

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395695	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/12/2024
NAME OF PROVIDER OR SUPPLIER Greenery Center for Rehab and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 2200 Hill Church-Houston Road Canonsburg, PA 15317	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39311</p> <p>Based on review of facility policy, clinical records, and staff interview, it was determined that the facility failed to notify physicians of increased capillary blood glucose (CBG) levels for three of seven residents (Resident R2, R3, and R4).</p> <p>Findings include:</p> <p>Review of the facility policy Physician Communication/Change in Condition dated 8/9/24, indicated to notify a physician for glucose levels if:</p> <ol style="list-style-type: none"> 1. Follow specific physician orders if present; or 2. Greater than 300 mg/dl (milligrams per deciliter) in a diabetic patient not using sliding-scale insulin; or 3. Greater than 450 mg/dl (or machine registers hi) in a diabetic patient using sliding scale insulin. <p>Review of the clinical record indicated Resident R2 was admitted to the facility on [DATE].</p> <p>Review of Resident R2's facility diagnoses list included heart failure (a progressive heart disease that affects pumping action of the heart muscles) and diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time).</p> <p>Review of a physician's orders dated 9/18/24, indicated for Resident R2 to receive insulin Degludec (long-acting injectable medication to lower blood sugar), 12 units in the evening.</p> <p>Review of Resident R2's physician's orders did not include an order for sliding scale insulin.</p> <p>Review of Resident R2's plan of care for diagnosis of diabetes mellitus dated 9/19/24, indicated for staff to Administer diabetes medication as ordered by doctor and Monitor labs as ordered and report abnormalities to medical provider.</p> <p>Review of the Resident R2's blood sugar level record for 9/18/24, through 9/21/24, revealed the following blood sugar levels:</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>9/18/24, at 8:27 p.m. the CBG was 111 mg/dl.</p> <p>9/19/24, at 8:10 p.m. the CBG was 268 mg/dl.</p> <p>9/20/24, at 8:54 p.m. the CBG was 390 mg/dl.</p> <p>9/21/24, at 6:49 p.m. the CBG was 483 mg/dl.</p> <p>Review of Resident R2's progress notes failed to reveal notifications to the physician of Resident R2's blood sugar levels greater than 300 mg/dl in a resident not on sliding scale insulin.</p> <p>Review of a clinical record indicated Resident R3 was admitted to the facility on [DATE].</p> <p>Review of the MDS dated [DATE], included diagnoses of diabetes and history of a stroke.</p> <p>Review of a physician's order dated 9/18/24, indicated to inject Novolog insulin (fast-acting medication to lower blood sugar levels) per sliding scale. For blood sugar levels 401-999 mg/dl, to give 12 units and call the doctor.</p> <p>Review of Resident R3's plan of care for diagnosis of diabetes mellitus dated 9/18/24, indicated for staff to Administer diabetes medication as ordered by doctor and Monitor labs as ordered and report abnormalities to medical provider.</p> <p>Review of Resident R3's blood sugar record for 10/16/24, through 11/5/24, failed to reveal physician notification of the following blood sugar levels:</p> <p>10/16/24, at 5:14 a.m. the CBG was 488 mg/dl.</p> <p>10/28/24, at 6:18 a.m. the CBG was 437 mg/dl.</p> <p>10/29/24, at 6:05 p.m. the CBG was 401 mg/dl.</p> <p>10/30/24, at 12:26 p.m. the CBG was 452 mg/dl.</p> <p>Review of a clinical record indicated Resident R4 was admitted to the facility on [DATE].</p> <p>Review of the MDS dated [DATE], included diagnoses of diabetes and high blood pressure.</p> <p>Review of a physician's order dated 7/27/24, indicated to inject insulin aspart (fast-acting medication to lower blood sugar levels) per sliding scale. For blood sugar levels 401-999 mg/dl, to give 12 units and call the doctor.</p> <p>Review of Resident R4's plan of care for diagnosis of diabetes mellitus dated 7/30/24, indicated for staff to Administer diabetes medication as ordered by doctor and Monitor labs as ordered and report abnormalities to medical provider.</p> <p>Review of Resident R4's blood sugar record for 10/16/24, through 11/5/24, failed to reveal physician notification of the following blood sugar levels:</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>10/24/24, at 2:26 p.m. the CBG was 479 mg/dl.</p> <p>10/30/24, at 12:24 p.m. the CBG was 463 mg/dl.</p> <p>11/05/24, at 12:57 p.m. the CBG was 587 mg/dl.</p> <p>11/05/24, at 4:59 p.m. the CBG was 466 mg/dl.</p> <p>During an interview on 11/1/24, at 2:12 p.m. Licensed Practical Nurse (LPN) Employee E1 was asked when she would notify a provider for an abnormal blood sugar level. LPN Employee E1 stated that usually the parameters are written in the insulin order. When asked at what blood sugar level she would notify for, for a resident without specific sliding scale insulin orders, LPN Employee E1 stated, 200.</p> <p>During an interview on 11/1/24, at 2:19 p.m. Registered Nurse (RN) Employee E2 was asked at what blood sugar level she would notify a provider for, for a resident without specific sliding scale insulin orders. RN Employee E2 stated, 400.</p> <p>During an interview on 11/1/24, at 2:25 p.m. LPN Employee E3 was asked at what blood sugar level she would notify a provider for, for a resident without specific sliding scale insulin orders. LPN Employee E4 stated, below 70 or over 400.</p> <p>During an interview on 11/7/24, at approximately 2:00 p.m. the Nursing Home Administrator confirmed that the facility failed to notify physicians of increased capillary blood glucose levels for three of seven residents.</p> <p>28 Pa. Code 201.18 (b)(1) Management.</p> <p>28 Pa. Code 201.29(d) Resident rights.</p> <p>28 Pa. Code 211.10 (c)(d) Resident care policies.</p> <p>28 Pa. Code 211.12 (d)(1)(2)(3)(5) Nursing services.</p>		

