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	12/09/2025

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 notify the resident representative and ombudsman, in writing, regarding the reason for hospitalization, and failed to notify the resident about the facility's bed-hold policy at the time of transfer for three of 42 residents reviewed (Residents 2, 29, 105), and failed to provide a reconciliation of all pre-discharge medications with the resident's post-discharge medications for two of 42 residents reviewed (Resident 103 and 105).Findings include: A nursing note for Resident 2, dated January 30, 2025, at 12:21 a.m. revealed that the resident was transferred to the hospital for evaluation after a fall due to a radius (a bone in the lower arm) fracture. There was no documented evidence that a written notice of Resident 2's transfer to the hospital was provided to the emergency contact or the long-term ombudsman regarding the reason for transfer or was notified about the facility's bed-hold policy at the time of transfer. A nursing note for Resident 29, dated September 30, 2025, at 6:26 p.m., revealed that the resident was admitted to the hospital with sepsis (a life-threatening medical emergency where the body damages its own tissues and organs in response to an infection) and urinary tract infection. There was no documented evidence that a written notice of Resident 29's transfer to the hospital was provided to the resident's emergency contact or the long-term ombudsman regarding the reason for transfer or was notified about the facility's bed-hold policy at the time of transfer. A nursing note for Resident 105, dated July 4, 2025, at 11:71 p.m., revealed that the resident was admitted to the hospital with sepsis and hypotension (low blood pressure). There was no documented evidence that a written notice of Resident 105's transfer to the hospital was provided to the resident's responsible party or ombudsman regarding the reason for transfer or was notified about the facility's bed-hold policy at the time of transfer.Interview with the Director of Nursing on November 5, 2025, at 2:23 p.m. confirmed that the facility did not provide a written notice of the reason for transfer to the hospital to Residents 2, 29, and 105 or to the responsible parties and ombudsman, and also confirmed that bed hold notices were not provided when the residents were transferred to the hospital.A nursing note for Resident 103 dated September 17, 2025, revealed that the resident ceased to breathe and the body was being released to the funeral home. There was no documented evidence in Resident 103's clinical record of a medication reconciliation post death.A nursing note for Resident 105 dated July 24, 2025, revealed that her son came to pick up her personal effects, and that she wouldn't be returning to the facility. There was no documented evidence in Resident 105's clinical record of a medication reconciliation post discharge. Interview with the Interim Director of Nursing on November 06, 2025, at 12:59 p.m. confirmed that medication reconciliations were not completed for Residents 103 and 105 and should have been. 28 Pa Code 201.14(a) Responsibility of licensee.

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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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to respond to a pharmacy recommendation for five of 42 residents reviewed (Residents 11, 29, 37, 57, 71).Findings include:A facility policy related to medication regimen review, March 26, 2025, revealed that when the pharmacist identifies a time-sensitive medication related concern the issue will be escalated to the medical director for immediate action by facility staff, and the Medication regimen review will be addressed by the attending physician in a timely manner. A Quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 11, dated September 4, 2025, revealed that the resident was cognitively impaired, required partial assistance for care from staff, and had diagnosis of hypertension (high blood pressure), coronary heart disease, and anemia (low iron levels). A pharmacy consultant note for Resident 11, dated August 15, 2025, revealed that the pharmacist recommended that the resident have Comprehensive Metabolic Panel (a blood test to check for organ health, electrolytes, and check blood sugar) Fasting Lipids (a blood test to check fat levels) CBC (a common blood test that measures the components of blood), Magnesium, Iron, and Vitamin D levels drawn on the next lab day. A physician order for Resident 11 dated September 2, 2025, for a comprehensive metabolic panel, electrolytes, fasting lipids, CBC, magnesium, Iron and Vitamin D levels were to be drawn that day. Laboratory results for Resident 11 revealed that the blood work was completed on September 2, 2025. An interview with the Interim Director of Nursing on November 4, 2025, at 9:52 a.m. confirmed that the physician should have addressed the pharmacist recommendation sooner since it was time sensitive, and the laboratory test should have been completed on the next laboratory day and they were not. A quarterly MDS assessment for Resident 29, dated October 18, 2025, revealed that the resident was cognitively intact, was dependent on staff for daily care needs, and was receiving an antibiotic. A pharmacy consultant note for Resident 29, dated October 17, 2025, revealed a pharmacist recommendation to temporarily discontinue simvastatin during daptomycin therapy. Daptomycin and statin therapy with simvastatin may be associated with myopathy and rhabdomyolysis (a medical condition characterized