STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395695	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenery Center for Rehab and Nursing	2200 Hill Church-Houston Road Canonsburg, PA 15317

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep residents' personal and medical records private and confidential. Based on observation and staff interviews it was determined that the facility failed to maintain the confidentiality of residents' personal identifiable information on two of three nursing units (North and South Nursing Units) and failed to provide privacy during provision of care on one of three nursing units (North Nursing Unit). Findings include:During an observation on 3/11/26, at 8:57 a.m., the North nurse's station had resident personal identifiable information regarding care and showers taped to desk for any passerby to see.During an observation on 3/11/26, at 9:02 a.m., the South nurse's station had resident identifiable information regarding care lying on the desk for any passerby to see.During an observation on 3/11/26, at 8:52 a.m., Nurse Aide Employee E4 and E5 were observed to have earbuds in while providing care on residents of the North Nursing Unit. During an interview on 3/11/26, at 1:31 p.m., the Assistant Director of Nursing Employee E1 confirmed that the facility failed to maintain the confidentiality of residents' personal identifiable information as required and failed to maintain privacy during provision of care.28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.29(c.3) Resident Rights.28 Pa. code: 211.5(b) Medical records.28 Pa. Code: 211.12(d)(1)(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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observations and staff interviews, it was determined that the facility failed to provide a safe, clean, comfortable, and homelike environment on three of three nursing units (North, South and [NAME] nursing units). Based on observations and staff interviews, it was determined that the facility failed to provide a safe, clean, comfortable, and homelike environment on two of two nursing units (North and South nursing units).Findings included:During an observation on 3/11/26, at 9:21 a.m., the following was observed:Resident room [ROOM NUMBER](unoccupied) had peeled wallpaper with black mold identified on the walls under the window.Resident room [ROOM NUMBER] had broken drywall areas behind bed B and the unused floor heater panel was broken leaving exposed sharp metal pieces.Resident room [ROOM NUMBER] had a floor heater unit with no cover leaving exposed sharp metal pieces.Floors on both North and South nursing units had broken floor tiles identified which had the potential to cause tripping accidents.During an interview on 3/11/26, at 9:21 a.m., Maintenance Director Employee E2 confirmed that the facility failed to provide a safe, clean, comfortable, and homelike environment on three of three nursing units (North, South and [NAME] nursing units).Review of the facility grievances and review of a complaint indicated that there are not enough clean and available wash cloths, bed pads and towels available throughout the whole day.During an observation on 3/11/26, from 9:22 a.m., through 11:26 a.m., the linen carts throughout the facility there were approximately six sheets, both bottom and top, seven towels and two or three wash cloths on each linen cart, the census is 106 currently.During an observation on 3/11/26, at approximately 1:32 p.m., the Laundry/Housekeeper Supervisor Employee E3 confirmed that the facility was aware of the complaints of running out of wash cloths, towels and bed pads and confirmed that the facility failed to provide a safe, clean, comfortable, and homelike environment on three of three nursing units (North, South and [NAME] Nursing Units).28 Pa. Code: 207.2(a) Administrator's responsibility.28 Pa. Code: 201.29(k) Resident rights.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation and staff interview, it was determined the facility failed to maintain an environment free of potential accident hazards and obstacles for safe mobility and use of mobility assistance devices on two of three nursing units (North and South Nursing Units). Findings include:During observations throughout the day of the survey 3/11/26, from 8:17 a.m., through approximately 5:15 p.m., the hallways of the North and South Nursing units had equipment such as wheelchairs, linen carts, soiled double linen carts, medication carts and lifts in hallways of each unit. These items obstructed continued access to the handrails which are to be used for resident ambulation or mobility assistance and did not create a homelike environment and did not allow unobstructed egress through the halls or for potential emergency staff to access residents. During an interview on 3/11/26, at 5:15 p.m., the Assistant Director of Nursing Employee E1 stated that resident care areas should be maintained in a clean and orderly manner and confirmed the facility failed to maintain an environment free of potential accident hazards and obstacles for safe mobility and use of mobility assistance devices on two of three nursing units (North and South Nursing Units).28 Pa. Code 201.18 (e)(2.1) Management28 Pa. Code 205.9 (c) Corridors

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, clinical record review, and resident and staff interviews, it was determined that the facility failed to provide pharmaceutical services to meet the needs of each resident on three of three nursing units (North, South and [NAME] Nursing units). Findings Include:Review of facility policy, Medication Ordering and Receiving from Pharmacy, last reviewed 1/5/26, indicated that the facility maintains a supply of commonly used over the counter medications considered as floor stock to be administered upon receipt of an order from an authorized prescriber.Review of a complaint and a grievance dated January 2026, identified that common over the counter medications are not available. During interviews with three of five nurses who wish to remain anonymous identified that MiraLAX and Prilosec (or generic form) are not available and one resident bought his own MiraLAX so it would be available for him as he has bowel issues. The nurses stated