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	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greene Health & Rehab Center	119 Industrial Park Road Greensburg, PA 15601

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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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records and staff interviews, it was determined that the facility failed to ensure that a resident's legal representative (power of attorney) was given the opportunity to make decisions regarding physical/sexual contact between residents for one of 14 residents reviewed (Resident 12).Findings include:A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 12, dated March 18, 2026, indicated that the resident was severely confused, was independent with ambulation, and had diagnoses that included Korsakoff's dementia (a type of brain disorder that causes memory loss, impaired thinking and behaviors). Resident 12's clinical record revealed that his daughter, Family Member 1 was his power of attorney and decision maker.Observations of Resident 12 on April 21, 2026 at 10:22 a.m. revealed that he was walking with Resident 11 with her holding his arm as they walked. Staff redirected them from the exit door and had them sit together at the dining table.Nursing note for Resident 12, dated December 14, 2025 at 5:29 a.m. revealed that Resident 12 was observed talking with Resident 11, holding her hand and kissing her.Nursing note for Resident 12, dated December 14, 2025 at 1:24 p.m. indicated that Resident 12 was wandering the unit with Resident 11 and they were trying to leave the unit.Nurse's note for Resident 12, dated December 29, 2025 indicated that Resident 12 was walking with and holding hands with Resident 11.Nurse's note for Resident 12, dated March 12, 2026 at 7:10 p.m. revealed that he was found in Resident 11's bed next to her with his pants unbuttoned and he was exposed to her. When the facility notified his daughter/POA she was angry because she was previously told that they would be separated.Interview with Family Member 1 on April 22, 2026 at 9:26 a.m. revealed that she was told in early December, shortly after Resident 12's admission, that Resident 11 had attached herself to him like he was her boyfriend. She stated that because her father is only [AGE] years old and is still married to her mother, she did not want him around Resident 11. She said that she had visited several times and each time Resident 11 would follow them around and tell Resident 12 that they needed to leave together. She said on March 12, 2026 the nurse phoned her and told her that her father was found in bed with Resident 11 and that he was exposed. She said she was angry and came to the facility within an hour or so and when she arrived he was sitting with Resident 11 on the bench in front of the nurse's station. She said he was holding Resident 11's hand and she had her head resting on his shoulder. She said she was angry because she asked that they be separated and that any contact between them not be permitted or encouraged. She said that she has made it very clear that she does not want her father to be around Resident 11.Interview with Assistant Director of Nursing on April 22, 2026 at 2:30 p.m. revealed that Resident 11 believes Resident 12 to be her boyfriend and that they are always together. She further stated that Resident 12's daughter has said she does not want her father with Resident 11, but that Resident 11 is too difficult to redirect.28 Pa. Code 211.12(d)(3) Nursing services.

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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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on review of policies, clinical records, and facility grievance forms, as well as staff interviews, it was determined that the facility failed to include the steps taken to investigate the grievance, a summary of the pertinent findings or conclusion regarding the family's concerns, or any corrective action taken or to be taken by the facility as a result of the grievance for one of 14 residents reviewed (Resident 6).Findings include: The facility's grievance policy, dated April 20, 2026, indicated that the resident had a right to voice grievances to the facility, or other agencies or entities that hear grievances, without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment that has been furnished, the behavior of staff, and other residents and any other concern regarding the resident's stay. Upon receipt of an oral, written, or anonymous grievance submitted by a resident, the Grievance Official would take immediate action to prevent further potential violations of any resident right while the alleged violation was being investigated, if indicated. The Grievance Committee/Grievance Official would complete an investigation of the residents' grievance. This may include a review of the facility processes, programs and policies, as well as interviews with staff, residents and visitors, as indicated, and any other review deemed necessary by the Grievance Committee. The grievance review would be completed in a reasonable time frame consistent with the type of grievance, but in no event would the review exceed thirty days. Upon completion of the review, the Grievance Official would complete a written grievance decision the included the date the grievance was received, a summary of the statement of the resident's grievance, steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns, a statement as to whether the resident's grievance was confirmed or not confirmed, whether any corrective action was taken or would be taken, and the date the written decision was issued.An admission Minimum Data Set (MDS) assessment (a federally-mandated assessment of a resident's abilities and care needs) for Resident 6, dated March 30, 2026, revealed that the resident was moderately cognitively impaired, able to make her needs known, and had a urinary tract infection.A nursing note written by the Case Manager , dated April 15, 2026, at 8:03 a.m. revealed that a voicemail was received from Resident 6's family member to return her call regarding Resident 6. Resident Family Member 6 was upset about being moved from a private room and multiple other things on the 400 wing. It was explained that she would speak with management on this in the morning meeting, and she would return her call.However, there was no documented evidence that Resident Family Member 6's concerns were followed up with, as indicated in the nurse's notes. There was no documented evidence that Resident Family Member 6's complaint/grievance was thoroughly investigated.A review of the Grievance log for April 2026 revealed that there was no grievance investigation regarding Resident Family Member 6's concerns.Interview with the Case Manager on April 22, 2026, at 11:47 a.m. confirmed that she did not make a follow up call to Resident Family Member 6 regarding her concerns.Interview with Social Service on April 22, 2026, at 12:21 p.m. revealed that Resident Family Member 6 had concerns regarding being moved out of a private room and that staff weren't being nice to her. She confirmed that there had been no call to the family and they were very angry.28 Pa. Code 201.29(i) Resident rights.