by the breakdown of muscle tissue, leading to the release of harmful substances into the bloodstream). There was no documented evidence in the clinical record for Resident 29 the medical director reviewed the pharmacist recommendations. An interview with the Interim Director of Nursing on November 5, at 3:04 p.m. confirmed that the physician did not review any of the pharmacist medication regimen reviews for the month of October and they should have been addressed. A quarterly MDS assessment for Resident 37, dated August 14, 2025, indicated the resident was cognitively intact, required assistance, was understood, had pain, took opioid, anticoagulant, and antidepressant medications medications, and had diagnoses that included heart failure, anxiety and depression.A pharmacy medication regimen review note for Resident 37, dated August 15, 2025, indicated that there were irregularities noted and had recommendations to be reviewed. However, there was not documented evidence of the pharmacy medication review findings, and it was not reviewed by the medication director or practitioner. Interview with the Interim Director of Nursing on November 5, 2025, at 3:42 p.m. confirmed that there was no documented evidence on Resident 37's pharmacy review available and could not find any documentation when it was received or reviewed.An admission MDS assessment for Resident 57, dated October 10, 2025, indicated the resident was cognitively intact, required assistance, was understood, and had diagnoses that included renal failure and dementia.A pharmacy medication regimen review note for Resident 57, dated May 15, 2025, indicated that there were irregularities noted and had recommendations to be reviewed. However, there was not documented evidence of the pharmacy medication review findings, and it was not reviewed by the medication director or practitioner. Interview with the Interim Director of Nursing on November 5, 2025, at 3:42 p.m. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	confirmed that there was no documented evidence on Resident 57's pharmacy review available, and could not find any documentation when it was received or reviewed.A quarterly MDS assessment for Resident 71, dated October 6, 2025, revealed that the resident was cognitively intact, required assistance with care needs, received oxygen and intravenous medications (administration of fluids and/or medications directly into a person's vein), and had diagnoses including hypertension (high blood pressure), hyperlipidemia (high cholesterol), congestive heart failure (the heart can ' t pump blood well enough to meet the body's needs) and respiratory failure (blood does not have enough oxygen and causes difficulty breathing).A pharmacy medication regimen review for Resident 71, dated October 15, 2025, indicated that recent lab results (from September 9, 2025) showed an elevated ALT of 53 (had been 8 on August 8, 2025). The resident was ordered Acetaminophen 1000 milligrams (mg) at bedtime, Atorvastatin (medication used to treat high cholesterol) 20 mg at bedtime, and recently received Solu-Medrol injections (injectable corticosteroid medication used to treat severe inflammation). It was indicated that these medications could be the cause and the pharmacist recommended to consider monitoring a liver function test (LFT) panel. There was no documented evidence in the resident ' s clinical record that the recommendations from the pharmacist were addressed by the physician.An interview with the Director of Nursing on November 5, 2025, at 2:15 p.m. confirmed that there was no documented evidence in Resident 71's clinical record that the recommendations from the pharmacist on October 15, 2025, were addressed by the physician.28 Pa. Code 211.10(c) Resident care policies.28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to inform the resident or resident representative in advance of the risks and benefits of a psychotropic medication (medications that affect the persons mental state, emotions and behavior) and the treatment alternatives prior to initiating the administration of the medication for two of 42 residents reviewed (Residents 37 and 57).Findings include:A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 37, dated August 14, 2025, indicated the resident was cognitively intact, was understood, took antidepressant medications, and had diagnoses that included depression and anxiety.A nursing noted dated October 7, 2025, for Resident 37 indicated that she was evaluated by psychological consult because she reported feelings of anxiety, sadness, anger, and increased sleep disturbances. A psychological consult for Resident 37, dated October 7, 2025, indicated that the resident has gone three days without sleeping and feels upset and depressed. The resident has been feeling jumpy and wanted to cry a a lot. The resident was recommended to start Zoloft (antidepressant medication) and have her Trazodone (antidepressant medication) increased at bedtime. Physicians orders for Resident 37, dated October 7, 2025, revealed that the resident was to receive 100 milligram (mg) of Trazodone at bedtime for depression and 100 mg of Zoloft once a day for depression. There was no documented evidence in Resident 37's clinical record to indicate that the facility informed the resident or the resident's representative in advance of the risks and benefits of a psychotropic medication or alternative treatment options.An admission MDS assessment for Resident 57, dated October 10, 2025, indicated the resident was cognitively intact, required assistance, was understood, took antipsychotic medication, and had diagnoses that