Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 04/10/2026
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)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility review of policy, manufacturer's instructions, clinical records and staff interviews, the facility failed to notify physicians of elevated or decreased Capillary Blood Glucose (CBG) levels, failed to assess residents for hyperglycemia (high blood glucose) and hypoglycemia (low blood sugar) resulting in immediate jeopardy for 12 of 21 residents (R2, R4, R16, R33, R37, R46, R47, R56, R70, R80, R97, and R116).Findings include: Review of the facility policy Episodic and Narrative Documentation dated 1/6/26, indicated a narrative entry will be made for physician notification. During an interview with the Nursing Home Administrator on 4/8/26, at approximately 10:00 a.m. policies for management of diabetes, hypoglycemia, or hyperglycemia were requested. The NHA confirmed the facility was unable to provide policies. Review of the Facility Assessment last reviewed 4/14/25, indicated the facility will provide care for residents diagnosed with diabetes. Review of the United States Food and Drug Administration prescribing information for basaglar insulin (insulin glargine, a long-acting injectable medication to diabetes) dated 12/2015, indicated basaglar insulin begins to work several hours after administration, the maximum effect of basaglar insulin is approximately 12 hours after administration, and works over 24 hours to lower blood sugar levels. Review of the glucometer manufacturer's instructions indicated Low refers to less than 20 mg/dl, and High refers to greater than 600 mg/dl. Review of the clinical record indicated that Resident R2 was admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS - periodic assessment of resident care needs) dated 3/24/26, included diagnoses of diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time) and chronic kidney disease. Review of a physician order dated 1/5/26, indicated that Resident R2 received insulin lispro on a sliding scale. If below 70 (mg/dl) to follow hypoglycemic protocol. If over 400 (mg/dl) to notify the provider. Review of Resident R2's current plan of care for diabetes initiated 11/3/25, indicated Fasting Serum Blood Sugar/finger stick blood sugar monitoring as ordered by doctor. Review of Resident R2's blood sugar record for January 2026, through April 2026, revealed the following blood sugar values failed to have documentation of notification or follow-up: 1/8/26, 8:55 p.m., BS 520, no notes or documentation 1/14/26, 4:57 p.m., BS 508, no notes or documentation 1/14/26, 10:30 p.m., BS 453, no notes or documentation 1/29/26, 10:05 p.m., BS 500, had a note, but no recheck. 3/25/26, 3:54 p.m., BS 421, no notes or documentation Review of the clinical record indicated that Resident R4 was admitted to the facility on [DATE]. Review of the MDS dated [DATE], included diagnoses of diabetes and CAD. Review of a physician order dated 1/5/26, indicated that Resident R4 received Novolog on a sliding scale and if over 400 (mg/dl) to notify the MD (doctor of medicine). Review of Resident R4's current plan of care for diabetes initiated 3/10/26, indicated Fasting Serum Blood Sugar/finger stick blood sugar monitoring as ordered by doctor. Review of Resident R4's blood sugar record for January 2026, through April 2026, revealed the following blood sugar value failed to have documentation of notification or follow-up: 3/15/26, 8:30 a.m., BS 483, no notes or documentation Review of the clinical record indicated that Resident R16 was admitted to the facility on [DATE]. Review of the MDS dated [DATE], included diagnoses of diabetes and Congestive Heart Failure (CHF). Review of a physician order dated 1/31/26, through 3/30/26, indicated that Resident R16 was to receive blood sugar checks (continued on next page)