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	395604	A. Building B. Wing	04/22/2026

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on clinical record reviews and staff interviews, it was determined that the facility failed to provide the resident/resident's responsible party with complete information regarding medications upon discharge for one of 14 residents reviewed (Resident 6) who were discharged to home.Findings include:An admission Minimum Data Set (MDS) assessment (a federally mandated assessment of a resident's abilities and care needs) for Resident 6, dated November 21, 2025, revealed that the resident was cognitively intact, was incontinent of bowel and bladder, was at risk for developing pressure ulcers, and had no current pressure ulcers.An admission Minimum Data Set (MDS) assessment (a federally mandated assessment of a resident's abilities and care needs) for Resident 6, dated March 30, 2026, revealed that the resident was moderately cognitively impaired, able to make her needs known, and had a urinary tract infection.Physician's orders, dated March 12 and 24, and April 6, 2026, included orders for the resident to receive 650 milligrams (mg) of acetaminophen every six hours as needed, 100 mg of allopurinol (used to treat gout) twice a day, 5 mg of Eliquis (blood thinner) twice day, 10 mg of famotidine (used to treat acid reflux and heartburn) daily, 800 micrograms (mcg) of folic acid (supplement) daily, 24 units of Lantus(insulin glargine) daily, 500 mg of levetiracetam (anti-convulsant medication) twice a day, 25 mcg of levothyroxine (used to treat thyroid disease) daily, a multivitamin daily, 20 mg of nadolol (used to treat heart disease) daily, a sliding scale (amount of insulin based on blood sugar results) of Novolog (insulin) before meals and at bedtime, 50 mg of pregabalin (anti-convulsant medication) daily, 17 grams of polyethylene glycol as needed for constipation, 100 mg of thiamine (vitamin B supplement) daily, 50 mg of tramadol (pain medication) every six as needed, and 550 mg of Xifaxan (antibiotic) twice a day.A nursing note dated April 15, 2026, at 11:12 a.m. revealed the resident's family member was in to take Resident 6 home. The resident was educated on all discharge orders and medications and all belongings and medications including narcotics were sent home with the resident.The discharge instructions for Resident 6, dated April 15, 2026, revealed that the resident was being discharged home and the current list of medications and instructions provided to the resident at the time of discharge on ly included Novolog, Lantus, acetaminophen, and polyethylene glycol. There was no documented evidence that the resident or her family was provided a complete list of current medications and instructions.Interview with the Director of Nursing on April 22, 2026, at 6:07 p.m. confirmed that there was no documented evidence that Resident 6 or her family was provided a complete list of her current medications and instructions.28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on review of clinical records and staff interviews, it was determined that the facility failed to develop a comprehensive care plan that included specific and individualized interventions to address the care needs of residents with dementia for two of 14 residents reviewed (Residents 8, 12) and failed to develop a comprehensive care plan that included specific and individualized interventions to address the activity preferences of residents residing within the Memory Impaired Unit for 1 of 14 residents reviewed (Resident 9). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 8, dated March 11, 2026, indicated that the resident was cognitively impaired, required moderate assistance with daily care needs, and had diagnoses that included Dementia (a type of brain disorder that causes memory loss, impaired thinking and behaviors). There was no documented evidence that a care plan was developed to address Resident 8's individual care and treatment needs related to her dementia.A quarterly MDS assessment for Resident 12, dated March 18, 2026, indicated that the resident was severely confused, was independent with ambulation, and had diagnoses that included Korsakoff's dementia (a type of brain disorder that causes memory loss, impaired thinking and behaviors). Observations of Resident 12 on April 21, 2026 at 10:22 a.m. revealed that he was walking with Resident 11 with her holding his arm as they walked. Staff redirected them from the exit door and had them sit together at the dining table.Nursing note for Resident 12, dated December 14, 2025 at 5:29 a.m. revealed that Resident 12 was observed talking with Resident 11, holding her hand and kissing her.Nursing note for Resident 12, dated December 14, 2025 at 1:24 p.m. indicated that Resident 12 was wandering the unit with Resident 11 and they were trying to leave the unit.Nurse's note for Resident 12, dated December 29, 2025 indicated that Resident 12 was walking with and holding hands with Resident 11.Nurse's note for Resident 12, dated March 12, 2026 at 7:10 p.m. revealed that he was found in Resident 11's bed next to her with his pants unbuttoned and he was exposed to her. When the facility notified his daughter/POA she was angry because she was previously told that they would be separated.There was no documented evidence that a care plan was developed to address Resident 12's individual care and treatment needs related to his dementia or behaviors. A quarterly MDS assessment for Resident 9, dated March 30, 2026, revealed that the resident was cognitively impaired, required staff assistance for daily care needs, and had diagnoses that included dementia. There was no documented evidence that a care plan was developed to address Resident 9's individual activity preferences, likes, or dislikes.An interview with the Activity Director and Social Services Director on April 22, 2026 at 4:33 p.m. revealed that they were not educated regarding care planning for resident's dementia needs and that is why Resident's 8 and 12 did not have dementia specific care plans or activity care plans.28 Pa. Code 211.11(d) Resident care plans.28 Pa. Code 211.12(d)(1)(5) Nursing services.

