

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  09/05/2025
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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>Based on review of Pennsylvania's Nursing Practice Act and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that a professional (registered) nurse assessed a resident after a change in condition for one of eight residents reviewed (Resident 4). Findings include: The Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.11 (a)(1)(2)(4) indicated that the registered nurse was to collect complete and ongoing data to determine nursing care needs, analyze the health status of individuals and compare the data with the norm when determining nursing care needs, and carry out nursing care actions that promote, maintain, and restore the well-being of individuals. The facility's Registered Nurse Charge Nurse job description, undated, revealed the primary purpose of the job was to assess resident's needs. An essential function of the position was to notify the physician, responsible parties, or other necessary parties with changes in condition. The facility's policy regarding pain management, dated July 22, 2025, indicated that acute pain was usually sudden onset and time-limited with a duration of less than one month and often caused by injury, trauma, or medical treatments. A pain evaluation would occur with any onset of new pain. The physician or provider would be notified of new onset or pain or a significant increase in pain as appropriate. The facility's policy regarding change in condition, dated July 22, 2025, indicated that the physician/provider would be notified when there has been a significant change in the resident's physical, emotional, and mental condition. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 4, dated June 25, 2025, revealed that the resident was cognitively intact, was usually understood, and could usually understand, and required assistance from staff for daily care needs. A nursing note written by a licensed practical nurse dated September 2, 2025, at 4:47 a.m. indicated Resident 4 was having a lot of pain this shift that was not relieved with her scheduled Tylenol (pain medication). Resident 4 was complaining of her leg and back hurting; she cried out in pain if she was moved at all and yelled to stop touching her leg when she is being rolled. She cried multiple times that she just wanted to die and doesn't understand why she had to live in such pain. A note was written in the physician's communication book requesting comfort care, stronger pain medicine, or hospice. There was no documented evidence in the clinical record to indicate that Resident 4 was assessed by a registered nurse when she had pain that was uncontrolled with Tylenol, when she was crying out while being rolled, or after stating that she just wanted to die. Interview with the Director of Nursing on September 5, 2025, at 6:11 p.m. confirmed there was no documented evidence of a registered nurse assessment at the time of Resident 4's pain, and there should have been. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  Facility ID: 395604	If continuation sheet Page 1 of 6

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>Based on review of facility policies, clinical records, and shower schedules, as well as staff interviews, it was determined that the facility failed to ensure that residents were provided with showers as scheduled for one of eight residents reviewed (Resident 5). Findings include: The facility policy for bathing and showering, dated July 22, 2025, indicated that residents will be bathed or showered according to their preferences. Each resident will be scheduled to receive bathing a minimum of two times per week unless they prefer less frequently. If the bath/shower cannot be given or the resident refuses, the nursing assistant will promptly report this to the charge nurse. The charge nurse will speak to the resident who refuses to ascertain why they are refusing and to determine if alternative arrangements that suit the resident can be made. If the resident continues to refuse, the charge nurse will document the resident's refusal in the medical record. An admission Minimum Data Set (MDS) assessment (a mandatory assessment of a resident's abilities and care needs) for Resident 5, dated July 7, 2025, revealed that the resident was cognitively impaired, required partial/moderate assistance with bathing, was occasionally incontinent of urine and had a diagnosis of diabetes. A care plan for Resident 5, dated July 2, 2025, indicated that the resident preferred to shower two times per week on the day shift on Sundays and Thursdays, and may refuse showers at any time and a prompt bed bath would be administered with skin checks. A review of the bathing detail report and weekly skin sheets for Resident 5 from July 3, 2025, through August 17, 2025, revealed that there was no documented evidence that the resident received a shower per her preference and care plan, and there was no documented evidence that the resident refused her showers, requiring that a bed bath be given. Interview with the Director of Nursing on September 5, 2025, at 5:23 p.m. confirmed that there was no documented evidence that Resident 5 received and/or refused showers from July 3, 2025, through August 17, 2025, as per the resident's preferences and plan of care. He indicated that he also noticed some days when 'did not occur' was documented and could not explain why it was being documented that way. 28 Pa. Code 211.12(d)(5) Nursing services.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on clinical record reviews, as well as staff interviews, it was determined that the facility failed to follow physician's orders for one of eight residents reviewed (Resident 5). Findings include: An admission Minimum Data Set (MDS) assessment (a mandatory assessment of a resident's abilities and care needs) for Resident 5, dated July 7, 2025, revealed that the resident was cognitively impaired, required partial/moderate assistance with care needs, and received routine pain medication. Physician's orders for Resident 5, dated July 1, 2025, included an order for the resident to receive 500 milligrams (mg) of Naproxen (a non-steroidal anti-inflammatory pain medication) twice a day with meals. A review of Resident 5's Medication Administration Record (MAR) for August 2025 revealed no documented evidence that the resident received the Naproxen on August 6, 2025 at 6:00 p.m.; August 9, 2025 at 6:00 p.m.; August 21, 2025 at 9:00 a.m. and 6:00 p.m.; August 25 at 9:00 a.m. and 6:00 p.m.; and August 27 at 9:00 a.m. Interview with the Director of Nursing on September 5, 2025, at 5:23 p.m. confirmed that Resident 5 did not receive her Naproxen on the above-mentioned dates and times as per physician's orders. He indicated that Naproxen is stocked in the emergency box, and that Naproxen is an over the counter medication that could be obtained as a stock medication. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>Based on review of facility policies, and residents' clinical records, as well as staff interviews, it was determined that the facility failed to provide pain management for one of eight residents reviewed (Resident 4). Findings include: The facility's policy regarding pain management, dated July 22, 2025, indicated that acute pain was usually a sudden onset and time-limited with a duration of less than one month, and often caused by injury, trauma, or medical treatments. A pain evaluation would occur with any onset of new pain. The physician or provider would be notified of a new onset of pain, or a significant increase in pain, as appropriate. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 4, dated June 25, 2025, revealed that the resident was cognitively intact, was usually understood, and could usually understand, and required assistance from staff for daily care needs. Physician orders for Resident 4 dated November 20, 2024, included an order for her to receive 650 milligrams (mg) Phorbetol (Tylenol, an over-the-counter medication used for the temporary relief of minor aches and pains and to reduce fever) three times a day. A review of the physician's communication book revealed an entry dated August 28, 2025, indicating that Resident 4 had swelling, couldn't sleep, and had increased pain. A nursing note for Resident 4, dated August 29, 2025, at 2:29 p.m. indicated that she had a Doppler (a medical test that uses sound waves to visualize and assess blood flow in vessels and organs) which was positive for a deep vein thrombosis (DVT - a blood clot in a vein) in the left lower extremity. New orders were received for Eliquis (anticoagulant blood thinning medication) 10 mg twice a day for seven days then 5 mg twice a day. A nursing note for Resident 4, dated September 2, 2025, at 4:47 a.m. revealed: The resident was having a lot of pain this shift that was not relieved with her scheduled Tylenol (pain medication). She was complaining of her leg and back hurting and cries out in pain if she is moved and yelled to stop touching her leg when being rolled. She cried multiple times that she just wanted to die and doesn't understand why she had to live in such pain. A note was placed in the physician's communication book (notebook where staff document resident issues for the physician to address when they are in the facility next) requesting comfort care, stronger pain medicine, or hospice for Resident 4. However, there was no documented evidence in the clinical record to indicate that the physician was contacted at that time for additional interventions or treatment to relieve her pain. Interview with the Director of Nursing on September 5, 2025, at 5:45 p.m. confirmed that Resident 4's acute pain was not controlled and should have been. 28 Pa. Code 211.12(d)(3)(5) Nursing Services.</p>