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	twice daily. This order did not include parameters for provider notification. Review of a physician order dated 1/24/26, through 2/22/26, indicated that Resident R16 received Tresiba (long-acting insulin) 32 units daily; 2/22/26, through 3/21/26, indicated that Resident R16 received Tresiba 36 units daily. 3/21/26, through 3/21/26, indicated that Resident R16 received Tresiba 40 units daily; 3/30/26, (current order) indicated that Resident R16 received Tresiba 44 units daily. These orders did not include parameters for provider notification. Review of a physician order dated 3/30/26, indicated that Resident R4 received Novolog on a sliding scale and if over 400 (mg/dl) to notify the provider. Review of Resident R16's current plan of care for diabetes initiated 1/19/24, indicated Fasting Serum Blood Sugar/finger stick blood sugar monitoring as ordered by doctor. Review of Resident R16's blood sugar record for January 2026, through April 2026, revealed the following blood sugar values failed to have documentation of notification or follow-up: 2/6/26, 7:24 p.m., BS 426, no notes or documentation 2/26/26, 7:43 a.m., BS 495, no notes or documentation. Resident left for a leave of absence without reevaluation. 2/27/26, 11:00 p.m., BS 471, no notes or documentation. 2/28/26, 7:42 p.m., BS 459, no notes or documentation 3/2/26, 5:34 p.m., BS 470, no notes or documentation Review of the clinical record indicated that Resident R33 was admitted to the facility on [DATE]. Review of the MDS dated [DATE], included diagnoses of diabetes and CAD. Review of a physician order dated 1/16/26, through 2/23/26, indicated that Resident R33 received insulin lispro on a sliding scale and if under 70 (mg/dl) or over 400 (mg/dl) to notify the provider . Review of Resident R33's current plan of care for diabetes initiated 1/16/26, indicated Fasting Serum Blood Sugar/finger stick blood sugar monitoring as ordered by doctor. Review of Resident R33's blood sugar record for January 2026, through April 2026, revealed the following blood sugar value failed to have documentation of notification or follow-up: 1/21/26, 1:12 a.m., BS 402, no notes or documentation Review of the clinical record indicated that Resident R37 was admitted to the facility on [DATE]. Review of the MDS dated [DATE], included diagnoses of diabetes and dementia. Review of a physician order dated 6/9/25, through 4/6/26, indicated that Resident R37 received insulin lispro on a sliding scale and if under 70 (mg/dl) or over 400 (mg/dl) to notify the MD. Review of Resident R37's current plan of care for diabetes initiated 4/3/24, indicated Fasting Serum Blood Sugar/finger stick blood sugar monitoring as ordered by doctor. Review of Resident R37's blood sugar record for January 2026, through April 2026, revealed the following blood sugar value failed to have documentation of notification or follow-up: 3/12/26, 1:39 p.m., BS 487, no notes or documentation Review of the clinical record indicated that Resident R46 was re-admitted to the facility on [DATE]. Review of the MDS dated [DATE], included diagnoses of diabetes and COPD. Review of a physician order dated 9/14/25, and reordered 1/18/26, indicated that Resident R46 received Novolog on a sliding scale and if under 70 (mg/dl) or over 400 (mg/dl) to notify the MD. Review of Resident R46's current plan of care for diabetes initiated 3/13/24, indicated Fasting Serum Blood Sugar/finger stick blood sugar monitoring as ordered by doctor. Review of Resident R46's blood sugar record for January 2026, through April 2026, revealed the following blood sugar value failed to have documentation of notification or follow-up: 1/8/26, 8:49 p.m., BS 401, no notes or documentation 1/30/26, 6:36 p.m., BS 429, no notes or documentation 2/2/26, 2:00 p.m., BS 426, no notes or documentation 2/11/26, 12:47 p.m., BS 517, no notes or documentation 2/17/26, 10:06 p.m., BS 402, no notes or documentation 2/26/26, 5:15 p.m., BS 418, no notes or documentation 3/11/26, 12:05 p.m., BS 401, no notes or documentation 3/13/26, 9:57 p.m., BS 414, no notes or documentation 3/20/26, 10:49 a.m., BS 414, no notes or documentation 3/30/26, 9:44 p.m., BS 401, no notes or documentation Review of the clinical record indicated that Resident R47 was admitted to the facility on [DATE]. Review of the MDS dated [DATE], included diagnoses of diabetes and End Stage Renal Disease. Review of a physician order dated 3/15/26, indicated that Resident R47 received insulin lispro on a sliding scale and Call MD if greater than 400 for additional orders! Review of Resident R47's current plan of care for diabetes initiated 3/14/24, indicated Fasting Serum Blood Sugar/finger stick blood sugar monitoring as ordered by doctor. Review of Resident R47's blood sugar record for March 2026, through April 2026, revealed the following blood (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	sugar value failed to have documentation of notification or follow-up: 3/19/26, 9:23 p.m., BS 522, no notes or documentation3/20/26, 9:12 a.m., BS 538, no notes or documentation.3/20/26, 1:22 p.m., BS 543, no notes or documentation3/21/26, 2:16 p.m. Progress Note: Meter reading HI (over 600)3/21/26, 5:44 p.m., BS 439, no notes or documentation3/24/26, 6:31 p.m., BS 591, no notes or documentation3/25/26, 12:48 p.m., BS 582, no notes or documentation3/26/26, 10:00 a.m., BS 582, no notes or documentation3/26/26, 1:17 p.m., BS 538, no notes or documentation3/29/26, 11:00 a.m., BS 547, no notes or documentation3/29/26, 2:08 p.m., BS 458, no notes or documentation3/30/26, 9:36 a.m., BS 546, no notes or documentation4/2/26, 8:30 a.m., BS 505, no notes or documentation4/2/26, 5:36 p.m., BS 429, no notes or documentation4/5/26, 10:13 a.m., BS 440, no notes or documentation4/7/26, 8:17 a.m., BS 502, no notes or documentation Review of the clinical record indicated that Resident R56 was admitted to the facility on [DATE]. Review of the MDS dated [DATE], included diagnoses of diabetes and CKD. Review of a physician order dated 1/8/26, indicated that Resident R56 received Admelog on a sliding scale and if under 70 (mg/dl) or over 400 (mg/dl) to notify the MD. Review of Resident R56's current plan of care for diabetes initiated 12/20/23, indicated Fasting Serum Blood Sugar/finger stick blood sugar monitoring as ordered by doctor. Review of Resident R56's blood sugar record for January 2026, through April 2026, revealed the following blood sugar value failed to have documentation of notification or follow-up: 1/13/26, 10:46 p.m., BS 66, no notes or documentation 1/16/26, 6:00 a.m., BS 69, no notes or documentation 1/25/26, 7:12 p.m., BS 495, no notes or documentation 2/17/26, 6:35 p.m., BS 420, no notes or documentation 3/6/26, 5:48 a.m., BS 57, no notes or documentation4/4/26, 6:11 a.m., BS 55, no notes or documentation Review of the clinical record indicated that Resident R70 was admitted to the facility on [DATE]. Review of the MDS dated [DATE], included diagnoses of diabetes and dementia. Review of a physician order dated 8/18/25, through 3/1/26, indicated Resident R70 will have her blood sugar checked twice per day, on Mondays, Wednesdays, and Fridays. This order did not include parameters for provider notification. Review of a physician order dated 2/24/26, indicated that Resident R70 received Lantus 6 units. This was increased on 3/2/26, to 12 units, and on 3/25/26, to 16 units. These orders did not include parameters for provider notification. Review of Resident R70's current plan of care for diabetes initiated 7/9/25, indicated Fasting Serum Blood Sugar/finger stick blood sugar monitoring as ordered by doctor. Review of Resident R70's blood sugar record for February 2026, through April 2026, revealed the following blood sugar value failed to have documentation of notification or follow-up: 2/6/26, 7:24 p.m., BS 426, no notes or documentation2/26/26, 7:43 a.m., BS 495, no notes or documentation. 2/27/26, 11:00 p.m., BS 471, no notes or documentation. 2/28/26, 7:42 p.m., BS 459, no notes or documentation3/2/26, 5:34 p.m., BS 470, no notes or documentation Review of the clinical record indicated that Resident R80 was admitted to the facility on [DATE]. Review of the MDS dated [DATE], included diagnoses of diabetes and COPD. Review of a physician order dated 7/14/25, through 2/28/26, indicated Resident R80 will have insulin lispro (8 units plus a sliding scale) before meals and at bedtime every Tuesday, Thursday, Saturday, and Sunday. This order indicated to notify the provider if greater than 400 (mg/dl). Review of a physician order dated 7/15/25, through 2/28/26, indicated Resident R80 will have insulin lispro (8 units plus a sliding scale) before meals and at bedtime every Monday, Wednesday, and Friday. This order indicated to hold the insulin if blood sugar levels was less than 130 (mg/dl) and notify the provider if greater than 400 (mg/dl). Review of a physician order dated 2/28/26, indicated Resident R80 will have insulin lispro on a sliding scale before meals and at bedtime. This order indicated to notify the provider if greater than 400 (mg/dl). Review of Resident R80's current plan of care for diabetes initiated 12/4/24, indicated Fasting Serum Blood Sugar/finger stick blood sugar monitoring as ordered by doctor. Review of Resident R80's blood sugar record for January 2026, through April 2026, revealed the following blood sugar value failed to have documentation of notification or follow-up: 1/26/26, 11:07 a.m., BS 404, no notes or documentation1/30/26, 10:25 p.m., BS 454, no notes or documentation2/28/26, 10:17 p.m., BS 438, no (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on review of employee files, and staff interviews, it was determined that the facility failed to employ a full-time qualified dietary services manager in the absence of a full-time qualified dietitian for 25 of 25 days. (March 16, 2026, through April 10,2026) Findings include: Review of the job description Dietary Manager indicated they oversee all food service operations to ensure residents receive nutritious, safe, and appealing meals that must meet clinical and dietary requirements. The key responsibilities included the following: - Manage daily operations of the dietary department.- Work closely with a Registered Dietitian to implement meal plans- Maintain food safety standards.- Hire, train, schedule and supervise dietary staff (cooks, aides, dishwashers)- Ensure food quality, taste, temperature, and presentation meets expectations.- Order food and supplies and maintain inventory During an interview on 4/7/26, at 10:05 a.m. interim Dietary Manager Employee E12 stated she currently does not have her CDM license. She previously held a CDM license but allowed it to lapse after October 2024 after the nursing home she was employed at closed and she decided to pursue a different career path. She also stated the RD only works at the facility on Mondays. Review of employee files indicated the following: - Employee E12 was hired on 1/29/26, as a Graduate Nurse (GN) while she awaited her Registered Nurse State Board test to be completed (scheduled for 4/22/26).- On 3/19/26, Employee E12 signed the Dietary Manager job description. During an interview on 4/10/26, at approximately 11:00 a.m. the Nursing Home Administrator (NHA) confirmed the facility was unable to provide a job description for the Registered Dietitian (RD) position and stated the RD is a consultant for the facility so she did not have a job description. The NHA confirmed there was not a full-time dietitian employed at the facility and that the facility did not employ a qualified dietary manager in the absence of a full-time dietitian. 28 Pa. Code 201.18(b)(3) Management.

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 04/10/2026

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on observations, resident interviews, review of facility documents, and staff interviews, it was determined that the facility failed to provide sufficient dietary staff to perform essential kitchen duties. Findings include: Review of the facility document Meal Service Times, indicated the following meal schedules: Main Dining room:Breakfast 730 - 830 a.m. Lunch 11:30 - 12:30 p.m.Dinner 5:15 pm - 6:15 pm. Cart Service:Breakfast 7:45 a.m. - 8:30 a.m.Lunch 11:45 a.m. - 12:30 p.m.Dinner 5:30 p.m. - 6:15 p.m. Review of Food Committee meeting notes from 1/5/26, indicated concerns related to condiments not being on carts, lack of notice about menu changes, and meal delivery being late due to carts of trays not being distributed when brought to the floor. Review of Food Committee meeting notes from 3/2/26, indicated concerns related to posted menu not being followed, missing items from meal trays, meals being late, food being cold, and running out of food before meal service is complete. During an interview on 4/7/26, at 10:05 a.m. interim Dietary Manager Employee E12 stated the facility did not have enough staff for the kitchen to run efficiently. She stated the Certified Dietary Manager (CDM) walked out of the facility without notice on 3/16/26, and she stepped into the position temporarily on 3/19/26. She held the position of CDM at a different nursing facility that closed in 2024 but let her certification lapse as she pursued another career path. She stated the facility only had a Registered Dietician one day a week, on Mondays. During an interview on 4/7/26, at 11:00 a.m. Resident R59 stated the food is consistently cold, and staff refuse to microwave it for them. During an interview on 4/7/26, at 11:06 a.m. Resident 115 stated if residents want warm food they eat in the dining room, because the meals delivered to his room are always cold and staff refuse to heat it for him. During an interview on 4/7/26, at approximately 11:19 a.m. Resident R98 stated the food tastes bad and is often cold. During an interview on 4/7/26, at 11:23 a.m. Resident R76 stated he eats in the dining room because the food is cold if he eats in his room. During an interview on 4/8/26, at approximately 3:30 p.m. Resident R9 stated that, meals are late and ice cold. During a confidential group interview on 4/8/26, at 2:00 p.m. 14 of 14 residents collectively confirmed that meals are consistently late and cold. During observations on 4/9/26, at 12:07 p.m. tray line was still being assembled in the dining room. At 12:15 p.m. the residents in the dining room began to get their meals. Carts delivery to resident rooms began at 1:15 p.m. During an interview on 4/9/26, at 12:10 p.m. acting Dietary Manager stated lunch was running about 30 minutes behind due to not having enough staff to prepare the meal timely. The menu for the day was roasted turkey, mashed potatoes, carrots, and tapioca pudding. The morning kitchen staff included one [NAME] Employee E15, [NAME] (in training) Employee E17, and Dietary Aide Employee E18. During an interview on 4/10/26. at 3:00 p.m. the Nursing Home Administrator confirmed the facility failed to provide sufficient dietary staff to perform essential kitchen duties. 28 Pa. Code 211.6(b)(c)(d) Dietary Services