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Greene Health & Rehab Center	119 Industrial Park Road Greensburg, PA 15601

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on review of the Pennsylvania Nursing Practice Act, residents' clinical records, and staff interviews, it was determined that the facility failed to ensure that a registered nurse completed a timely assessment when changes in condition occurred for one of 14 residents reviewed (Resident 8).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.A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 8, dated March 11, 2026, revealed that the resident was cognitively impaired and required assistance from staff for daily care. A nursing note for Resident 8, dated March 29, 2026, at 6:00 p.m. revealed that the resident reported pain in peri area (area of skin and muscle between the genitals and anus) when sitting in chair in dining area. Resident reports she has no pain with laying in bed or walking. During a shower the Licensed Practical Nurse was called in to observe resident's peri area, where resident had previously had a prolapse observed, now the area is very enlarged more than three times any size previously observed. Licensed Practical Nurse reported to supervisor the prolapse and complaints of pain when sitting in a chair. Will monitor and await supervisor's assessment and any changes made by physician. There was no documented evidence that a registered nurse assessed Resident 8's change in condition when she complained of pain. Interview with the Clinical Consultant on April 22, 2026, at 1:21 p.m. confirmed that Resident 8 should have been assessed by a registered nurse and the assessment should have been documented in the resident's medical record.28 Pa. Code 211.12(d)(1)(3) Nursing services. 28 Pa. Code 211.12(d)(5) Nursing services.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. Based on a review of facility policy, the facility assessment and clinical records, as well as observations and family and staff interviews, it was determined that the facility failed to provide adequate ongoing activities designed to meet the needs of six of six residents reviewed (Residents 7, 8, 9, 10, 11, 12) who resided in the Memory Impaired Unit (MIU) and had behaviors and/or dementia. Findings include:The facility's policy regarding Dementia Care, dated April 20, 2026 revealed that staff will be trained to provide necessary care and services that are person-centered and reflect the resident's goals, while maximizing the dignity, autonomy, privacy, socialization, independence, choice, and safety of the resident. Staff would be familiar with dementia care approaches and each resident's person-centered care plan. Individualized, non-pharmacological approaches to care will be utilized, including the provision of meaningful life enrichment activities.The facility's assessment, dated April 6, 2026 revealed that the MIU offers specialized cognitive activities provided by staff trained in dementia care and that the Life Enrichment staffing requirements were one full time director and three full time aides.An quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 7, dated March 18, 2026, revealed that the resident was cognitively impaired, was dependent on staff for care needs, and had diagnoses that included dementia (a brain disorder that causes memory loss). The resident's care plan failed to identify the resident's activity preferences.A quarterly MDS assessment for Resident 8, dated March 11, 2026, revealed that the resident was cognitively impaired, required staff assistance for daily care needs, was independently ambulatory, and had diagnoses that included dementia. The resident's care plan failed to identify the resident's activity preferences.A quarterly MDS assessment for Resident 9, dated March 30, 2026, revealed that the resident was cognitively impaired, required staff assistance for daily care needs, and had diagnoses that included dementia. The resident's care plan failed to identify the resident's activity preferences.A quarterly MDS assessment for Resident 10, dated January 29, 2026, revealed that the resident was cognitively impaired, required assistance from staff with daily care needs, and had diagnoses that included dementia. The resident's care plan, dated March 5, 2026, was not individualized to identify the resident's activity preferences.A quarterly MDS for Resident 11, dated March 29, 2026, revealed that the resident was cognitively impaired, ambulated independently, had verbal behaviors, and had diagnoses that included dementia. The resident's care plan, dated November 11, 2025, indicated that the resident had behaviors and that staff were to provide activities that resembled her prior lifestyle, however, the resident's care plan was not individualized to reflect the resident's prior lifestyle or what she enjoyed to do.A quarterly MDS assessment for Resident 12, dated March 18, 2026, revealed that the resident was cognitively impaired, ambulated independently, and had diagnoses that included dementia. The resident's care plan failed to identify the resident's activity preferences. Observations in the MIU on April 21, 2026 at 11:20 a.m. revealed that there were 14 residents sitting around the tables in the common room. The activity aide was playing music, but was not engaging the residents in any activity. One resident pulled her shirt over her head exposing her breasts multiple times and staff was not always present in the common room to pull the resident's shirt down or cover her up. There were no further activities observed in the MIU on April 21, 2026. Observations in the MIU on April 22, 2026 at 10:00 a.m. revealed that the activity aide brought a coffee cart with donuts into the unit. At 10:20 a.m. the first resident was served a half a donut and a cup of iced tea. At 10:31 a.m. she finished passing donuts and drinks to the residents. There were two residents in the common room that were not offered donuts or drinks. She did not engage any residents in a group activity. Residents were observed wandering aimlessly, getting into the cupboards and drawers around the room, and yelling out. There were no other activities observed in the MIU on April 22, 2026.Observations in the MIU on April 22, 2026 at 10:46 a.m. revealed that there were two residents wandering the unit aimlessly, 11 residents sitting in the common area with no stimulation, and six residents sleeping in the common area.Interview with (continued on next page)

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	395604	A. Building B. Wing	04/22/2026

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Family Member 2 on April 21, 2026 at 12:14 p.m. revealed that she visits her mother daily and she has not seen any activities in the MIU for several months. She stated that she has asked that her mother be able to participate in some activities, especially bingo, but that none have been provided. She said she tries to interact with as many residents as she can so that they get some kind of stimulation because she felt bad that they just sit around and do nothing but sleep. She further stated that the activity aide was putting on a show today because she has not done anything in the MIU for months.Interview with Registered Nurse 1 on April 21, 2026 at 12:53 p.m. revealed that there have not been any activities in the MIU for some time. She stated that activities would help some of the residents who have behaviors and keep them from acting out, but she does not have time to do activities with them, nor do the nurse aides. She stated that the MIU might have three nurse aides scheduled, but one is usually pulled to go on appointments and that leaves two nurse aides for 30 residents and they do not have time to do activities.Interview with the Activities Director on April 21, 2026 at 1:36 p.m. revealed that she does not have enough staff to do activities in the MIU currently. She stated that she hopes to hire more staff, but in the mean time there is no one available to provide activities in the MIU and there has not been anyone for at least two months. Interview with the Nursing Home Administrator on April 22, 2026 at 3:24 p.m. revealed that the activity department is currently understaffed and that she is in the process of hiring new staff. She acknowledged that there is a need for activities in the MIU.28 Pa. Code 211.11(d) Resident care plan.28 Pa. Code 211.12(d)(3) Nursing services.