included bipolar disorder (mental health condition characterized by extreme mood swings) and dementia.A psychological consult for Resident 57, dated October 27, 2025, indicated that the resident looked liked she hadn't slept, was irritable, and reported she was still manic. The recommendation was made to increase Olanzpine (antipsychotic medication) by adding a morning dose.Physician's orders for Resident 57, dated October 24, 2025, included an order for the resident to receive 10 milligram (mg) of Olanzapine daily in the morning. There was no documented evidence in Resident 57's clinical record to indicate that the facility informed the resident or the resident's representative in advance of the risks and benefits of a psychotropic medication or alternative treatment options.An interview with the Social Services Director on November 4, 2025, at 1:15 p.m., revealed that she obtained signed consents for treatment for the psychiatry consult services, but does not obtain any consents for psychotropic medications.Interview with the Interim Director of Nursing of Nursing on November 5, 2025, at 9:50 a.m., confirmed that there was no documented evidence of informed consent and that the facility had failed to inform the resident or resident representative in advance of the risks and benefits of a psychotropic medication and other treatment options for Resident 37 and 57, and should have.28 Pa. Code 201.29(a)(j) Resident Rights.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility documents and clinical records, as well as staff interviews, it was determined that the facility failed to accommodate the resident's needs by failing to provide a bariatric broda chair for one of 42 residents reviewed (Resident 96). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 96, dated September 17, 2025, indicated that the resident was cognitively intact, was not ambulatory and was dependent for mobility in a wheelchair, was dependent for transfers, and had a diagnosis of morbid obesity. Observations of Resident 96 on November 3, 2025, at 12:47 p.m. revealed the resident was lying in a bariatric bed. An interview with the resident at that time revealed that she wanted to get out of bed. She indicated that they did not have a chair big enough. She stated that she was able to get up before and now she does not because they said she was not safe in her chair. An occupational therapy evaluation for Resident 96, dated September 12, 2025, indicated that the resident's current seating was a broda chair with huntingtons package and that the resident's weight at that time was 340 pounds and the current broda chair maximum weight was 350 pounds. Recommendations were made for the resident to have a bariatric broda chair with a huntingtons package due to the resident's increased risk for pressure injury with the current seating system. It was noted that the facility at that time did not have a bariatric broda chair available.A dietary note for Resident 96, dated September 18, 2025, at 7:06 p.m. indicated that due to the resident's weight gain, nursing and therapy were reporting that she is unable to fit safely in her broda chair. A physician note for Resident 96, dated October 2, 2025, at 9:10 p.m. indicated that the resident had a bariatric wheelchair to promote out of bed activity and that physical therapy had worked with resident on this issue in the past and a wider wheelchair is difficult to accommodate due to the facility door frames. Interview with Occupational Therapist 2 on November 6, 2025, at 12:19 p.m. indicated that Resident 96 had voiced her desire to get out of bed. A bariatric broda chair was being looked at to trial due to the resident not fitting well in her current broda chair and risk for skin impairment, but the facility did not have one. She did indicate that they did call around to the other [NAME] facilities to see it they could find a bariatric broda chair to trial, but they could not find one. She indicated that the only issue with getting a bariatric wheelchair or broda chair was that it would not fit through the doorway and the resident would have to use it outside of her room. She was not sure if the resident would be agreeable to that as she preferred to stay in her room. She also indicated that the resident was a safety risk in a bariatric wheelchair related to her lack of trunk control. Interview with Resident 96 on November 6, 2025, at 12:23 p.m. indicated that she would be agreeable to sit in a chair outside of her room if it meant she could get out of bed.Interview with the Nursing Home Administrator on November 6, 2025, at 1:58 p.m. indicated that they were aware that Resident 96 was recommended a bariatric broda chair and they could have gotten her one but did not due to the possibility of her being placed elsewhere to a facility that could better meet her needs. 28 Pa. Code 211.12(d)(5) Nursing services.