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on a review of facility policy, facility documents, resident interviews, staff interviews and observations, it was determined the facility failed to provide the residents with food and drink that is at a safe and appetizing temperatures for five of 21 residents interviewed (R59, R115, R98, R76 and R9), 14 of 14 residents in a confidential group meeting, two of three resident council minutes reviewed (1/5/26 and 3/2/26), and observations of a test tray (4/9/26).Findings include: Review of facility policy Dietary/ Food Handling reviewed 1/5/26, indicated guidelines for the safe preparation, handling, and storage of perishable food. Temperatures must be maintained at the following (Fahrenheit) settings for the items indicated below: Cold food - 45 degrees or belowFrozen food - 0 (zero) degrees or belowHot food - 140 degrees or aboveReview of the USDA Food Safety Minimal Internal Temperature chart indicated all poultry should reach 165 F to ensure thorough cooking and should be kept at 140 F or higher for holding temperature. During an interview on 4/7/26, at 11:00 a.m. Resident R59 stated the food is consistently cold, and staff refuse to microwave it to heat it up. During an interview on 4/7/26, at 11:06 a.m. Resident 115 stated if residents want warm food they eat in the dining room, because the meals delivered to his room are always cold and staff refuse to heat it for him. During an interview on 4/7/26, at approximately 11:19 a.m. Resident R98 stated the food tastes bad and is often cold. During an interview on 4/7/26, at 11:23 a.m. Resident R76 stated he eats in the dining room because the food is cold if he eats in his room. During an observation on 4/8/26, at 9:28 a.m. breakfast was still being served to the residents on the North Unit. The metal kitchen cart was observed left open between staff removing the trays with five resident trays left in the cart. The back hallway on North Unit was observed to have four resident trays on a cooling rack being used to deliver meals. During an interview on 4/8/26, at 9:30 a.m. Nurse Aid (NA) Employee E5 confirmed the cart doors are left open between trays. During an observation on 4/8/26, at 9:36 a.m. the metal kitchen cart was left open with nine resident trays still inside. During an interview on 4/8/26, at 9:36 a.m. NA Employee E22 stated they were unaware the kitchen carts needed to be closed between removing resident meal trays. During an interview on 4/8/26, at approximately 3:30 p.m. Resident R9 stated that, meals are late and ice cold. During a confidential group interview on 4/8/26, at 2:00 p.m. 14 of 14 residents collectively confirmed that meals are consistently late and cold. During observations on 4/9/26, at 12:07 p.m. tray line was still being assembled in the dining room. At 12:15 p.m. the residents in the dining room began to get their meals. During an observation on 4/9/26, at 1:00 p.m. food temperatures were as follows: -Roasted turkey (sliced and placed in metal tray, no liquid): 99 F -Mashed potatoes: 207 F-Gravy: 162 F-Diced carrots were 159 FDuring an observation on 4/9/26, at 1:15 p.m. revealed lunch trays for cart delivery to the nursing unit began. During an observation on 4/9/26, at 2:35 p.m. a test tray was obtained as the last tray was delivered to the remaining resident. Food temperatures were as follows: -Sliced turkey was 48 F-Mashed potatoes with gravy on top was 55.8 F-Diced carrots: 51 F The food was palatable and smelled savory but was not at an appealing or appetizing temperature. The presentation was in a circular pattern with carrots brightening the plate. During an interview on 4/9/26, at 2:40 p.m. the acting Dietary Manager Employee E12 confirmed the temperatures of the test tray and stated the facility only had one small, insulated food cart, and two metal uninsulated carts for meal tray delivery. During an interview on 4/10/26, at approximately 3:30 p.m. the Nursing Home Administrator confirmed the facility failed to provide the residents with food that is at a safe and appetizing temperature. 28 PA Code: 211.6(b)(c)(d) Dietary services.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 documents and resident and staff interviews, it was determined that the facility's Quality Assurance Performance Improvement (QAPI) committee failed to ensure that the delivery of care and services was effectively provided to residents. Findings include: Review of the facility's Performance Improvement Program Plan indicated, It is the policy of Greenery Center to continually improve the delivery of health care services by designing, measuring, assessing, improving, and redesigning processes of resident care; thereby improving performance. When processes are will designed, they establish expectations and draw on a variety of information sources. New and/or modified processes should meet the following criteria: a. Be consistent with the organization's mission, vision, values and standards of care. b. Met the needs of the staff and individuals served. c. Must be clinically sound and current d. Must be consistent with sound business practices e. Incorporate available information from other sources about the occurrence of sentinel events.f. Incorporate results of performance improvement activities. During a confidential resident group interview on 4/8/26, at 2:00 p.m. residents expressed concerns that the resident restorative program had been discontinued, and the restorative duties were placed on the nurse aides. The residents in the group confirmed that they are not receiving restorative care. Review of Resident Council minutes dated 2/2/26, revealed concerns expressed by residents that the restorative program had been discontinued. During an interview on 4/10/26, at approximately 11:00 a.m. the Nursing Home Administrator (NHA) confirmed that the facility is currently in the state enforcement process for a lack of nurse aide care, dating back to February 2026. It was confirmed with the NHA that residents, the Resident Council, the local Ombudsman, resident interviews, and facility staffing data all indicated that nurse aide staffing was insufficient to meet the basic resident care needs. When asked if the facility had used its QAPI process and plan to ensure effective delivery of the restorative program to residents, the NHA confirmed that the plan was not utilized. It was then confirmed with the NHA that had the QAPI plan had been utilized it would have revealed that placing additional job duties on nurse aides, when currently the facility is experiencing nurse aide staffing shortages, was not a feasible replacement for the restorative program. During an interview on 4/10/26, at approximately 3:00 p.m. the NHA confirmed that the facility's Quality Assurance Performance Improvement committee failed to ensure that the delivery of care and services was effectively provided to residents. 28 Pa. Code 201.14(a) Responsibility of licensee.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on review of facility policy, documentation, and staff interviews it was determined that the facility failed to implement control measures for Legionella within the facility for three of twelve months (February, March, and April 2026). Findings include: Review of the facility policy Legionella Policy and Water Management Plan dated 1/5/26, indicated water testing will be via monthly water temperatures and flushes to ensure water is being maintained and specific actions should be taken for prevention of Legionella and for investigation should a case occur. A review of the water temperature monitoring logs dated February, March, and April 2026 did not include evidence of monthly testing per facility policy. During an interview on 4/10/26 at approximately 1:45 p.m., the interim Maintenance Director, Employee E14 confirmed the facility had no documentation of water testing as per the Legionella Policy for February, March, and April 2026. 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.18(b)(1)(e)(1) Management.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility documents, resident council minutes, and resident interviews, it was determined that the facility failed to provide services in an atmosphere of dignity and respect for six of twenty residents (Residents R9, R21, R26, R63, R64, and R86) and seven of fourteen confidential group residents (Residents R100, R200, R400, R600, R700, R900, and R901).Findings Include: Review of the facility-provided document, Your Rights and Protections as a Nursing Home Resident indicated:At a minimum, Federal law specifies that nursing homes must protect and promote the following rights of each resident. You have the right to: Be Treated with Respect: You have the right to be treated with dignity and respect, as well as make your own schedule and participate in the activities you choose. You have the right to decide when you go to bed, rise in the morning, and eat your meals.Be Free from Abuse and Neglect: You have the right to be free from verbal, sexual, physical, and mental abuse. Nursing homes can't keep you apart from everyone else against your will. If you feel you have been mistreated (abused) or the nursing home isn't meeting your needs (neglect), report this to the nursing home, your family, your local Long-Term Care Ombudsman, or State Survey Agency. Review of a facility-provided letter dated 3/3/26, signed by nine residents, indicated: As residents we are joining together in anticipation of a serious problem at this facility rectified. Each of us has been either neglected, dismissed, or left unattended by aides or employees who are not doing their jobs. The most frustrating reasons include that they are constantly in possession of their cell phones or wearing earbuds and are either talking, eating, watching silly videos, or listening to music when they should be working. Residents are being left in the dining room until 8:30-9pm because aides are sitting in the breakrooms near the nursing stations playing on their phones. There are residents who are not being fed, left lying in dirty briefs and waiting hours to be transferred from their wheelchairs to their beds, aides/employees in the dining room carrying a hot plate in one hand and their cell phone in the other while residents sit at tables waiting and aides vaping in the halls an din the employee bathroom. This has become an enormous problem that is greatly affecting out quality of care and safety. During a resident group interview on 4/8/26, at 2:00p.m. 13 of 14 residents voiced concerns with staff ignoring their care needs. During the group interview, Residents R200 and R700 became tearful. Concerns voiced during Resident Group meeting on 4/8/26, at 2:00 p.m. -They have no intention of taking care of us. 13/14 residents. -Staff turn call lights off, without providing care. 13/14 residents.-Told by administration that We will look into it. 13/14 residents stated this does not happen. -Staff members are using phones while providing care.-All residents who need assistance getting in and out of bed stated they have concerns with not getting staff assistance.-Residents feel dismissed and dehumanized. 13/14 residents.-13/14 residents fear retaliation if they file a complaint. Resident R100:-From the time I was put in my chair, I have had to wait until 10:45 p.m. before they even thought to put me to bed. I rang for a very long time. Nobody attempted to even try.-You don't know if you are going to get back on bed at all.-Told to stay in bed, that I am too much work. -I don't know if anyone even sees me, or if I am invisible. -They don't want to help you.-I was left from 11a to 11 at night. This is too long. My legs were swollen, I was in a lot of pain. -I try to help by being polite, by waiting my turn. But I feel like I'm being completely ignored. -I feel like I'm a table. Just push me in a corner. -I feel like I'm ignored. I say excuse me, hello? I feel like I'm saying stuff, but no one hears. -They say they don't have to time to pull me back up in bed.-It's a 15 to 30 minute wait. Resident R200:-Left on the bed pan through dinner. Staff refused to assist.-On Monday, at 8:30 I pushed my button, and the aide came in, but she was a smart [NAME]. Said she would change me, but wouldn't put me on the bed pan. The she said she would put me on the bed pan and come back in 30-40 minutes. She put me on the bed pan and she didn't come back. Resident R400:-I'm scared. I don't want to be here. -The nurses don't care.-I kept waiting and waiting, I kept on asking her. They left me (continued on next page)