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	395604	A. Building B. Wing	04/22/2026

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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 review of clinical records, as well as staff interviews, it was determined that the facility failed to ensure that physician's orders were followed for four of 14 residents reviewed (Residents 4, 10, 11, 12). Findings include:A comprehensive Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 4, dated March 13, 2026, revealed that the resident was cognitively impaired and was dependent on staff for daily care needs.Physician's orders for Resident 4 dated November 7 and December 26, 2025, March 14 and April 15, 2026, included orders for the resident to receive 0.2 milligrams (mg) of Clonidine HCl (used to treat high blood pressure) every day in the morning, 20 mg of Lasix (used to treat fluid retention) every day in the morning, 10 mg of Memantine (used to treat memory) two times a day in the morning and evening, 50 mg Metoprolol tartrate (used to treat high blood pressure) two times a day in the morning and evening and 50 mg of Sertraline (used to treat depression) every day in the morning.Interview with Licensed Practical Nurse 1 on April 21, 2026, at 12:44 p.m. revealed that the morning medication administration times were between 6:15 and 10:00 a.m. and as of April 21, 2026, at 12:44 p.m. Resident 4 did not receive her morning medications as ordered by the physician.Interview with the Nursing Home Administrator on April 21, 2026, at 12:54 p.m. confirmed that Resident 4 did not receive her morning medication as ordered by her physician and she should have.A quarterly MDS assessment for Resident 10, dated January 29, 2026, revealed that the resident was cognitively impaired, required assistance from staff with daily care needs, and had diagnoses that included dementia. Nurse Practioner's note for Resident 10, dated April 6, 2026 revealed that the resident had fallen and that staff were to obtain orthostatic blood pressures (blood pressure taken while sitting, then standing, then lying) for three days. There was no documented evidence that staff obtained orthostatic blood pressures for Resident 10 as ordered. A quarterly MDS for Resident 11, dated March 29, 2026, revealed that the resident was cognitively impaired, ambulated independently, had verbal behaviors, and had diagnoses that included dementia. A quarterly MDS assessment for Resident 12, dated March 18, 2026, revealed that the resident was cognitively impaired, ambulated independently, and had diagnoses that included dementia. Nurse's note for Resident 12, dated March 12, 2026 at 7:10 p.m. revealed that he was found in Resident 11's bed next to her with his pants unbuttoned and he was exposed to her. When the facility notified his daughter/POA she was angry because she was previously told that they would be separated and she was told that Resident 12 would be seen by psychiatric services in the morning. Nursing note for Resident 11, dated March 16, 2026 revealed that the resident's legal guardian and daughter were notified of the incident with Resident 12 and that Resident 11 would be seen by psychiatric services in the morning. There was no documented evidence that Resident 11 or Resident 12 were seen by psychiatric services after the incident on March 12, 2026 as their families were told would happen. An interview with the Nursing Home Administrator and Clinical Consultant on April 22, 2026 at 4:24 p.m. revealed that the orthostatic blood pressures were not obtained for Resident 10, and Residents 11 and 12 were not seen by psychiatric services and they should have been. 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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	395604	A. Building B. Wing	04/22/2026

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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 reviews and staff interviews, it was determined that the facility failed to follow recommendations from the optometrist for a follow-up appointment for one of 14 residents reviewed (Resident 5).Findings include:A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 5, dated December 31, 2025, revealed that the resident was cognitively intact and required maximum assistance for daily care needs.An optometry (a profession that specializes in caring for your eyes) consult for Resident 5, dated March 21, 2025, revealed that the resident presented for a diabetic eye exam and an evaluation of bilateral cataracts (a progressive eye condition that causes blurred vision) and recommended that the resident returned in six months for a follow up examination. There was no documented evidence that the optometrist recommendation for Resident 5 to return in six months was completed or that the resident's physician disagreed with the optometrist's plan of care.Interview with the Nursing Home Administrator on April 22, 2026, at 3:10 p.m. confirmed that there was no documented evidence that Resident 5 had a follow up appointment completed as recommended by the optometrist.28 Pa. Code 211.12(d)(3)(5) Nursing Services.

