

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395875	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/21/2024
NAME OF PROVIDER OR SUPPLIER  Greenwood Center for Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  149 Lafayette Avenue Tamaqua, PA 18252	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0865</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Have a plan that describes the process for conducting QAPI and QAA activities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48277</b></p> <p>Based on review of select facility policy and reports and clinical records and resident and staff interviews, it was determined that the facility failed to demonstrate the implementation of ongoing QAPI programs, to include the use of systems for investigating and analyzing the root cause of adverse events as evidenced by one resident out of six sampled (Resident B1).</p> <p>Findings include:</p> <p>Review of the facility policy titled Quality Assurance and Performance Improvement last reviewed in January 2024, revealed that the facility shall develop, implement and maintain an effective, comprehensive, data-driven QAPI program that is focused on indicators of the outcomes of care and quality of life for the residents.</p> <p>The policy guidance of the QAPI program is to:</p> <p>(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program which may include but is not limited to:</p> <p>a. systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and</p> <p>b. documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities;</p> <p>(2) Present QAPI plan to State Survey Agency as requested;</p> <p>(3) Presents its QAPI plan to State Survey Agency or Federal surveyor at each annual recertification survey; and</p> <p>(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, federal surveyor or CMS upon request.</p> <p>Clinical record review revealed that Resident B1 was admitted to the facility on [DATE], with diagnoses to include end stage renal disease, dependence on renal dialysis (process of removing waste products and excess fluid from the body when the kidneys are not able to adequately filter the blood), and diabetes (failure of the body to produce insulin).</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0865</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of a significant change Minimum Data Set assessment (MDS - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated June 7, 2024, revealed that the resident was cognitively intact with a BIMS (brief interview to assess cognitive status) score of 15 (score of 13-15 indicated that the resident was cognitively intact), and required partial/moderate assistance to perform rolling tasks.</p> <p>Review of the resident's care plan, dated September 21, 2016, revealed that she utilized assist bars as enablers for bed mobility. The care plan also indicated that Resident B1 had multiple pressure related skin failures related to impaired mobility, moisture , history of diabetes, end state renal disease, atherosclerosis, incontinence and mechanical lift use,</p> <p>A nurses note dated May 8, 2024, at 2:10 PM indicated that after receiving wound care treatment from the wound care physician, Resident B1 required a bed linen change. While turning the resident toward the nurse, the nurse heard/felt a pop near the resident's right knee in her thigh. The nurse indicated that the resident's body was in correct alignment during turning. The resident called out in pain. Areas assessed by RN once lying flat, no swelling noted, pain with palpation.</p> <p>Continued review of nurses notes dated May 8, 2024, at 3:00 PM revealed that an attempt was made to contact the physician at 2:15 PM to obtain an x-ray, however the physician did not respond. The facility contacted the on-call answering service and received an x-ray order at 2:55 PM.</p> <p>Review of the mobile x-ray report of the right hip, femur and knee dated May 8, 2024, at 4:57 PM revealed no acute fracture.</p> <p>Review of the facility incident report dated May 8, 2024, at 3:15 PM revealed that wound rounds were completed with the consultant wound care physician and nurse aide. Linens needed to be changed after treatment. While turning the resident towards the nurse to change the linens with the wound care nurse aide, they heard/felt a pop near her right knee, in her thigh. Body in correct alignment during turning. Resident yelled out in pain.</p> <p>Review of the witness statement from Employee 1 (registered nurse) dated May 8, 2024 (no time indicated) revealed that after wound care, the wound care nurse aide and I were changing soiled bed linens. I went to turn her {the resident} toward me, felt/heard a pop in right leg, and heard {Resident B1} cry in pain. Proper turning was being performed by staff.</p> <p>Review of the witness statement from Employee 2 (wound care nurse aide) dated May 8, 2024, (no time indicated), revealed that while changing soiled linen, {Employee 1} and I properly turned her {the resident}. The resident complained of pain in her knee while being turned.</p> <p>At the time of the survey ending June 21, 2024, the facility was unable to provide documented evidence that a witness statement from the cognitively intact Resident B1 was obtained to obtain the resident's account of the incident that resulted in her injury on May 8, 2024.</p> <p>Review of nurses notes dated between May 9, 2024, and May 31, 2024, revealed that Resident B1 continued to experience increased pain in her right knee. On May 15, 2024, a new physician's order for an MRI of the right knee was obtained. An MRI was not performed until May 30, 2024.</p> <p>(continued on next page)</p>		