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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	

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	sitting in a urine accident. I was all wet. They just walked out the room. For eight hours I sat in poop and piss. I had a rash. They just put the cream on, they don't even wash me properly. Cream on top of cream. -I'm very disappointed.-Everyone is forgetting about me. Resident R600:-I've had to wait an hour, hour and a half. I had to call my mom one time to have her get somebody down there to get me out of the room, they shut the door and nobody could see me or hear me. Resident R 700:-They answer your light and say they will be right with you. But they never come. Resident R900:-Every other word when we met with the Administrator was about profit. It was not about patient care, it was not about us. Resident R901:-They are always on their phones. They were these earbuds, and you think they are talking to you. And they're not. When you are feeding someone, you should communicate with them. -They are not paying attention to what they are supposed to be doing. This is our home, they are supposed to be caring for us. They don't care. During an interview on 4/9/26, at 2:17 p.m. when asked if she felt the facility maintained sufficient staffing to care for the residents, Resident R86 stated, Whenever they come in, they don't help put me on the bedpan. I tell them, but they don't do anything. I call the supervisors and tell them, ?Please, I want someone to come in.' Resident R86 stated that she is not incontinent, but it becomes painful to hold her bladder for extended times, stated that she is not always provided fresh waters, and that call lights take a very long time to be responded to. Resident R86 stated that to the staff, It's a big nothing. I feel very ignored. Resident R86 became tearful during at time. I see staff walking by, but no one comes in. Makes me feel like I'm dying, I'm not worthy. I try to do everything I can do, because I know there's not enough people. I don't say anything bad, but sometimes I feel like I want to. During an interview on 4/10/26, at 10:00 a.m. Resident R9 stated, They don't give a f**k about us. During an interview on 4/10/26, at 10:10 a.m. Resident R64 stated that she is rushed during care, that there weren't washcloths and she had to be cleaned with a pillowcase. Resident R64 stated that she feels like she isn't treated like a human being. During an interview on 4/10/26, at 10:23 a.m. Resident R21 stated, No and Sometimes it takes four to five hours to get help. During an interview on 4/10/26, at 10:25 a.m. Resident R63 stated that she has been left in a soiled brief for a long time, causing skin irritation. During a follow-up interview on 4/10/26, at 1:2 p.m. Resident R86 stated, Last night I had to wait a long time. I get told to wait because they are going to do somebody else, but they don't come back. Resident R86 again became tearful. During an interview on 4/10/26, at 3:00 p.m. the Nursing Home Administrator confirmed the facility failed to provide services in an atmosphere of dignity and respect for six of twenty residents and seven of fourteen confidential group residents. 28 Pa. Code 201.29(j) Resident Rights28 Pa. Code 211.10(a)(b)(c)(d) Resident Care Policies28 Pa. Code 211.12(d)(1)(2)(3)(4) Nursing Services

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on review of facility documents, resident council documents, resident council group interview, resident interview, and staff interview it was determined that the facility failed to respond to concerns from resident council and failed to respond to concerns in a timely manner for six out of six months (10/7/25, 11/4/25, 12/2/25, 1/6/26, 2/2/26, 2/4/26, and 3/3/26).Findings include: Review of Resident council minutes dated 10/7/25, 11/4/25, 12/2/25, 1/6/26, 2/2/26, 2/4/26, and 3/3/26 identified resident concerns with inadequate staff response to resident care needs. 11/4/25: Call light response times, lack of licensed nursing response to needs, nurse aides taking breaks together, leaving insufficient staff on the unit to meet needs. 12/2/25: Nurse aides taking breaks together, leaving insufficient staff on the unit to meet needs, late meals, not being assisted out of bed timely. 1/6/26: Call light response times, lack of sufficient staff on the unit to meet needs. 2/2/26: Lack of licensed nursing response to needs. 2/4/26: Call light response times, nurse aides too busy to complete restorative care, staff not checking on residents, residents not assisted from the dining room after evening meal, not being assisted from or to bed timely. 3/3/26: Lack of call light response, call lights shut off without care being provided, nurse aides too busy to complete restorative care. Review of a facility-provided letter dated 3/3/26, signed by nine residents, indicated: As residents we are joining together in anticipation of a serious problem at this facility rectified. Each of us has been either neglected, dismissed, or left unattended by aides or employees who are not doing their jobs. The most frustrating reasons include that they are constantly in possession of their cell phones or wearing earbuds and are either talking, eating, watching silly videos, or listening to music when they should be working. Residents are being left in the dining room until 8:30-9pm because aides are sitting in the breakrooms near the nursing stations playing on their phones. There are residents who are not being fed, left lying in dirty briefs and waiting hours to be transferred from their wheelchairs to their beds, aides/employees in the dining room carrying a hot plate in one hand and their cell phone in the other while residents sit at tables waiting and aides vaping in the halls and in the employee bathroom. This has become an enormous problem that is greatly affecting out quality of care and safety. During a resident group interview on 4/8/26, at 2:00p.m. 13 of 14 residents voiced concerns with the facility administration not resolving their concerns over inadequate staff response to resident care needs. On 4/10/26, the Nursing Home Administrator provided a document completed on 4/10/26, which outlined the facility response to voiced Resident Council Concerns. Nurse aides not getting residents up: It has been explained to both the staff and residents that each department has specific tasks to complete. Specifically with residents on the therapy caseload, they had been made aware that nursing must follow the transfer status of therapy, to help ensure safety of the resident and this is provided to upon completion an assessment within the therapy department. Further review of the document failed to reveal education/instruction to nursing staff to assist residents out of bed timely. Nurse aides sitting in the courtyard for extended times: Staff have been redirected to taking breaks in the assigned breaking areas. Further review of the document failed to reveal that the extended breaks were addressed, only the location. On 4/10/26, evidence of the education and instructions to staff of these and other concerns addressed on this document. By survey end, this information was not provided by the facility. During an interview on 4/10/26, at approximately 3:00 p.m. the Nursing Home Administrator confirmed that the facility failed to respond to concerns from resident council and failed to respond to concerns in a timely manner for six out of six. 28 Pa. Code 201.18(b)(1) Management28 Pa. Code 211.12(d)(3) Nursing Services