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	395604	A. Building B. Wing	04/22/2026

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on a review of facility policy and clinical records, observations, and staff interviews, it was determined that the facility failed to ensure that a device for fall prevention was in place as care planned for one of 14 residents reviewed (Resident 10).Findings include:The facility's policy regarding fall prevention and management, dated April 20, 2026, indicated if risks are identified, preventive measures will be put in place as care planned.A comprehensive Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 10, dated January 29, 2026, revealed that the resident had severe cognitive impairment, was sometimes understood, rarely/never understand, and had diagnoses that included dementia. Resident 10's care plan, dated March 5, 2026, indicated that the resident utilized a chair alarm while she is in her chair, and for staff to ensure the alarm is always working.Observations of Resident 10 on April 21, 2026, at 11:56 a.m. revealed that she was sitting in her Broda chair (specialized wheel chair) and that there was chair alarm visible. Observations of Resident 10 on April 21, 2026 at 12:27 p.m. revealed that she stood up out of her chair, no alarm sounded, and staff was not aware of her standing.Interview with Registered Nurse 2 on April 21, 2026, at 12:34 p.m. confirmed that Resident 10's chair alarm was not in place, and that it should have been.Interview with the Nursing Home Administrator on April 21, 2026, at 3:50 p.m. confirmed that Resident 10's chair alarm should have been in place.28 Pa. Code 211.10(a) Resident care policies.28 Pa. Code 211.12(d)(3)(5) Nursing services.