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on clinical record reviews and staff interviews, it was determined that the facility failed to provide the required notice to the resident or the resident's representative following the end of their Medicare coverage for two of 42 residents reviewed (Resident 40 and 106). Findings include:A Skilled Nursing Facility Beneficiary Protection Notification Review form, completed by the facility and dated October 15, 2025, revealed that Medicare coverage for Resident 40 started on September 27, 2025, and that her last covered day was October 10, 2025. The form indicated that the facility initiated discontinuation from Medicare Part A coverage, and that the resident's benefit days were not exhausted. The Advanced Beneficiary Notice of Non-coverage for Resident 40 was not issued.A Skilled Nursing Facility Beneficiary Protection Notification Review form, completed by the facility and dated June 6, 2025, revealed that Medicare coverage for Resident 106 started on June 2, 2025, and that her last covered day was June 6, 2025. The form indicated that the facility initiated discontinuation from Medicare Part A coverage, and that the resident's benefit days were not exhausted. The Advanced Beneficiary Notice of Non-coverage for Resident 106 was not issue.Interview with the Business Office Manager on November 4, 2025, at 11:30 a.m. indicated that the facility had some recent staff changes and the Advanced Beneficiary Notices of Non-coverage forms for residents 40 and 106 were not provided as required. Interview with the Nursing Home Administrator on November 4, 2025, at 11:50 a.m. confirmed that Resident 40 and 106 were not provided with an Advanced Beneficiary Notice of Non-coverage as required when their Medicare coverage ended, and they should have been.28 Pa. Code 201.18(e)(1) Management.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies, owners manual, as well as observations and staff interviews, it was determined that the facility failed to provide a clean and homelike environment in one of three pantries reviewed (300/400 hall pantry).Findings include:The facility's policy regarding homelike environment, dated July 22, 2025, indicated that the facility staff and management were to the extent possible, maintain a facility that reflected a personalized homelike setting including a clean and sanitary environment.Observations of the 300/400 hall pantry on November 3, 2025, at 1:39 p.m. revealed that there was a moderate to large amount of brownish/black removable substance on the inside ceiling of the cooking cavity of the microwave. In addition, there were three areas on the inside frame of the microwave that ranged from one half inch to six inches in length where the paint was worn off and metal was exposed. The [NAME] Beach microwave oven owners manual for Model No.P11O43ALH-WTB indicated that the appliance should not be operated if it has been damaged in any way. Interview with the Maintenance Director and Assistant Director of Nursing on November 3, 2025, at 2:20 p.m. revealed that they were not aware of the dried on debris in the microwave, or the worn off paint and exposed metal on the inside frame of the microwave. They both indicated that it was unacceptable and that maintenance would remove the microwave from the pantry.28 Pa. Code 207.2(a) Administrator's Responsibility.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on review of policies, clinical records, and investigation documents, as well as staff interviews, it was determined that the facility failed to ensure that residents were free from abuse or neglect for one of 42 residents reviewed (Resident 7). Findings include:The facility's abuse policy, dated July 22, 2025, indicated that it is the facility's policy to investigate all allegations, suspicions and incidents of abuse, neglect, involuntary seclusion, intimidation, exploitation of residents, misappropriation of resident property and injuries of an unknown source. An annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 8, dated August 7, 2025, revealed that the resident was severely cognitively impaired. Resident 7's care plan, dated August 6, 2025, indicated that the resident had an overall decline in status with activities of daily living related to deconditioning and weakness and will be monitored for signs and symptoms of skin and/or wound infections. Nurse Aide Documentation for October 11, 2025, revealed that Resident 7 has a new bruise of unknown origin on her right wrist and forearm. There was no documented evidence that the facility conducted an investigation to rule out abuse or neglect as the cause of Resident 7's bruise. Interview with the Interim Director of Nursing on November 4, 2025, at 11:34 a.m. confirmed that the facility was not made aware of the new bruise of unknown origin and did not complete an investigation to rule out abuse. 28 Pa. Code 201.14(a) Responsibility of Licensee.28 Pa. Code 201.18(b)(1)(e)(1) Management.28 Pa. Code 201.29(a)(j) Resident Rights.28 Pa. Code 211.12(d)(5) Nursing Services.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on review of policies, investigative reports, and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that allegations of possible abuse were reported timely to the Nursing Home Administrator for one of 42 residents reviewed (Resident 7).Findings include:The facility's abuse policy dated July 22, 2025 indicated that staff were to report all allegations of abuse, neglect, involuntary seclusion, injuries of unknown source, and misappropriation resident property must be reported immediately to their direct supervision, the resident's responsible party and attending physician, if appropriate, will be notified. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 7, dated September 17, 2024, revealed that the resident was cognitively impaired and was dependent on staff for all daily care needs. Nurse Aide documentation for Resident 7 dated October 11, 2025, revealed that she had a bruise of unknown origin on her right wrist and forearm. However, as of November 4, 2025, there was no documented evidence that the nurse aide reported the bruise of unknown origin on Resident 7's right wrist and forearm per the facility's policy. Interview with the Director of Nursing on November 4, 2024, at 11:34 a.m. confirmed that the nurse aide should have reported the bruise on Resident 7's right arm and forearm timely. 