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observations and staff interviews, it was determined that the facility failed to provide information regarding how to file a grievance and information on the grievance official on three of three nursing units (South, North, and [NAME] nursing units).During an observation of the North nursing unit on 4/9/26, at approximately 10:00 a.m. a grievance box was noted, with forms. Information on the grievance official's name and contact information, the right to file grievances orally, in writing, or anonymously, and the expected time frame for completion of the grievance review was not provided. During an observation of the South nursing unit on 4/9/26, at approximately 10:05 a.m. a grievance box was noted, with forms. Information on the grievance official's name and contact information, the right to file grievances orally, in writing, or anonymously, and the expected time frame for completion of the grievance review was not provided . During an observation of the [NAME] nursing unit on 4/9/26, at approximately 10:10 a.m. a grievance box was not located. During an observation of the dining area on 4/9/26, at approximately 10:15 a.m. a grievance box was noted, with forms. Information on the grievance official's name and contact information, the right to file grievances orally, in writing, or anonymously, and the expected time frame for completion of the grievance review was not provided. During an observation on 4/9/26, at 12:00 p.m. a bulletin board was observed in the hallway leading to the dialysis area, activities room, and the conference room. The information for the grievance official and information on filing grievances was posted but noted to be posted far above the eyesight of a person seated in a wheelchair. During an interview on 4/10/26, at approximately 3:00 p.m. the Nursing Home Administrator confirmed the facility failed to provide information regarding how to file a grievance and information on the grievance official on three of three nursing units. 28 Pa. Code: 201.18(e)(4) Management.

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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	