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	04/22/2026

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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 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. Based on review of facility policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure that residents were provided with proper colostomy care for two of 14 residents reviewed (Residents 3, 10). Findings include:The facility's policy regarding colostomy care (care for an artificial opening in the bowel), dated April 20, 2026, indicated that when colostomy care was provided and the drainage bag was replaced, staff were to measure the stoma (surgically created opening that connects the intestines to the outside) size using the measuring guide and trace the pattern of the size of the opening on the wafer (adhesive component that attaches to the skin around the stoma) backing and cut the opening to size.A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 3, dated February 24, 2026, indicated that the resident was cognitively impaired, required assistance from staff for daily care needs, and had an ostomy (a surgically created opening in the abdomen- part of the body between the chest and the hips). A physician's order, dated September 19, 2025, included an order for the colostomy bag and set up to be changed every three days, and the bag to be dated when changed, per the family request.Observations of Resident 3 on April 21, 2026, at 1:15 p.m. with Licensed Practical Nurse 3, revealed that there was no date marked anywhere on her colostomy bag.Interview with Licensed Practical Nurse 3 on April 21, 2026, at 1:15 p.m. confirmed that the colostomy bag was not dated and should have been.A quarterly MDS assessment for Resident 10, dated January 29, 2026, revealed that the resident was cognitively impaired, required assistance from staff for all her daily care needs, and had a colostomy (an opening in the abdomen that allows waste to exit the body).Observations of Resident 10 on April 21, 2026, at 12:35 p.m. revealed that the resident's colostomy bag/site was being changed by Registered Nurse 1. The registered nurse was standing at her medication cart in the common room where she was observed to cut a hole in the ostomy wafer and gathered other materials. Once in the resident's room Registered Nurse 1 cleaned the skin around the stoma, applied skin prep (a barrier applied on skin to be a barrier between the skin and adhesive), and then applied the wafer and attached bag. The wafer was visibly large compared to the stoma. Registered Nurse 1 did not measure the stoma site or apply the wafer close to the stoma.Interview with Registered Nurse 1 on April 21, 2026, at 12:35 p.m. revealed that she did not measure the stoma to cut the wafer and stated she just eyeballs it.Interview with the Director of Nursing on April 21, 2026, at 2:48 p.m. confirmed that staff should measure the stoma to cut the wafer to size. 28 Pa. Code 211.12(d)(5) Nursing Services.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide for the safe, appropriate administration of IV fluids for a resident when needed. Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that intravenous catheters were flushed according to the facility's policy for one of 14 residents reviewed (Resident 4). Findings include:The facility's policy regarding flushing intravenous (IV) catheters (a thin tube placed in a vein that can be used for an extended period of time to deliver fluids and/or medications), dated April 20, 2026, revealed that flushing is performed to ensure and maintain catheter patency and to prevent the mixing of incompatible medications/solutions. All peripheral IV catheters are flushed between incompatible medications with normal saline or other flush solution as recommended by the manufacturer.A comprehensive Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 4, dated March 13, 2026, revealed that the resident was cognitively impaired and was dependent on staff for daily care needs.Physician's orders for Resident 4, dated April 13, 2026, included orders to insert a peripheral IV catheter to administer 1 gram (gm) of Rocephin (an antibiotic) once a day during the evening from April 14 thru April 18, 2026. Review of Resident 4's Medication Administration Records (MAR's) for April 2026 revealed that the resident received 1 gm Rocephin in the evening from April 14 thru April 18, 2026; however, there was no documented evidence that staff flushed the peripheral IV catheter before and after the administration.Interview with the Director of Nursing on April 22, 2026, at 8:49 a.m. confirmed that there was no documented evidence that Resident 4's IV catheter was flushed before and after the medication administration.