STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395743	A. Building B. Wing	04/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greentree Skilled Nursing and Rehabilitation Ctr	1848 Greentree Road Pittsburgh, PA 15220

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39311 Based on clinical and facility record review, facility submitted documents, and staff interviews, it was determined that the facility failed to provide adequate supervision to be aware of resident's departure from the facility for one of seven residents (Resident R1). Review of the clinical record revealed Resident R1 was admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS - periodic assessment of resident care needs) dated 2/11/24, included diagnoses of high blood pressure and obesity. Review of an Elopement Risk Assessment completed on 11/10/23, indicated Resident R1 was not risk for elopement. Review of Resident R1's plan of care for Potential for Discharge initiated 11/9/23, indicated that Resident R1 will be discharged home when clinical and rehabilitation goals are met. Review of a progress note written by the Director of Nursing, dated 3/31/24, at 1:16 p.m., written on 4/1/24, at 11:20 a.m., indicated Resident returned from LOA (leave of absence) with son around 10:30 pm on Easter (3/21/24), Son packed up all belongings and cleared her room out. Did not sign AMA papers, nor took medications. MD notified, Police asked to do a wellness check. Resident alert and oriented x3. Review of a progress note written by Registered Nurse (RN) Employee E1 dated 4/1/24, at 9:00 a.m. indicated Resident not in room. Per roommate resident packed her belongings and left with her son at approximately 1 AM. Unit Manager notified. During an interview with Resident R2 (roommate of Resident R1) on 4/4/24, at approximately 11:30 a.m., that she was still awake Resident R1 left, at what she thought was about 1:00 a.m. Resident R2 stated She left with her boy, her son. She didn't even say good-bye. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/4/24, at approximately 1:30 p.m. Unit Manager Employee E2 stated that she was notified during morning meeting, by RN Employee E1 that while completing her morning medication pass, Resident R1 was not on the floor. Unit Manager Employee E2 stated she was told by both RN Employee E1 and Nurse Aide (NA) Employee E3 that neither were informed during the report provided by night shift working from 3/31/24, into 4/1/24, that Resident R1 had left the building. Unit Manager Employee E2 further confirmed she called NA Employee E4, who had Resident R1 as part of her assignment on the night shift from 3/31/24, into 4/1/24, and NA Employee E4 stated to her that she was not aware that Resident R1 had left the building. During an interview on 4/4/24, at approximately 3:30. the Nursing Home Administrator was made aware that the facility's failure to provide adequate supervision to be aware of a resident's departure from the facility for one of seven residents. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(e)(1) Management. 28 Pa. Code 201.20(b)(1) Staff Development. 28 Pa. Code 201.29(a) Resident rights. 28 Pa. Code 211.10(c)(d) Resident care policies. 28 Pa. Code 211.11(d) Resident care plan. 28 Pa Code 211.12(d)(1)(2)(5) Nursing services.