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy and clinical record review and staff interview, it was determined that the facility failed to complete a restorative nursing program for four of six residents reviewed for ADLs (activities of daily living) concerns (Residents R24, R31, R78, and R93).Findings include: Review of the facility policy Restorative Nursing Program dated 1/5/26, indicated the facility will safely and effectively improve or maintain the patient's current functional status or to prevent deterioration of current functional status as part of the restorative nursing program. During an interview on 4/9/26 at 3:00 p.m., the Physical Therapy Director Employee E20 revealed that restorative activities are documented on the daily Restorative Nursing Care Flow Record. Clinical record review for Resident R24 revealed a diagnoses list that included stroke and right sided weakness. Review of the current care plan for Resident R24 revealed the resident requires assistance with walking and transferring. An intervention included moderate assistance with all ADLs. Review of the physical therapy Discharge summary dated [DATE], indicated highest practical level achieved. Review of the current Restorative Nursing Programs status indicated Resident R24 walked to dine 100 feet with a wheeled walker with staff supervision. Review of the daily Restorative Nursing Care Flow Record dated January through March 2026 did not include documentation that the restorative task was completed. Clinical record review for Resident R31 revealed a diagnoses list that included Parkinson's disease (a progressive movement disorder of the nervous system). Review of the current care plan for Resident R31 revealed the resident requires assistance with walking. An intervention included supervision with all ADLs. Review of the physical therapy Discharge summary dated [DATE], recommended ambulation with staff and wheeled walker. Review of the current Restorative Nursing Programs status indicated Resident R31 walked to dine 100 feet with a wheeled walker with staff supervision. Review of the daily Restorative Nursing Care Flow Record dated January through March 2026 did not include documentation that the restorative task was completed. Clinical record review for Resident R78 revealed a diagnoses list that included quadriplegia and diabetes. Review of the current care plan for Resident R78 revealed the resident is dependent on staff with all ADLs. Review of the physical therapy Discharge summary dated [DATE], recommended supine/seated exercise program 3X10 reps (three sets of 10 repetitions) to LE (lower extremities). Review of the current Restorative Nursing Programs status indicated Resident R78 requires passive stretching of right elbow to extension as tolerated. Review of the daily Restorative Nursing Care Flow Record dated January through March 2026 did not include documentation that the restorative tasks were completed. Clinical record review for Resident R93 revealed a diagnoses list that included dementia, diabetes, and history of falls. Review of the current care plan for Resident 93 revealed the resident walks at liberty with distant supervision and a wheeled walker. An intervention included supervision assistance with ADLs. Review of the physical therapy Discharge summary dated [DATE], indicated resident is able to walk in hallways with wheeled walker and encourage increased walking to maintain. Review of the current Restorative Nursing Programs status indicated Resident R93 to have AROM (assisted range of motion) to bilateral upper and lower extremities on all planes (side to side, front to back, and rotationally) to tolerance. Review of the daily Restorative Nursing Care Flow Record dated January through March 2026 did not include documentation that the restorative tasks were completed. During an interview on 4/9/26 at 2:05 p.m. Nursing Assistant (NA) Employee E21 revealed restorative nursing was not being completed. During an interview on 4/9/26 at 3:00 p.m. the Physical Therapy Director Employee E20 revealed restorative nursing was not being completed. During an interview on 4/9/26 at 1:45 p.m., The Nursing Home Administrator confirmed the above findings and that the facility failed to complete a restorative nursing program for ADLs concerns for Residents R24, R31, R78, and R93.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review, and staff interviews, it was determined that the facility failed to properly monitor weight as ordered for four of six residents (Residents R15, R18, R29, and R33).Findings include: Review of the facility policy, Weight Protocol dated 1/6/26, indicated Residents will be weighed within 24 hours upon admission/re-admission by the CNA (nurse aide). Residents will be weighed weekly for 4 weeks and then monthly ongoing by designated staff. Review of the clinical record indicated Resident R15 was admitted to the facility on [DATE]. Review of Resident R15's Minimum Data Set (MDS - periodic assessment of resident's care needs) dated 2/9/26, included diagnoses chronic obstructive pulmonary disease (COPD, a group of progressive lung disorders characterized by increasing breathlessness) and a communication deficit. Review of Resident R15's current plan of care, initiated 2/6/26, indicated for the facility to, Monitor wts. (weights) per facility policy/approach. Review of a physician's order dated 2/4/26, indicated, Weekly weights x 4 weeks then monthly. Review of Resident R15's weight record for February 2026, failed to include a weight evaluation on 2/11/26, through discharge on [DATE] (discharge to hospital). Review of a physician's order dated 2/25/26, indicated, Weekly weights x 4 weeks then monthly. Review of Resident R15's weight record for March 2026, and April 2026, failed to reveal a weight recorded after 3/3/26, with no refusals of monitoring documented. Review of the clinical record indicated Resident R18 was admitted to the facility on [DATE]. Review of Resident R18's MDS dated [DATE], included diagnoses of 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). Review of Resident R18's current plan of care, initiated 2/6/26, indicated for the facility to, Monitor wts per facility policy/approach. Review of a physician's order dated 3/22/26, indicated, Weekly weights x 4 weeks then monthly. Review of Resident R18's weight record for March 2026, failed to include a weight evaluation after 3/22/26. Review of the clinical record indicated Resident R29 was admitted to the facility on [DATE]. Review of Resident R29's MDS dated [DATE], included diagnoses of heart failure and diabetes. Review of Resident R29's current plan of care, initiated 2/6/26, indicated for the facility to, Monitor wts per facility policy/approach. Review of a physician's order dated 2/12/26, indicated, Weekly weights x 4 weeks then monthly. Review of Resident R29's weight record for February 2026 through April 2026, revealed weight evaluations on 3/3/26 (338 pounds) and 3/5/26 (336 pounds). Per surveyor request, a weight assessment was completed on 4/10/26, which indicated 285 pounds, a change of 51 pounds in 36 days. Review of the clinical record indicated Resident R33 was admitted to the facility on [DATE]. Review of Resident R33's MDS dated [DATE], included diagnoses of heart failure and kidney disease. Review of Resident R33's current plan of care, initiated 1/16/26, indicated for the facility to, Monitor wts per facility policy/approach. Review of a physician's order dated 3/4/26, indicated, Weekly weights x 4 weeks then monthly. Review of Resident R33's weight record for February 2026 through April 2026, failed to reveal weights captured after 2/1/26. Per surveyor request, a weight assessment was completed on 4/10/26, which indicated 199 pounds, a change of approximately 15 pounds in two months. During an interview on 4/10/26, at approximately 3:00 p.m. the Nursing Home Administrator confirmed that the facility failed to properly monitor weight as ordered for four of six residents. 28 Pa. Code: 211.6(b) Dietary services.28 Pa. Code: 211.10(c)(d) Resident care policies.28 Pa. Code: 211.12(d)(1)(3)(5) Nursing services.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility documents, resident observations and interviews, Resident Council minutes, confidential resident group interview, and grievance review, it was determined that the facility failed to have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of eleven of twenty residents (Resident R21, R26, R56, R63, R64, R86, R117, R118, R119, R120, R121), seven of fourteen confidential group residents (Residents R100, R200, R400, R500, R600, R700, and R900), and for five of six Resident Council monthly meetings (October 2025, November2025, December 2025, and February 2026 and March 2026).Findings Include: Review of the Facility Assessment dated 4/14/25, indicated that the facility will follow state required staffing ratios to meet resident to aide/nurse ppd (per patient day) and would provide care for -Activities of Daily Living: (Bathing, showers, oral/denture care, dressing, eating, support with needs related to hearing/vision/sensory impairment; supporting resident independence in doing as much of these activities by himself/herself).-Mobility and fall/fall with injury prevention: Transfers, ambulation, restorative nursing, contracture prevention/care; supporting resident independence in doing as much of these activities by himself/herself.-Bowel/bladder: Bowel/bladder toileting programs, incontinence prevention and care, intermittent or indwelling or other urinary catheter, ostomy, responding to requests for assistance to the bathroom/toilet promptly in order to maintain continence and promote resident dignity. During an interview on 4/9/26, at 2:17 p.m. when asked if she felt the facility maintained sufficient staffing to care for the residents, Resident R86 stated, Whenever they come in, they don't help put me on the bedpan. I tell them, but they don't do anything. I call the supervisors and tell them, ?Please, I want someone to come in.' Resident R86 stated that she is not incontinent, but it becomes painful to hold her bladder for extended times, stated that she is not always provided fresh waters, and that call lights take a very long time to be responded to. During an interview on 4/10/26, at 9:30 a.m. Resident R23 stated she often must leave her room to get staff to assist her roommate (Resident R10). During an interview and observation on 4/10/26, at 10:10 a.m. Resident R64 stated there's not enough staff, she feels her care is rushed, and that meals are often late. Resident R64 was noted to have greasy appearing skin and an unclean face. During an interview on 4/10/26, at 10:16 a.m. when asked if he felt if the facility maintained sufficient staffing to care for the residents, Resident R56 stated No, not at all. Resident R56 stated call light response times are long. During an interview on 4/10/26, at 10:23 a.m. when asked if she thought the facility maintained sufficient staffing to care for residents, Resident R21 stated, No and Sometimes it takes four to five hours to get help. During an interview on 4/10/26, at 10:25 a.m. when asked if she thought the facility maintained sufficient staffing to care for residents, Resident R63 stated, Sometimes the call lights can be long. When asked, Resident R63 confirmed that she has been left in a soiled brief for a long time, causing skin irritation. During a follow-up interview on 4/10/26, at 1:2 p.m. Resident R86 stated, Lat night I had to wait a long time. I get told to wait because they are going to do somebody else, but they don't come back. Review of Resident Council minutes from 10/7/25: Call light response. 11/4/25: Staff not being present on the floor to provide care, not getting residents out of bed. 12/2/25: Staff not responding to call lights unless it is their section, lack of call light response on evening shift. 2/4/26: Staff not getting residents out of bed, left in the dining room after meals, waiting a long time to be assisted to bed. 3/3/26: Call lights being shut off, care not provided. During a confidential resident group interview on 4/8/26, at 2:00 p.m. the following concerns were voiced:-They have no intention of taking care of us. 13/14 residents. -Staff turn call lights off, without providing care. 13/14 residents.-All residents who need assistance getting in and out of bed stated they have concerns with not getting staff assistance. Resident R100: -From the time I was put in my chair, I have had to wait until 10:45 p.m. before they (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	even thought to put me to bed. I rang for a very long time. Nobody attempted to even try.-You don't know if you are going to get back on bed at all.-Told to stay in bed, that I am too much work. -They are short-staffed. -They don't want to help you.-I was left from 11a to 11 at night. This is too long. My legs were swollen, I was in a lot of pain. -I try to help by being polite, by waiting my turn. But I feel like I'm being completely ignored. -They say they don't have to time to pull me back up in bed.-It's a 15 to 30 minute wait. Resident R200:-Left on the bed pan through dinner. Staff refused to assist.-On Monday (4/6/25), at 8:30 I pushed my button, and the aide came in, but she was a smart [NAME]. Said she would change me, but wouldn't put me on the bed pan. The she said she would put me on the bed pan and come back in 30-40 minutes. She put me on the bed pan and she didn't come back. -My roommate doesn't get changed for 4 to 5 hours. Resident R400-They are way understaffed. -I kept waiting and waiting, I kept on asking her. They left me sitting a urine accident. I was all wet. They just walked out the room. For eight hours I sat in poop and piss. I had a rash. They just put the cream on, they don't even wash me properly. Cream on top of cream. Resident R500-There's not enough staff on the weekends, particularly 11p to 7a. Resident R600-Biggest concern is not enough people and staff not answering call lights.-I've had to wait an hour, hour and a half. I had to call my mom one time to have her get somebody down there to get me out of the room, they shut the door and nobody could see me or hear me. Resident R700-One night there was only two on my floor. -They answer your light and say they will be right with you. But they never come.-The nurses say they have so many patients they need to get to. Resident R900-The staff loaf around. The aide keeps disappearing when it's time to pass out trays. -11-7 is the worst times, and the weekends. The call light wait times are so long. Review of a grievance on Resident R118's behalf on 10/1/25, stated, Family concerned not receiving appropriate oral care, am and pm hygiene - bed linens not being changed and not out of bed. Review of a grievance on Resident R117's behalf on 10/7/25, stated, Family in to visit. Resident was up in chair however her nails were in poor condition, feces under nails. Pad on bed was soiled/urine/feces. Review of a grievance submitted by Resident R86 on 12/20/25, stated, Stated she is not getting the care she needs. Review of a grievance on Resident R119's behalf on 12/22/25, stated, Concerned for her mom and roommate (Resident R120) not being set up for meals in bed. Review of a grievance submitted by Resident R86 on 12/23/25, included concerns relating to long call light response times and not being assisted out of bed. Review of a grievance on Resident R121's behalf on 1/5/26, stated, Resident's wife reported aide told resident to use brief and not urinal. Review of a grievance submitted by Resident R78 on 2/12/26, included concerns relating to not receiving showers and not being assisted to bed until midnight. During an interview on 4/10/26, at approximately 3:00 p.m. the Nursing Home Administrator confirmed that the facility failed to have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of eight of eleven residents, seven of 14 confidential group residents, and for five of six Resident Council monthly meetings. 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code 201.18(e)(6) Management. 28 Pa. Code: 201.20(a) Staff development.28 Pa. Code: 211.12(a)(c)(d)(1)(2)(3)(4) Nursing services.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on review of facility documents and staff interview, it was determined that the facility failed to complete annual performance evaluations for five of five nurse aides (Employees E2, E3, E4, E5, and E6).Finding include: During an interview on 4/10/26, at approximately 10:00 a.m. Human Resources Director Employee E1 confirmed that the facility did not complete performance reviews for Employees E2, E3, E4, E5, and E6. During an interview on 4/10/26, at approximately 3:00 p.m. the Nursing Home Administrator confirmed that the facility failed to provide the required 12 hours annual in-service education within 12 months of their hire date anniversary for five of five nurse aides. 28 Pa. Code: 201.14(a) Responsibility of Licensee.28 Pa. Code: 201.20(a)(b)(c)(d) Staff Development.28 Pa. Code: 211.12(c)(d)(1)(2)(5) Nursing Services.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on review of job descriptions, clinical records, and staff interviews, it was determined that the Nursing Home Administrator (NHA) and the Director of Nursing (DON) failed to effectively manage the facility to ensure provider notification of resident changes in condition. This failure resulted in immediate jeopardy for 12 of 21 residents (R2, R4, R16, R33, R37, R46, R47, R56, R70, R80, R97, and R116).Findings include: Review of the facility-provided Nursing Home Administrator (NHA) job description indicated, The Nursing Home Administrator (NHA) is responsible for the overall leadership, management, and operation of The Greenery Center for Rehab and Nursing. This role ensures the delivery of high-quality short-term rehabilitation and long-term care services while maintaining compliance with all federal, state (Pennsylvania), and local regulations. The NHA promotes a resident centered environment focused on clinical excellence, safety, and compass. Review of the facility-provided Director of Nursing (DON) job description indicated, The Director of Nursing (DON) is responsible for the overall clinical leadership and management of nursing services at The Greenery Center for Rehab and Nursing. This role ensures the delivery of high-quality, resident-centered care in both short-term rehabilitation and long-term care settings, while maintaining full compliance with Pennsylvania Department of Health and CMS regulations. Based on findings identified in this report, the facility failed to ensure that physicians or other advanced practice providers were notified of capillary blood glucose levels beyond the parameters set in the physicians' orders. The NHA and the DON failed to fulfill their essential job duties to ensure the federal and state guidelines and regulations were followed. During an interview on 4/10/26, at approximately 3:00 p.m. the NHA and current DON confirmed that facility administration failed effectively manage the facility to ensure provider notification of changes in condition. This failure created an Immediate Jeopardy situation for 12 of 21 residents. 28 Pa. Code 201.14(a) Responsibility of licensee.28 Pa. Code 201.18(b)(1)(3)(e)(1) Management.28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of select facility policies and procedures, current Centers for Disease Control (CDC) guidelines, clinical record review, and staff interview, it was determined that the facility failed to document each resident was offered a Covid 19 immunization and the resident or resident's representative was provided education regarding the benefits and potential side effects of immunizations, for four of five residents reviewed for immunizations (Residents R20, R24, R31, and R98).Findings include: A review of facility policies, Covid Protocols Post PHE, dated 1/5/26, indicated vaccines are administered in accordance with Centers for Disease Control and Prevention (CDC) recommendations. All residents are encouraged to remain up to date with all recommended Covid 19 vaccine doses. Staff and residents will be educated on the risks/benefits of the Covid vaccination and will be offered the vaccination. A review of the clinical record indicated Resident R20 was admitted to the facility on [DATE], with diagnoses that included COPD (chronic obstructive lung disorder). A review of the Resident Influenza/Pneumococcal/Covid-19 Consent Declination dated 10/8/25 did not include evidence that the resident was offered the Covid-19 vaccine. A review of the clinical record Immunizations documentation on 4/10/26 at 11:00 a.m., did not include information that the Covid-19 vaccines were offered or declined. A review of the clinical record indicated Resident R24 was admitted to the facility on [DATE], with diagnoses that included stroke. A review of the Resident Influenza/Pneumococcal/Covid-19 Consent Declination dated 10/2/25 did not include evidence that the resident was offered the Covid-19 vaccine. A review of the clinical record Immunizations documentation on 4/10/26 at 11:00 a.m., did not include information that the Covid-19 vaccines were offered or declined. A review of the clinical record indicated Resident R31 was admitted to the facility on [DATE], with diagnoses that included Parkinson's (a progressive movement disorder of the nervous system) and bipolar disorder. A review of the Resident Influenza/Pneumococcal/Covid-19 Consent Declination dated 10/14/25 did not include evidence that the resident was offered the Covid-19 vaccine. A review of the clinical record Immunizations documentation on 4/10/26 at 11:00 a.m., did not include information that the Covid-19 vaccines were offered or declined. A review of the clinical record indicated Resident R98 was admitted to the facility on [DATE], with diagnoses that included congestive heart failure, and diabetes. A review of the Resident Influenza/Pneumococcal/Covid-19 Consent Declination dated 10/8/25 did not include evidence that the resident was offered the Covid-19 vaccine. A review of the clinical record Immunizations documentation on 4/10/26 at 11:00 a.m., did not include information that the Covid-19 vaccines were offered or declined. During an interview on 4/10/26 at 11:00 a.m., the Infection Control Preventionist (ICP) Employee E13 confirmed the above findings, and that the facility failed to document each resident was offered a Covid-19 vaccine and the resident or resident's representative was provided education regarding the benefits and potential side effects of immunizations, for Residents R20, R24, R31, and R98.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on review of facility documents, staff education records, and staff interviews, it was determined that the facility failed to conduct at least 12 hours of in-service education, within 12 months of their hire date anniversary, for nurse aides as required for five of five nurse aides (Employees E2, E3, E4, E5, and E6).Finding include: Review of the Facility Assessment last reviewed 4/15/25, indicated the facility follows all state and federal guidelines for staffing education. Review of the facility provided, Nursing Assistant In-Service Hours document indicated that Nurse Aide (NA) Employees E2, E3, 14, and E5, E6 had the following education: Nurse Aide (NA) Employee E2 had a hire date of 3/7/86, with 2.00 hours in-service education between 3/7/25, and 3/7/26.NA Employee E3 had a hire date of 3/6/20, with 2.00 hours in-service education between 3/6/25, and 3/6/26.NA Employee E4 had a hire date of 9/30/91, with 4.00 hours in-service education between 9/30/24, and 9/30/25.NA Employee E5 had a hire date of 12/21/00, with 4.00 hours in-service education between 12/21/24, and 12/21/25.NA Employee E5 had a hire date of 1/22/24, with 4.00 hours in-service education between 1/22/25, and 1/22/26. No additional documentation of hours were provided to the survey team, as requested, by the end of the survey. During an interview on 4/10/26, at approximately 3:00 p.m. the Nursing Home Administrator confirmed that the facility failed to provide the required 12 hours annual in-service education within 12 months of their hire date anniversary for five of five nurse aides. 28 Pa. Code: 201.14(a) Responsibility of Licensee.28 Pa. Code: 201.20(c) Staff Development.28 Pa. Code: 211.12(c)(d)(1)(2)(5) Nursing Services.