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 - Some	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility policy, facility's assessment, clinical record reviews, observations, family interviews and staff interviews, it was determined that the facility failed to provide appropriate treatment and services for four of six residents reviewed who reside in the Memory Impaired Unit (MIU) (Residents 9, 10, 11, 12) who had dementia which has led to frequent falls and behaviors.Findings include: The facility's assessment, dated April 6, 2026 revealed that the MIU offers specialized cognitive activities provided by staff trained in dementia care and that the Life Enrichment staffing requirements were one full time director and three full time aides. A quarterly MDS assessment for Resident 9, dated March 30, 2026, revealed that the resident was cognitively impaired, required staff assistance for daily care needs, and had diagnoses that included dementia. The resident's care plan failed to identify the resident's activity preferences. A quarterly MDS assessment for Resident 10, dated January 29, 2026, revealed that the resident was cognitively impaired, required assistance from staff with daily care needs, and had diagnoses that included dementia. The resident's care plan, dated March 5, 2026, was not individualized to identify the resident's activity preferences. A quarterly MDS for Resident 11, dated March 29, 2026, revealed that the resident was cognitively impaired, ambulated independently, had verbal behaviors, and had diagnoses that included dementia. The resident's care plan, dated November 11, 2025, indicated that the resident had behaviors and that staff were to provide activities that resembled her prior lifestyle, however, the resident's care plan was not individualized to reflect the resident's prior lifestyle or what she enjoyed to do. A quarterly MDS assessment for Resident 12, dated March 18, 2026, revealed that the resident was cognitively impaired, ambulated independently, and had diagnoses that included dementia. The resident's care plan failed to identify the resident's activity preferences. Observations in the MIU on April 21, 2026 at 11:20 a.m. revealed that there were 14 residents sitting around the tables in the common room. The activity aide was playing music, but was not engaging the residents in any activity. One resident pulled her shirt over her head exposing her breasts multiple times and there were not always staff in the common room to pull her shirt down or cover her up. There were no further activities observed in the MIU on April 21, 2026. Observations in the MIU on April 22, 2026 at 10:00 a.m. revealed that the activity aide brought a coffee cart with donuts into the unit. At 10:20 a.m. the first resident was served a half a donut and a cup of iced tea. At 10:31 a.m. she finished passing donuts and drinks to the residents. There were two residents in the common room that were not offered donuts or drinks. She did not engage any residents in a group activity. Residents were observed wandering aimlessly, getting into the cupboards and drawers around the room, and yelling out. There were no other activities observed in the MIU on April 22, 2026. Observations in the MIU on April 22, 2026 at 10:46 a.m. revealed that there were two residents wandering the unit aimlessly, 11 residents sitting in the common area with no stimulation, and six residents sleeping in the common area. Nursing note for Resident 9, dated April 17, 2026 at 4:26 p.m. revealed that he was in a physical altercation with his roommate where he punched his roommate in the face. Nursing note for Resident 10, dated January 30, 2026 revealed that she fell out of bed onto the floor. Nursing note dated February 5, 2026 revealed that she fell while self-transferring. Nursing note dated February 6, 2026 revealed that Resident 10 was found in another resident's room, attempted to self-transfer and fell. Nursing note dated February 8, 2026 revealed that she fell while trying to self-transfer. Nursing note dated February 10, 2026 revealed that she threw herself on the floor after being redirected out of another resident's room. Nursing note dated March 16, 2026 revealed that she fell when trying to self-transfer in the common room. Nursing note dated March 18, 2026 revealed that she fell while attempting to self-transfer from one chair to another and that she had another fall in her later that night. Nursing note dated April 2, 2026 revealed that she attempted to self-transfer and fell to the (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	floor in the common room. Nursing note dated April 4, 2026 revealed that the resident fell while trying to take herself to the bathroom. Nursing note dated April 8, 2026 revealed that the resident removed her ostomy bag (a bag connected to a surgical opening on the abdominal wall to allow feces to leave the body) and staff could not locate it and that the resident was smearing feces around in miscellaneous places. Nursing note dated April 15, 2026 revealed that the resident fell in her room while trying to self-transfer to her bed and later that evening had another fall in front of