28 Pa. Code 201.18(e)(1) Management.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on 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 care plan was updated/revised to reflect the resident's specific care needs for three of 42 residents reviewed (Residents 2, 7 and 68).Findings include: The facility's policy regarding care plans, dated July 22, 2025, indicated that a resident care plan conference is scheduled at least weekly to disucss each resident, review the previous care plan and to finalize the development of the current care plan. Adjustments are made by the interdisciplinary team to ensure that all programs and identified category of needs are addressed and that the plan is orientewd toward preventing a decline in functioning. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 2, dated October 9, 2025, revealed that the resident was cognitively impaired and was dependent on staff for care needs. Review of the care plan for Resident 2 dated December 12, 2024, indicated that the resident was receiving an anti-psychotic medication. A review of the clinical record for Resident 2 revealed that as of November 4 2025, there was no documented evidence the resident was receiving anti-psychotic medications. Review of the care plan for Resident 7 dated October 15, 2024, indicated that the resident was receiving an anti-psychotic medication. A review of the clinical record for Resident 7 revealed that as of November 4, 2025, there was no documented evidence the resident was receiving anti-psychotic medications. Interview with the Director of Nursing on November 5,2025 at 11:34 a.m. confirmed that the care plans for Residents 2 and 7 did not reflect the gradual dose reductions that were completed in January 2025, and that their care plans should have been updated to reflect they were no longer on the anti-psychotic.An annual MDS assessment for Resident 68, dated October 29, 2025, revealed that the resident was cognitively impaired and required assistance with care needs. A care plan for the resident, dated January 12, 2024, indicated that the resident had a potential for altered skin integrity related to limited mobility, altered cardiovascular status and edema and included an intervention for ace wraps as per orders on in the morning and off in the evening, and to monitor skin integrity with donning and doffing. There was no documented evidence in the resident's clinical records that he was ordered ace wraps. Interview with the Director of Nursing on November 6, 2025, at 11:51 a.m. confirmed that Resident 68's ace wraps were discontinued on July 29, 2025, and that his care plan should have been revised to reflect that they were discontinued.28 Pa. Code 211.12(d)(5) Nursing Services.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. Based on clinical record review and interviews with staff, it was determined that the facility failed to complete ambulation and transfer programs as ordered for one of 42 residents reviewed (Resident 10).Findings include:A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 10, dated October 22, 2025, revealed that the resident was cognitively impaired and was dependent on staff for transfers and ambulation. Physician's orders for Resident 10, dated October 16, 2025, included orders for the resident to walk in the corridor for 50 feet with a rollator (a walker with wheels) and one assist twice a day, and to stand and pivot with one assist from bed to wheelchair twice a day up to 15 minutes. A restorative care plan, dated October 24, 2025, indicated that Resident 10 was to stand and pivot twice a day for 15 minutes each time and walk in the corridor 50 ft with the rollator and gait belt twice a day for 15 minutes. There was no documented evidence in Resident 10's clinical record to indicate that the resident was offered and declined, or completed the standing/pivoting and ambulation program twice per day as ordered. Interview with the Director of Nursing on November 6, 2025, at 2:00 p.m. confirmed that the stand and pivot program and the ambulation program for Resident 10 were not completed twice per day per physician's orders or the resident's care plan. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 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 received proper care for indwelling urinary catheters for one of 42 residents reviewed who had an indwelling urinary catheter (Resident 100).Findings include:The facility's policy regarding indwelling urinary catheter (a flexible catheter used to drain urine from the bladder into a drainage collection bag) care procedure, dated July 22, 2025, indicated that the urinary drainage bag must be placed below the bladder level but not on the floor.An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 100, dated October 21, 2025, revealed that the resident was cognitively intact, had an indwelling urinary catheter, and had a diagnosis of obstructive uropathy (blockage of the urinary tract). A care plan for the resident, dated July 23, 2025, and revised October 28, 2025, revealed that the resident had an indwelling urinary catheter with an intervention not to allow the tubing or any part of the drainage system to touch the floor.Observations of Resident 100, on November 3, 2025, at 1:12 p.m. revealed that the resident was lying in his bed. His indwelling urinary catheter drainage bag/tubing were lying directly on the floor on the left side of the bed. Interview with Licensed Practical Nurse 3 on November 3, 2025, at 1:22 p.m. confirmed that Resident 100's indwelling urinary catheter bag/tubing should not have been on the floor and should at least be hanging on the bed or in a basin. He indicated that therapy had just brought him back and put him in bed.Interview with the Nursing Home Administrator on November 3, 2025, at 3:25 p.m. confirmed that Resident 100's indwelling catheter bag/tubing should not have been in direct contact with the floor.28 Pa. Code 211.12(d)(3)(5) Nursing Services.