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 04/10/2026

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records and staff interviews, it was determined that facility staff failed to maintain ongoing communication with the dialysis (a machine filters waste, salt and fluid from your blood when your kidneys are no longer healthy enough to do this work adequately) center for one of five residents reviewed (Resident R1).Findings include: Review of the facility policy Dialysis Management reviewed 1/5/26, indicated the facility has designed and implemented processes which strive to ensure the comfort, safety, and appropriate management of hemodialysis residents regardless of if the procedure is performed at the dialysis center. Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE], with diagnoses that included sepsis (overwhelming and life-threatening response to infection that causes organ failure), dependence on renal (kidney) dialysis, and diabetes. Review of the Minimum Data Set (MDS - periodic assessment of care needs) date 1/27/26, indicated the diagnoses remain current. Review of a physician's order dated 1/22/26, indicated Resident R6 was to receive dialysis three days a week on Monday, Wednesday, and Friday. Review of a care plan dated 1/22/26, indicated the following interventions:- Monitor pre and post dialysis weights.- Encourage the resident to go for the scheduled dialysis appointments.- Monitor vital signs as needed/ordered. Notify doctor of significant abnormalities. Review of the dialysis communication forms from January 2026 through April 2026, revealed 12 communication forms out of 16 not completed by the nursing facility pre-dialysis on 1/27/26, 2/2/26, 2/4/26, 2/6/26, 2/9/26, 2/11/26, 2/13/26, 2/18/26, 2/20/26, 2/25/26, 3/21/26, and 3/23/26; and 16 possible missing communication sheets on dialysis days 2/16/26, 2/23/26, 2/27/26, 3/2/26, 3/6/26, 3/9/26, 3/11/26, 3/13/26, 3/16/26, 3/18/26, 3/25/26, 3/27/26, 4/1/26, 4/3/26, and 4/6/26. During an interview on 4/10/26, at 9:00 a.m. the Registered Nurse Assessment Coordinator (RNAC) Employee E11 confirmed the facility failed to ensure the dialysis communication form was completed pre and post treatment between the facility and dialysis center and confirmed the missing dialysis sheets were not available at the facility. During an interview on 4/10/26, at approximately 3:00 p.m. the Nursing Home Administrator confirmed the facility failed to ensure dialysis communication sheets were completed prior to dialysis treatment. 28 Pa Code: 211.10(c)(d) Resident care policies.28 Pa Code: 211.12(d)(1)(2)(3)(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies, observations and staff interview, it was determined that the facility failed to make certain that out of date medications were discarded in one of three medication rooms (North Unit medication room) and failed to properly secure a treatment cart on one of two nursing units (South Unit). Findings include: Review of the facility policy Medication Storage in the Facility, dated [DATE], indicated medications and biologicals are stored safely, securely, and properly. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medication. Also, Outdated, contaminated, or deteriorated medication and those in containers that are cracked, soiled, or without secure closures are immediately removed from inventory. During an observation of the North Unit medication room on [DATE], at 1:40 p.m. revealed:(7) Blood collection tubes with an expiration date of [DATE].(15) Blood collection tubes with an expiration date of [DATE].(7) Blood collection tubes with an expiration date of [DATE].(1) Anaerobic blood culture bottle with an expiration date of [DATE].(1) Aerobic blood culture bottle with an expiration date of [DATE].(4) glycerin swab sticks with an expiration date of 1/2026.(62) hydrocortisone packets with an expiration date of 10/2025.(2) hydrocolloid dressings with an expiration date of 07/2024.(3) foam dressings with an expiration date of [DATE].(3) Huber needle sets with an expiration date of [DATE].(1) Silicone contact layer with an expiration date of [DATE]. During an interview on [DATE], at approximately 1:55 p.m. Licensed Practical Nurse Employee E7 confirmed the above items were expired. During an observation on [DATE], at 9:45 a.m. a treatment cart was unsecured inside the supply room with the door propped open. The treatment cart contained two bottles of peroxide, one bottle of rubbing alcohol, seven bottles of resident specific ammonium lactate 12 % (lotion used to treat dry, scaly skin conditions), and seven tubes of triamcinolone acetonide (cream used to reduce inflammation, itching, and redness, or joint pain), and various bandages and gauze. During an interview on the same date and time, Registered Nurse Assessment Coordinator (RNAC) Employee E11 confirmed the treatment cart should be secured when unattended, and the door to the supply room should not be propped open. During an interview on [DATE], at approximately 3:00 p.m. the Nursing Home Administrator confirmed that the facility failed to make certain that out-of-date medications were discarded in one of three medication rooms and failed to properly secure a treatment cart inside a propped door. 28 Pa. Code: S211.9(a)(1)(k) Pharmacy services.28 Pa. Code: S211.12(d)(1)(5) Nursing services.