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<p>F 0865</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the MRI results dated May 31, 2024, revealed that the resident had sustained a right lateral femoral condyle fracture extending from the posterior margin of the condyle through the anterior weight bearing surface. 2 mm articular surface step-off anteriorly. No displacement or articular malalignment.</p> <p>(The knee comprises of the thigh bone (femur), the kneecap (patella) and the shin bone (tibia) joining together. The femoral condyles are on the ball-shaped end of the femur which meet at the knee joint. Each leg has two condyles, one medial (to the inner side of the knee) and one lateral (to the outer side of the knee). Thus, fractures to this structure are either a medial femoral condyle fracture or a lateral femoral condyle fracture. The cause of medial and lateral femoral condyle fractures are mostly due to traumatic injuries, such as falling or jumping and landing from a great height. The force of this event may even fracture other bones within the knee or legs)</p> <p>During an interview with Resident B1 on June 21, 2024, at 11:00 AM while she was lying in bed, she stated that no one in the facility approached her to take her statement regarding the incident that occurred on May 8, 2024, during which she fractured her leg. She stated that she had just finished her wound treatment with the wound doctor and {Employee 1} told me to roll over. Well, you know how {Employee 1} is- she is fast at everything she does. I can do it (roll), but I wasn't fast enough for her, and she just grabbed my knee and pulled it. It popped and it hurt so bad, and I said Oh, you broke my leg!</p> <p>Continued interview with Resident B1 on June 21, 2024, revealed that the resident uses bilateral assist bars to help her roll side to side in bed. Resident B1 demonstrated to the surveyor how she was able to reach and hold onto the assist bar and pull her upper body toward the bar. Resident B1 reported that when rolling to the left the day of the incident on May 8, 2024, Employee 1 did not place her hand on the resident's shoulder or her hip to try to assist in rolling, she just pulled on her knee, which resulted in a significant injury, a right lateral femur fracture.</p> <p>Interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on June 21, 2024, at 11:45 AM, confirmed that the facility did not obtain a witness statement from Resident B1 although she is cognitively intact with a BIMS score of 15 . The NHA and DON further stated that they did not feel it was necessary to obtain a statement from Resident B1 to obtain the resident's account since both employees stated in their witness statement that proper turning was performed.</p> <p>During an interview with Employee 1 on June 21, 2024, at 11:50 AM she stated that she utilized a proper rolling technique when rolling Resident B1 on May 8, 2024. When asked to clarify proper rolling technique, Employee 1 stated she placed her hands on the resident's shoulder and hip/thigh region. The resident, when interviewed during the survey ending June 21, 2024, stated that Employee 1 did not use the technique described to the surveyor, and had not placed her hand the resident's shoulder or hip.</p> <p>Multiple attempts were made to contact Employee 2 at the time of the survey ending June 21, 2024, but the employee did not answer or return the telephone calls.</p> <p>At the time of the survey ending June 21, 2024, the facility had not thoroughly investigated this adverse event during which Resident B1 was seriously injured. The facility failed to obtain a witness statement from a cognitively intact resident, and therefore was unable to assure accurate identification of the root cause of the incident.</p> <p>(continued on next page)</p>		

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<p>F 0865</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident B1's statement obtained from the surveyor during the survey ending June 21, 2024, and the statements the facility obtained from the employees involved, were not consistent. The facility was unable to show any corrective actions developed as a result of the QAPI review of this event, as the investigation was incomplete. There was no evidence that the facility had fully investigated the circumstances surrounding the resident's injury to fully ascertain the underlying cause or contributing factors to this incident and to demonstrate the facility's good faith efforts to verify that Employee 1 and Employee 2 had in fact used proper technique and that remedial or corrective actions were not required with these employees to prevent injury to residents.</p> <p>There was no evidence at the time of the survey that the facility demonstrated an effective QAPI program to include outcomes of quality of care and quality of life by investigating resident incidents and maintaining thorough documentation to support their analysis of the data collected and any corrective actions developed and implemented.</p> <p>28 Pa. Code 201.18 (b)(1)(3)(e)(1)(4) Management</p> <p>28 Pa. Code 211.12(c) Nursing Services</p>		