that they have to borrow from each other.During an observation of the medication room where over the counter medications are stored and review of the [NAME] of medications ordered included one bottle of MiraLAX and Prilosec three bottles ordered in the last seven orders over three months reviewed.During observations of three of five medication carts did not identify a bottle of MiraLAX and two of the three did not have Prilosec or the generic version available.During an interview on 3/11/26, at 12:20 p.m., the Director of Nursing confirmed that the facility failed to provide pharmaceutical services to meet the needs of each resident on three of three nursing units (North, South and [NAME] Nursing units).28 Pa. Code 201.14(a) Responsibility of licensee28 Pa. Code 201.18(b)(1)(3) Management28 Pa. Code 211.9(a)(1) Pharmacy services 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident?s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Based on review of facility documents, resident council group interviews, and staff interviews, it was determined the facility failed to consistently provide snacks as desired by residents for three of three Nursing Units (North, South and [NAME] Nursing Units). Findings include:Review of the facility policy Greenery Snack Policy dated 1/5/26, indicated that between meal snacks shall be available for residents.During an interview on 3/11/26, at 8:25 a.m., two Nurse Aides who wish to be unknown stated that residents are unhappy and they are not getting snacks at bedtime and the facility is aware.Resident Council Meeting Minutes dated 1/6/26, 2/4/26 and 3/3/26, indicated resident stating that snacks are not being offered or delivered by the Nurse Aides.Review of Food Committee meeting minutes dared 1/5/26, 2/3/26 and 3/2/26, indicated snacks are not being delivered to the residents.During resident interviews, the residents indicated that the snacks are delivered to the floors, but the NAs eat them and/or they are not offered consistently or provided.During an interview on 3/11/26, at 1:31 p.m., the Assistant Director of Nursing confirmed that the facility failed to consistently provide snacks as desired for three of three Nursing Units (North, South and [NAME] Nursing Units).28 Pa. Code 211.12 (d)(3)(5) Nursing services.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on a review of facility policy, observations and staff interview it was determined that the facility failed to properly store food products in the Main Kitchen, which created the potential for foodborne illness and cross contamination. Findings Include:Review of the facility policy Dietary Food Handling dated 1/5/26, indicated that thermometers must be placed in hot and cold storage areas in accordance with public health standards. Foods must be stored off of the floor. Clean uniforms must be worn daily, and hairnets or caps must be worn in all food service areas.Review of the Pennsylvania Food Code S46.152 indicated employee shall wear hair restraints including beard restraints. All food items will be stored at least six inches off the floor.Review of S483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Frozen foods must be stored to allow adequate circulation of air around refrigerated products is essential to maintain appropriate food temperatures. Frozen foods must be maintained at a temperature to keep the food frozen solid. Labeling, dating, and monitoring refrigerated food, including, but not limited to leftovers, so it is used by its use-by date, or frozen (where applicable) or discarded. During an observation tour of the main kitchen on 3/11/26, at 8:35 a.m., revealed the following:Food being stored directly under the fans of the deep freezer with ice accumulation on pipes and food was touching the ceiling of the deep freezer. Not allowing proper air circulation around food.Dietary Aide Employee E6 was at the dining room tray line serving food with no beard restraint.Dietary Aide Employee E7 was in the kitchen by the freezer with no hair restraint, when asked he stated, he forgot to put one on.The dry storage area had 13 boxes of dry foods placed in boxes on the floor. A box of bacon bits and a box of cereal were unsealed allowing for exposure to possible contamination.The walk-in cooler had a cart with open undated meats. packages of butter were opened and sitting under fans of cooler. The ice cream freezer had ice buildup and ice cream stuck in the ice.The kitchen door to exit would not close and had to be pulled shut to prevent potential for animals or bugs to enter areas. The facility garbage areas were outside the door.During an interview on 3/11/26, at 12:21 p.m., the Nursing Home Administrator stated that the Dietary Manager would not be available.During an interview on 3/11/26, at 1:31 p.m., the Assistant Director of Nursing confirmed that the facility failed to properly store food products in the Main Kitchen, which created the potential for foodborne illness. Pa. 28 Code: 211.6(c)(d)(f) Dietary services.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on staff interviews and observations, it was determined the facility failed to maintain a fully functioning resident call bell system that allows residents to call for staff assistance through a communication system on one of three nursing units (West nursing unit). Findings include:During interviews on 3/11/26, at 9:32 a.m., with staff, Licensed Practical Nurse Employee E8, Nurse Aide Employee E9 and E10 all stated that they have to watch call lights outside of resident rooms because the call light sound system does not work and the shower room call light is constantly alarming.During an observation on 3/11/26, at 9:33 a.m., the shower room light was alarming, a resident had his call light illuminating above his door, but no alarm sound could be heard, and the central light was illuminating the shower room.During an interview on 3/11/26, at 1:46 p.m., the Maintenance Director Employee E1 confirmed that the confirmed that the facility failed to maintain a fully functioning resident call bell system that allows residents to call for staff assistance through a communication system on the [NAME] Nursing Units. 28 Pa Code 207.2(a) Administrators responsibility28 Pa Code 205.28 (c)(1)(4) Nurses station