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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 facility policy review, review of Quality Assurance attendance records, and staff interview, it was determined that the facility failed to conduct Quality Assessment and Assurance (QAA) meetings at least quarterly with all the required committee members for one of three quarterly meetings (Quarter four of 2025).Findings Include: The facility Quality Assurance and Performance Improvement (QAPI) policy dated 1/5/26, indicated the QAPI program is an ongoing comprehensive program that addresses all the systems of care and shall evaluate, monitor, and investigate quality of care in the facility. Meeting, at a minimum, at least quarterly; monthly or more often if needed. Review of Quality assurance and Performance Improvement sign in sheets and attendance records for Quarter Four of 2025, failed to reveal a meeting was held as required. During an interview on 4/10/26, at 10:40 a.m. the Nursing Home Administrator confirmed that the facility failed to conduct Quality Assessment and Assurance (QAA) meetings at least quarterly with all the required committee members for one of four quarterly meeting (Quarter Four of 2025), as required.

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F 0838 Level of Harm - Potential for minimal harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on review of facility documents and staff interview, it was determined that the facility failed to accurately complete the Facility Assessment. Findings include: Review of the Facility Assessment Tool, dated 4/15/25, revealed the facility did not complete the template to indicate accurate information on: The section titled Disease and Conditions included tables to document information on the categories of care and average number of residents who received special treatments. This table was left blank. Additionally, a table was included to document the levels of assistance with Activities of Daily Living that residents required. This table was left blank. The section titled Disease and Conditions indicated the facility denies resident admissions if they require ventilator care. Review of the section titled Physical Environment and Building/Plant Needs included ventilators as a type of physical equipment available for resident care. Review of the section titled Physical Environment and Building/Plant Needs included a gift shop, and a cafe/snack bar/bistro available for resident use. Review of the section titled Staffing Plan indicated that the facility follows all state and federal guidelines for staffing education. Review of facility provided in-service education information revealed no nurse aide met the 12-hour annual requirement. During an interview on 4/1026, at approximately 3:00 p.m. the Nursing Home Administrator confirmed that the facility failed to accurately complete the Facility Assessment. 28 Pa. Code 201.18(b)(3)(e)(2) Management.

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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	

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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 - Potential for minimal harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, it was determined that the facility failed to ensure that the resident and/or their representative received written notice of the facility bed-hold policy at the time of transfer for three of six residents reviewed for hospitalization (Resident R8, R15, and R30).Findings include: Review of federal regulation S483.15(d) Notice of Bed-Hold Policy, indicated, facilities must provide written information about these policies to residents prior to and upon transfer for such absences. This information must be provided to all facility residents, regardless of their payment source. These provisions require facilities to issue two notices related to bed-hold policies. The first notice could be given well in advance of any transfer, i.e., information provided in the admission packet. Reissuance of the first notice would be required if the bed-hold policy under the State plan or the facility's policy were to change. The second notice must be provided to the resident, and if applicable the resident's representative, at the time of transfer, or in cases of emergency transfer, within 24 hours. It is expected that facilities will document multiple attempts to reach the resident's representative in cases where the facility was unable to notify the representative. The notice must provide information to the resident that explains the duration of bed-hold, if any, and the reserve bed payment policy. It should also address permitting the return of residents to the next available bed. Review of the clinical record indicated Resident R8 was admitted to the facility on [DATE]. Review of Resident R8's minimum data set (MDS - periodic assessment of resident care needs) dated 3/31/26, included diagnoses of heart failure (a progressive heart disease that affects pumping action of the heart muscles) and history of a stroke. Review of Section C: Cognitive Patterns indicated Resident R8 had moderate cognitive impairment. Review of a progress note dated 9/9/25, at 12:32 p.m. indicated, wife request to send resident to ER for evaluation due to decline. No eating much, barely drinking, and vomiting anytime he tries to eat or drink. Labs are consistently getting worse. 911 called. Further review of Resident R8's clinical record failed to reveal notation that the written notice of bed hold notification was provided to the Resident or Resident Representative upon transfer. Review of the clinical record indicated Resident R15 was admitted to the facility on [DATE]. Review of Resident R15's MDS dated [DATE], included diagnoses chronic obstructive pulmonary disease (COPD, a group of progressive lung disorders characterized by increasing breathlessness) and a communication deficit. Review of Section C: Cognitive Patterns indicated Resident R10 had severe cognitive impairment. Review of a progress note dated 2/14/26, at 4:33 p.m. indicated, Resident left via EMS (emergency medical services) stretcher to [local hospital] for evaluation and treatment of R (right) leg. Wife and brother-in-law at the bed side. Family satisfied with plan of care at this time. Further review of Resident 15's clinical record failed to reveal notation that the written notice of bed hold notification was provided to the Resident or Resident Representative upon transfer. Review of a progress note dated 3/6/26, at 3:51 p.m. indicated, HGB (hemoglobin) result back and is 5.5. resident being sent out to hospital for transfusion per [nurse practitioner]. Family made aware of results and transport to hospital for transfusion. Further review of Resident 15's clinical record failed to reveal notation that the written notice of bed hold notification was provided to the Resident or Resident Representative upon transfer. Review of the clinical record indicated Resident R30 was readmitted to the facility on [DATE]. Review of Resident R30's MDS dated [DATE], included diagnoses of high blood pressure and history of a stroke. Review of Section C: Cognitive Patterns indicated Resident R10 had severe cognitive impairment. Review of a progress note dated 2/5/26, at 10:10 a.m. indicted, This nurse called to room to find resident on the commode in the bathroom slumped over and not responding per his normal. He was drooling and did not answer any questions or follow any verbal commands. [Nurse practitioner] notified and resident sent to the hospital via squad for evaluation. Further review of Resident 30's clinical record failed to reveal notation that the written (continued on next page)

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	notice of bed hold notification was provided to the Resident or Resident Representative upon transfer. Review of a progress note dated 4/5/26, at 2:55 a.m. indicated, This nurse was notified by floor nurse that resident was seizing and had been seizing and given medication without any effective results. 911 was called due to all interventions being ineffective. EMTs took over care and was able to administer medication through IJ line (internal jugular line is a central venous catheter placed into the internal jugular vein in the neck) seizure was stopped and resident was transported to hospital. Son called with no success from floor nurse, Provider notified. Further review of Resident 30's clinical record failed to reveal notation that the written notice of bed hold notification was provided to the Resident or Resident Representative upon transfer. During an interview on 4/10/26, at approximately 3:00 p.m. the Nursing Home Administrator and the Director of Nursing confirmed the facility failed to ensure that the resident and/or their representative received written notice of the facility bed-hold policy at the time of transfer for three of six residents reviewed for hospitalization. 28 Pa. Code 211.5(d)(f) Clinical Records