27, 2024, included an order for the resident to receive 50 mg of Tramadol every six hours as needed for moderate to severe pain rated a 7-10 on a pain scale. A review of the MAR for Resident 3, dated February and April 2025 revealed that 50 mg of Tramadol was administered to the resident on February 18 at 1:19 a.m. and April 22 at 9:08 p.m. However, a review of the resident's controlled medication record, dated February and April 2025, revealed no documented evidence that 50 mg of Tramadol was signed out for administration on the above-mentioned dates and times. An annual MDS assessment for Resident 4, dated February 4, 2025, revealed that the resident was cognitively intact, required assistance with care needs, had pain frequently rated a 4 of 10 on a pain scale of 0-10, was receiving opioid medications for pain, and had diagnoses that included osteoarthritis, chronic pain syndrome, and fibromyalgia (chronic condition causing pain in muscles and joints throughout the body). Physician's orders for Resident 4, dated December 10, 2024, included an order for the resident to receive 5-325 mg of oxycodone-acetaminophen (a narcotic pain medication) three times daily for pain. A review of the MAR for Resident 4, dated February 2025, revealed that 5-325 mg of oxycodone-acetaminophen was administered to the resident on February 8, at 2:00 p.m. However, a review of the resident's controlled medication record, dated February 2025, revealed no documented evidence that 5-325 mg of oxycodone-acetaminophen was signed out for administration on the above-mentioned date and time. Physician's orders for Resident 4, dated April 2, 2025, included an order for the resident to receive 7.5 mg of oxycodone (a narcotic pain medication) every six hours. A review of the MAR for Resident 4, dated April 2025, revealed that 7.5 mg of oxycodone was administered to the resident on April 22 at 12:00 p.m. and 6:00 p.m., and April 23 at 12:00 a.m. However, a review of the resident's controlled medication record, dated April 2025, revealed no documented evidence that 7.5 mg of oxycodone was signed out for administration on the above-mentioned dates and times. A quarterly MDS assessment for Resident 5, dated March 5, 2025, revealed that the resident was cognitively intact, required assistance with care needs, had pain frequently rated a 5 of 10 on a pain scale of 0-10, was receiving opioid medications for pain, and had diagnoses that include chronic pain and polyneuropathy, Physician's orders for Resident 5, dated December 27, 2023, included an order for the resident to receive 5-325 mg of hydrocodone-acetaminophen (a narcotic pain medication) twice daily for chronic pain. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the MAR for Resident 5, dated March 2025, revealed that 5-325 mg of hydrocodone-acetaminophen was administered to the resident on March 31 at bedtime. However, a review of the resident's controlled medication record, dated March 2025, revealed no documented evidence that 5-325 mg of hydrocodone-acetaminophen was signed out for administration on the above-mentioned date and time. Interview with the Director of Nursing on April 24, 2025, at 3:46 p.m. confirmed that there was no documented evidence that the above-mentioned medications were signed out for administration on the controlled medication sheets for Residents 1, 2, 3, 4, and 5 on the above-mentioned dates and times. 28 Pa Code 211.5(f) Clinical Records. 28 Pa. Code 211.12(d)(5) Nursing Services.