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>Based on review of policies and observations, as well as staff interviews, it was determined that the facility failed to serve palatable food that was at appropriate temperatures. Findings include: The facility's policy regarding food temperatures, dated February 5, 2025, revealed that hot foods would be plated at 135 degrees Fahrenheit (F) when plated and should be palatable at the point of delivery. Cold foods were to be served at a temperature of 41 degrees F or below. Review of the posted menus for the lunch meal on Friday, September 5, 2025, revealed that residents were to receive potato encrusted fish, rice pilaf, creamy coleslaw, sliced carrots (alternative), a citrus banana cup, and milk. A test tray for the lunch meal on the 200 nursing unit on September 5, 2025, revealed that the cart left the kitchen at 12:26 p.m., arrived on the nursing unit at 12:27 p.m., and the last resident was served at 12:53 p.m. The test tray was tasted at 12:54 p.m. and the potato encrusted fish was 121.1 degrees F, the sliced carrots were 120.4 degrees F, the creamy coleslaw was 67.7 degrees F, the fruit cup was 62.0 degrees F, and the milk was 59.8 degrees F. The fish and carrots were lukewarm and not hot to taste, and were not palatable at those temperatures. The fruit cup, coleslaw and milk were not cold to taste, and were not palatable at those temperatures. Interview with the Dietary Technician at that time confirmed that the foods were not served at the proper temperatures. 28 Pa. Code 211.6(f) Dietary Services.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on review of policies, as well as observations and staff interviews, it was determined that the facility failed to store and prepare food under sanitary conditions. Findings include: The facility's policy for storage of refrigerated foods, dated February 5, 2025, revealed that refrigerated foods would be marked to indicate the date the food would be consumed or discarded. A deep cleaning calendar, dated August 2025, revealed that staff were to clean an area of the kitchen each day of the week. On Sundays the morning dietary aide was to clean the outside of the dish machine and wipe all walls around the machine; however there was no documented evidence that this was completed each Sunday during the month. There were only two days of the month that staff signed off on the calendar that the cleaning was completed. Observations in the main kitchen on September 5, 2025, at 8:50 a.m. revealed that in the walk-in refrigerator there were cartons of macaroni salad and potato salad, and a container of pasta salad that were not labeled or dated; the convection oven had a build up of food and debris on the metal edges and had a build up of thick dust and debris on top where skillets were stored; a large black box (grease trap) located under the dishwasher area had a large build up of food and debris on the top of the box; a ceiling vent above the two compartment sink had a build of dust; the flooring around the stove and ice machine was black; and the ice machine filter located in the front of the ice machine had a build up of thick dust. Interview with the Dietary Technician on September 5, 2025, at 9:01 a.m. confirmed that the food in the walk in refrigerator should have been labeled, and confirmed that the items mentioned above were dirty and needed cleaned. 28 Pa. Code 211.6(f) Dietary Services.</p>