the nurse's station when trying to stand independently. Nursing note dated April 16, 2026 revealed that the resident fell while trying to take herself to the restroom. Nursing note dated April 17, 2026 revealed that the resident fell in her room while trying to self-transfer. Nursing note for Resident 11, dated December 16, 2025 revealed that the resident was spending more time with Resident 12 and that they were holding hands. Nursing note dated December 19, 2025 revealed that Residents 11 and 12 were trying to leave the unit and were unable to be separated from each other. Nursing note dated December 29, 2025 revealed that Resident 11 was walking with Resident 12 and holding hands and that staff were unable to redirect them. Nursing note dated January 7, 2026 revealed that Resident 11 continuously attempted to enter Resident 12's room. Nursing note dated March 6, 2026 revealed that Resident 11 punched another resident in the jaw and was then pushed to the floor by that resident. Nursing note dated March 12, 2026 revealed that Resident 11 was sitting on her bed with Resident 12 who had his pants unbuttoned and was exposed. Nursing note dated March 25, 2026 revealed that Resident 11 was attempting to hold Resident 12's hand and attempted to take him into her room. Nursing note for Resident 12, dated December 14, 2025 at 5:29 a.m. revealed that Resident 12 was observed talking with Resident 11, holding her hand and kissing her. Interview with Family Member 1 on April 22, 2026 at 9:26 a.m. revealed that she was told in early December, shortly after Resident 12's admission, that Resident 11 had attached herself to him like he was her boyfriend. She stated that because her father is only [AGE] years old and is still married to her mother, she did not want him around Resident 11. She said that she had visited several times and each time Resident 11 would follow them around and tell Resident 12 that they needed to leave together. She said on March 12, 2026 the nurse phoned her and told her that her father was found in bed with Resident 11 and that he was exposed. She said she was angry and came to the facility within an hour or so and when she arrived he was sitting with Resident 11 on the bench in front of the nurse's station. She said he was holding Resident 11's hand and she had her head resting on his shoulder. She said she was angry because she asked that they be separated and that any contact between them not be permitted or encouraged. She said that she has made it very clear that she does not want her father to be around Resident 11. Interview with Register Nurse 1 on April 21, 2026 at 12:53 p.m. revealed that there have not been any activities in the MIU for some time and that each resident has their own behaviors and sometimes they aren't able to get along with one another. Interview with Nurse Aide 2 on April 21, 2026 at 11:18 a.m. revealed that she is an agency aide but that she has come to the facility several times. She stated that she does not have time to do anything other than resident care and cannot watch the residents while she is in a room doing care. She said that the residents wander around the locked unit but that there is no one to redirect them while the two nurse aides are providing care and the nurse is passing medications or doing treatments. She stated that there were supposed to be three nurse aides, but one of them was called away to do something else. She explained that when she is providing care for a resident in the MIU she has to take her time and sometimes it can take up to a half an hour to get someone ready in the morning because she has to be able to explain what she is doing and go slowly or else the residents can get violent with her. Interview with Nurse Aide 3 on April 22, 2026 at 11:08 a.m. revealed that there were supposed to be three nurse aides in the MIU today, however, one of them was pulled to go on a trip with another resident leaving on the two nurse aides for 30 residents. She stated that the residents are pretty much on their own when they are doing care because there is no one else to watch them. She stated they try to take the residents into the common area, but that many of them wander and end up getting into things they should not, or into (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	rooms they should not go in. Interview with the Assistant Director of Nursing on April 22, 2026 at 2:01 p.m. revealed that the residents that reside on the Memory Impaired Unit require special care due to their dementia. Interview with the Nursing Home Administrator on April 22, 2026 at 3:24 p.m. revealed that the facility's staffing is currently out of compliance and according to the current staffing information provided by the Nursing Home Administrator, the facility is unable to meet the necessary nurse aide ratios or the daily PPD (direct nursing care per resident per day). 28 Pa. Code 211.11(d) Resident care plan. 28 Pa. Code 211.12(d)(5) Nursing services.