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. Based on review of facility policies and clinical records, as well as resident and staff interviews, it was determined that the facility failed to ensure that residents were assessed and received trauma-informed care to eliminate or mitigate triggers for residents with the diagnosis of Post Traumatic Stress Disorder (PTSD - a mental and behavioral disorder that develops related to a terrifying event) for one of 42 residents reviewed (Resident 81).Findings include:The facility's policy related to social services, dated July 22, 2025, indicated that social services would assist in implementing interventions for resident ' s needs by developing and maintaining care plans which are individualized, realistic, with measurable goals, including but not limited to trauma/PTSD. Social Services is responsible for assessing and ensuring residents who are trauma survivors receive culturally competent, trauma-informed care/approaches including identifying triggers and implementing approaches/interventions to help reduce the risk of re-traumatization.An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 81, dated October 21, 2025, revealed that the resident was cognitively intact and had diagnoses which included Post Traumatic Stress Disorder. A care plan for the resident, revised October 29, 2025, revealed that the resident was receiving antipsychotic medications related to PTSD.An interview with Resident 81 on November 6, 2025, at 3:22 p.m. revealed that she was in a domestic violence situation for 10 years with her first husband. She indicated that some of her triggers included loud noises and arguing and some male interactions. She stated that she follows with a female therapist that she has a good relationship with and takes medications that help. There was no documented evidence that the facility completed an assessment for a history of trauma for Resident 81 to identify specific triggers that could re-traumatize the resident.Interview with the Director of Nursing on November 6, 2025, at 3:40 p.m. confirmed that there was no documented evidence that the facility completed an assessment for a history of trauma for Resident 81 to identify specific triggers that could re-traumatize the resident.28 Pa. Code 211.12(a)(d)(3)(5) Nursing Services.28 Pa. Code 211.16(a) Social Services.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 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 two of 42 residents reviewed (Resident 37 and 73). Findings include:The facility's policy regarding medication administration, dated July 22, 2025, indicated that after medication administration, the facility staff should take all measures required by facility policy and applicable law, including but not limited to documenting necessary medication administration/treatment information (when the medication was given, prn/as needed medications) on appropriate forms. Document the administration of controlled substances in accordance with applicable law.A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 37, dated August 14, 2025, indicated the resident was cognitively intact, was understood, had pain, took opioid medications, and had diagnoses that included heart failure.Physician's orders for Resident 37, dated June 3, 2025, included an order for the resident to receive 5 milligrams (mg) of Oxycodone (a narcotic pain medication) every four every as needed for pain.Review of the controlled drug record (a form that accounts for each tablet/pill/dose of a controlled drug) for Resident 37, dated August 2025, revealed that a 5 mg tablet of Oxycodone was signed out on August 10 at 11:30 p.m. and August 20 at 10:30 a.m. However, there was no documented evidence in Resident 37's clinical record that the signed-out doses of Oxycodone were administered to the resident on the above-mentioned dates and times. Interview with the Interim Director of Nursing on November 6, 2025, at 2:20 p.m. confirmed that there was no documented evidence in Resident 37's clinical record to indicate that the signed-out doses of Oxycodone were administered to the resident on the above-mentioned dates and times.A quarterly MDS assessment for Resident 73, dated September 29, 2025, indicated that the resident was cognitively intact, required assistance with care needs, had pain and was taking an opioid medication (a narcotic medication used to treat pain).Physician's orders for Resident 73, dated August 7, 2025, included an order for the resident to receive 5 mg of Oxycodone every four hours as needed for moderate to severe pain.Review of the controlled drug record for Resident 73, dated August 2025 through October 2025, revealed that a 5 mg tablet of Oxycodone was signed out on August 8 at 8:05 a.m.; August at 8:20 a.m.; August 31 at 7:55 p.m.; September 10 at 2:15 a.m.; September 11 at 10:35 a.m.; September 12 at an undocumented time; September 14 at 9:15 p.m.; September 21 at 8:35 p.m.; September 28 at 8:30 a.m.; October 2 at 9:55 p.m.; October 5 at 8:42 p.m.; October 10 at 9:30 p.m.; October 16 at 8:25 p.m.; October 17 at 11:00 a.m.; October 20 at 8:40 a.m.; October 26 at 1:17 a.m.; October 27 at 2:00 a.m.; and October 30 at 7:00 p.m. However, there was no documented evidence in Resident 