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	02/04/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on a review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that a resident's dignity was maintained for two of five residents reviewed (Resident 2 and 4). Findings include: The facility's policy regarding call lights, dated October 28, 2025, indicated that staff members who are alerted of an activated call light are responsible for responding promptly to promote a secure atmosphere for residents. A quarterly Minimum Data Set (MDS) assessment (a federally-mandated assessment of a resident's abilities and care needs) for Resident 2, dated January 9, 2025, revealed that the resident was alert and oriented, able to make his needs known, required assistance from staff for daily care needs including toileting, hygiene, and transfers and had medical diagnosis that included multiple sclerosis (disease affects the nerves in the brain and spinal cord). Interview with Resident 2 on February 28, 2023, at 1:56 p.m. revealed that he had to wait for an extended period of time for staff to respond to his call bell. A call bell log for January 2026, for Resident 2 revealed that it took staff 19 minutes to respond to his call bell on January 1, 2026. It took staff 21 minutes to respond to his call bell on January 3; 27 minutes to respond on January 11; 19 minutes on January 26; 1 hour on January 27; 41 minutes on January 28; and 18 minutes on January 31, 2026. A call log for February 2026 revealed it took staff 16 minutes to respond to his call bell on February 1 at 8:51 a.m. and 46 minutes on February 1, 2026, at 2:48 p.m. An annual MDS assessment for Resident 4, dated January 6, 2026, revealed that the resident was cognitively intact, required assistance from staff for daily care needs including toileting, hygiene, and transfers and had medical diagnosis that included hemiplegia (severe or complete loss of strength on one side of the body) and hemiparesis (weakness on one side of the body)following a stroke and diabetes. Review of a grievance form for Resident 4 dated December 15, 2025, revealed that the resident stated that he was put into bed on Sunday at about 10:00 p.m. and no one checked on him until around 4:00 a.m. He tried calling the nurses station with his cellphone, but it just rang and rang. Then staff did come in and help him, and they told him they were short staffed. Review of a call bell log for Resident 4 dated December 14, 2025, through December 16, 2025, revealed that his call bell was activated on December 14, 2025, at 9:19:49 p.m. and the response time for that call out was one hour and 47 seconds. Interview with Resident 4 on February 3, 2026, at 3.24 p.m. revealed that on the evening of December 14, 2025, it took staff a long time to get him into bed after he made the request. He would sometimes call the front desk to get a faster response than waiting for staff to respond to his call bell, however, that night no one answered the telephone at the front desk. Interview with the Assistant Director of Nursing on February 3, 2026, at 3:22 p.m. revealed that the call bell wait times listed above were excessive and not acceptable, and that she expects the call bells to be answered within five minutes as anyone can answer a call bell. 28 Pa. Code 201.29(j) Resident rights.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 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 per their preferences and plan of care for one of five residents reviewed (Resident 5).Findings include: The facility policy for bathing and showering, dated October 28, 2025, indicated that residents will be bathed or showered according to their preferences in order to maintain healthy hygiene and skin conditions. The charge nurse will speak with 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. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 5, dated December 4, 2025, revealed that the resident is cognitively impaired, required assistance from staff for daily care needs including bathing, and had diagnosis that included dementia. A care plan dated July 29, 2024, revealed that the resident preferred showers twice a week on Wednesdays and Saturdays. She may refuse showers at any time, and a bed bath will be provided. A review of the bathing detail report for Resident 5 from December 1, 2025, through January 31, 2026, revealed that she did not receive showers on Saturday December 6, Wednesday December 10, Saturday December13, Wednesday December 17, Saturday December 20, Wednesday December 24, Saturday December 27, Wednesday December 29, 2025, Saturday January 3, Wednesday January 7, Saturday January 10, Saturday January 17, Wednesday January 21, Saturday January 24, and Saturday January 31, 2026. Interview with the Assistant Director of Nursing on February 3, 2026, at 1:06 a.m. confirmed that there is no documented evidence that staff offered Resident 5 showers and that she refused. She confirmed she should have had a shower per her preference. 28 Pa. Code 211.12(d)(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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on review of facility policies, observations, and staff interviews, it was determined that the facility failed to ensure that medications were properly stored and labeled for two of five residents reviewed (Residents 1, 3). Findings include: The facility's policy for medication administration dated October 28, 2025, indicated that facility staff should not leave medications or chemicals unattended.A quarterly Minimum Data Set (MDS) for Resident 1, dated December 17, 2025, indicated that the resident was cognitively intact, requires assistance with daily care needs, and has diagnosis that included heart failure, anxiety, depression. Observation of Resident 1 on February 3, 2026, at 9:14 a.m. revealed that the resident was lying in her bed in her room. An unsupervised medicine cup with twelve unlabeled pills in it was sitting on her overbed table. An interview with Resident 1 at that time revealed that she did know the pills were on her table and that nurses will frequently leave her pills sitting there. An interview with Licensed Practical Nurse 1 on February 3, 2026, at 9:16 a.m. revealed that he did leave medication in Resident 1's room because he thought she was going to take them after eating her breakfast tray. He did not stay in the room to observe the resident take the medication. An interview with the Assistant Director of Nursing on February 3, 2026, at 9:50 a.m. confirmed that medications should not have been left unsupervised and unlabeled at the bedside for Resident 1. A quarterly MDS for Resident 3, dated October 30, 2025, indicated that the resident was cognitively intact, requires assistance with daily care needs, and has diagnosis that included noninfective gastroenteritis and colitis (digestive tract inflammations). Physician's orders for Resident 3 dated January 19, 2026, included for the resident to receive triamcinolone 0.1% cream (a prescription-strength topical medication used to relieve skin inflammation) to her back and hips twice a day for dermatitis (conditions that cause inflammation of the skin). Observation of Resident 3 on February 3, 2026, at 9:26 a.m. revealed that the resident was laying in her bed in room and a box containing triamcinolone 0.1% cream was sitting on the bottom left side of her bed, next to the door, unsupervised by staff. Interview with the Assistant Director of Nursing on February 3, 2026, at 9:30 a.m. confirmed that the triamcinolone 0.1% cream should not have been left unsupervised on Resident 3's bed. 28 Pa. Code 211.9(a)(1) Pharmacy Services. 28 Pa. Code 211.12(d)(1) Nursing Services.