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>39311</p> <p>Based on review of facility policy, observations, and staff interview, it was determined that the facility failed to maintain the confidentiality of residents' medical information for one of three medication carts (North One medication cart).</p> <p>Findings include:</p> <p>Review of the facility policy Confidentiality and Non-Disclosure Agreement dated 8/9/24, indicated for staff Not to leave your computer terminal or workstation unattended without logging off or using your system 's screensaver function before leaving your work area.</p> <p>During an observation of the North One medication cart 11/1/24, at 2:12 p.m. the medication cart was in the hall, unattended by staff. The computer screen was open to a resident record, visible to persons in the hallway.</p> <p>During an interview on 11/1/24, at 2:17 p.m. Licensed Practical Nurse Employee E1 confirmed that she had stepped away from the computer without locking to screen to maintain privacy.</p> <p>During an interview on 11/7/24, at approximately 2:00 p.m. the Nursing Home Administrator confirmed that the facility failed to maintain the confidentiality of residents' medical information for one of two medication carts.</p> <p>28 Pa. Code 201.29(j) Resident rights.</p> <p>28 Pa. Code 211.5(b) Clinical records.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>39311</p> <p>Based on review of facility policy, observations, and staff interview, it was determined that the facility failed to make certain that medications were properly stored and/or disposed of in two of three medication carts (North One and North Three medication carts).</p> <p>Findings include:</p> <p>Review of facility policy Medication Storage in the Facility dated 8/9/24, stated that medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. All medications dispensed by the pharmacy are stored in the container with the pharmacy label. Outdated, contaminated, or deteriorated medications are immediately removed from inventory, disposed of according to procedures for medications disposal, and reordered from the pharmacy if a current order exists. Additionally, the policy stated, the nurse shall place a date opened sticker on the medication and enter the date opened and the new date of expiration, if applicable.</p> <p>Review of the U.S. FDA approved prescribing information for Lantus (a type of long-acting insulin) dated 05/2019, indicated that in-use vials must be used within 28 days.</p> <p>Review of the U.S. FDA approved prescribing information for Novolog (a type of rapid-acting insulin) dated 05/2008, indicated that in-use vials must be used within 28 days.</p> <p>Review of the U.S. FDA approved prescribing information for Latanoprost (a type of eye drop used to treat glaucoma) dated 06/2014, indicated that in-use bottles must be used within six weeks.</p> <p>During an observation of the North One medication cart on 11/1/24, at 2:12 p.m. the following was observed:</p> <ul style="list-style-type: none"> -Medication cart was unlocked, with one draw visibly open. -One bottle of Pataday (olopatadine) eye drops, opened, partially used, dated as opened on 9/11/24. -One bottle of artificial tears eye drops, opened, partially used, and undated. -One bottle of Lumigan (bimatoprost) ophthalmic solution opened, partially used, and undated. <p>During an observation of the North Three medication cart on 11/1/24, at 2:20 p.m. the following was observed:</p> <ul style="list-style-type: none"> -One Lantus (long-acting insulin) injection pen, opened, partially used, and undated. -One Novolog insulin aspart (rapid-acting insulin) injection pen, opened, without a label showing a resident name, or open-date. <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-One Lantus vial, opened, partially used, and undated.</p> <p>-One bottle of Tobradex (tobramycin/dexamethasone) ophthalmic solution opened, partially used, and undated.</p> <p>-One bottle of Latanoprost ophthalmic solution opened, partially used, and undated.</p> <p>During an interview on 11/7/24, at approximately 2:00 p.m. the Nursing Home Administrator the facility failed to make certain that out-of-date medications were disposed of in two of three medication carts.</p> <p>28 Pa. Code: 201.14 (a) Responsibility of licensee.</p> <p>28 Pa. Code: 201.18 (b)(1)(e)(1) Management.</p> <p>28 Pa. Code: 211.9 (a)(1) Pharmacy services.</p> <p>28 Pa. Code: 211.12 (d)(1)(3)(5) Nursing services.</p>

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<p>F 0908</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Keep all essential equipment working safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39311</p> <p>Based on observations and staff interviews it was determined that the facility failed to make certain that equipment was in safe operating condition for one of one crash carts (maintained with equipment used in cardiac emergencies).</p> <p>Findings include:</p> <p>During an observation of the unlocked, clean utility room on [DATE], at 2:32 p.m. revealed the facility emergency cart.</p> <p>No check lists were available at the cart to describe the contents, or documentation that the cart was periodically checked to verify sufficiency of equipment and that the equipment was in good working order and the supplies not expired.</p> <p>During an interview on [DATE], at 2:40 p.m. the Director of Nursing was unable to provide an inventory list, or documentation that the cart was periodically checked to verify sufficiency of equipment and that the equipment was in good working order and the supplies not expired.</p> <p>Review of a facility provided blank Crash Cart Checklist indicated that the crash cart is checked by nursing staff every 12-hour shift.</p> <p>During an interview on [DATE], at 2:00 pm. the Nursing Home Administrator confirmed the facility failed to ensure that equipment was in safe operating condition.</p> <p>28 Pa Code: 201.14(a) Responsibility of licensee.</p>		