73's clinical record that the signed-out doses of Oxycodone were administered to the resident on the above-mentioned dates and times. Interview with the Director of Nursing on November 6, 2025, at 1:00 p.m. confirmed that there was no documented evidence in Resident 73's clinical record to indicate that the signed-out doses of Oxycodone were administered to the resident 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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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that residents were free from unnecessary psychotropic medications (medications that affect the mind, emotions and behavior), by failing to ensure that non-pharmacological (non-medication) behavioral interventions (individualized, non-pharmacological approaches to care), were attempted prior to the administration of as needed antianxiety medications (psychotropic medication used to treat anxiety) for one of 42 residents reviewed (Resident 81).Findings include:The facility's policy regarding psychotropic gradual dose reduction, dated July 22, 2025, indicated that the facility will use psychotropic medications only when necessary and beneficial, ensuring appropriate use, evaluation and monitoring. A plan of care will be developed to include specific non-pharmacological interventions. The non-pharmacological interventions will also be placed on the Resident Care Card.An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 81, dated October 21, 2025, revealed that the resident was cognitively intact and had diagnoses which included bipolar disorder and anxiety. A care plan for the resident, dated July 3, 2025, and revised October 29, 2025, revealed that the resident was receiving psychotropic medications related to depression and anxiety.Physician's orders for Resident 81, dated October 17, 2025, and October 24, 2025, included orders for the resident to receive 1 milligrams (mg) of clonazepam (a psychotropic medication used to treat anxiety) once a day as needed for anxiety.Review of the Medication Administration Record (MAR) for Resident 81 for October and November 2025 revealed that the resident was administered 1 mg of clonazepam on October 22 at 6:43 a.m.; October 25 at 8:10 a.m.; October 26 at 08:15 a.m.; October 28 at 12:25 p.m.; October 31 at 7:20 a.m.; and November 4 at 6:47 a.m. There was no documented evidence that non-pharmacological behavioral interventions were attempted prior to administering clonazepam on the above-mentioned dates and times.Interview with the Director of Nursing on November 6, 2025, at 3:40 p.m. confirmed that non-pharmacological interventions should have been attempted prior to the administration of as needed clonazepam to Resident 81 on the above-mentioned dates and times.28 Pa. Code 211.12(d)(5) Nursing services.

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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 policies, as well as observations and staff interviews, it was determined that the facility failed to ensure that medications were properly secured in the medication cart.Findings include:The facility's policy regarding medication administration, dated March 26, 2025, indicated that the purpose was to provide a method for the safe, accurate administration of oral medications to residents. Observations of the top drawer of the 300 hall medication cart on November 3, 2025, at 10:55 a.m. revealed an undated/unmarked medication cup that contained two white oval tablets, one oval yellow tablet, one oval beige tablet, one white pearl shaped capsule, one white oblong tablet and one white small round tablet.Interview with Registered Nurse 4 at that time, confirmed that an undated/unmarked medication cup that contained medications was in the top drawer of the 300 hall medication cart, and it should not have been.Interview with the Interim Director of Nursing on November 3, 2023, at 11:08 a.m. confirmed that an undated/unmarked medication cup that contained medications should not have been in the top drawer of the medication cart.28 Pa. Code 211.9(a)(1) Pharmacy services. 28 Pa. Code 211.12(d)(5) Nursing services.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on a review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to maintain clinical records that were complete and accurately documented for two of 42 residents reviewed (Residents 37 and 73).Findings include:The facility's policy regarding medication administration, dated July 22, 2025, indicated that after medication administration, the facility staff should take all measures required by facility policy and applicable law, including but not limited to documenting necessary medication administration/treatment information (when the medication was given, prn/as needed medications) on appropriate forms. Document the administration of controlled substances in accordance with applicable law.A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 37, dated August 14, 2025, indicated the resident was cognitively intact, required assistance, was understood, had pain, took opioid medications, and had diagnoses that included heart failure.Physician's orders for Resident 37, dated June 3, 2025, included an order for the resident to receive 5 milligrams (mg) of Oxycodone (a narcotic pain medication) every eight hours as needed for pain.A review of the Medication Administration Record (MAR) for Resident 37, dated August 2025, revealed that 5 mg of Oxycodone was administered to the resident on August 11 at 1:54 a.m.; August 18 at 11:31 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 August 2025 revealed no documented evidence that 5 mg of Oxycodone was signed out for administration on the above-mentioned dates and times. Interview with the Interim Director of Nursing on November 6, 2025, at 2:20 p.m. confirmed that there was no documented evidence on Resident 37's controlled medication record that 5 mg of Oxycodone was signed out for administration on the above-mentioned dates and times. A quarterly MDS assessment for Resident 73, dated September 29, 2025, indicated that the resident was cognitively intact, required assistance with care needs, had pain and was taking an opioid medication (a narcotic medication used to treat pain).Physician's orders for Resident 73, dated August 7, 2025, included an order for the resident to receive 5 milligrams (mg) of Oxycodone (a narcotic pain medication) every four hours as needed for moderate to severe pain.A review of the Medication Administration Record (MAR) for Resident 73, dated August 2025 through October 2025, revealed that 5 mg of Oxycodone was administered to the resident on August 9 at 5:30 a.m.; September 15 at 5:27 a.m.; and October 14 at 9:18 p.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 August 2025, September 2025, and October 2025, revealed no documented evidence that 5 mg of Oxycodone was signed out for administration on the above-mentioned dates and times. Interview with the Director of Nursing on November 6, 2025, at 1:00 p.m. confirmed that there was no documented evidence on Resident 73's controlled medication record that 5 mg of Oxycodone was signed out for administration on the above-mentioned dates and times. 28 Pa Code 211.5(f) Clinical Records.28 Pa. Code 211.12(d)(5) Nursing Services.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on review of the facility's plans of correction for previous surveys, and the results of the current survey, it was determined that the facility's Quality Assurance Performance Improvement (QAPI) committee failed to correct quality deficiencies and ensure that plans to improve the delivery of care and services effectively addressed recurring deficiencies.Findings include:The facility's deficiencies and plans of corrections for State Survey and Certification (Department of Health) survey ending October 31, 2024, revealed that the facility developed plans of correction that included quality assurance systems to ensure that the facility maintained compliance with cited nursing home regulations. The results of the current survey, ending November 6, 2025, identified repeated deficiencies regarding maintaining a homelike environment, providing transfer notices and bed hold policies, care plan timing and revision, failure to provide proper catheter care, and the inability to ensure the proper storage of drugs and biologicals.The facility's plan of correction for a deficiency regarding maintaining a homelike environment, cited during the survey ending October 31, 2024, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F584, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding maintaining a homelike environment.The facility's plan of correction for a deficiency regarding transfer notices and bed hold policies, cited during the survey ending October 31, 2024, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F628, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding transfer notices and bed hold policies.The facility's plan of correction for a care plan timing and revision, cited during the survey ending October 31, 2024, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F657, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding care plan timing and revision.The facility's plan of correction for a deficiency regarding a failure to provide proper catheter care, cited during the survey ending October 31, 2024, revealed that the facility would complete audits and the results would be reviewed as part of quality assurance. The results of the current survey, cited under F690, revealed that the facility's QAPI committee was ineffective in maintaining compliance with the regulation regarding catheter care.The facility's plan of correction for a deficiency regarding providing proper storage of drugs and biologicals, cited during the survey ending October 31, 2024, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F761, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding the proper storage of drugs and biologicals.Refer to F584, F628, F657, F690 and F761. 28 Pa. Code 201.14(a) Responsibility of Licensee.28 Pa. Code 201.18(e)(1) Management.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on review of policies and attendance records for the facility's Quality Assurance Committee, as well as staff interviews, it was determined that the facility failed to ensure that all required members of the Quality Assurance Committee attended quarterly meetings.Findings include:The facility's policy for Quality Assurance and Performance Improvement, dated March 12, 2025, revealed that meetings would be held at least quarterly and would include the Nursing Home Administrator, Director of Nursing, Medical Director, direct care staff, staff from ancillary departments and a designated Infection Preventionist.Review of the attendance records for the facility's Quality Assurance Committee meetings revealed that the Infection Preventionist did not attend any meetings that were held during the first and fourth quarters of 2024-2025.Interview with the Director of Nursing on November 5, 2025, at 11:30 a.m. confirmed that the Infection Preventionist did not attend meetings of the Quality Assurance Committee that were held during the first and fourth quarters of 2024-2025.28 Pa code 201.18(b)(3) Management.