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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395875	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenwood Center for Nursing and Rehab	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)
F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on review of clinical records and staff interviews it was determined the facility failed to provide nursing services consistent with professional standards of quality to ensure that licensed staff properly evaluated and provided nursing care for one resident (Resident CR1) out of 5 residents reviewed. Findings include: According to the Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.11 (a)(1)(2)(4) indicates that the registered nurse was to collect complete ongoing data to determine nursing care needs, analyze the health status of individuals and compare the data with the norm when determining nursing care needs, and carry out nursing care actions that promote, maintain, and restore the well-being of individuals. Clinical record review revealed that Resident CR1 was admitted to the facility on [DATE], with diagnosis to include, COVID-19 positive, cognitive communication deficit (A cognitive communication deficit is a communication difficulty caused by a cognitive impairment) and acute kidney failure. An admission Minimum Data Set assessment (Minimum Data Set - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated [DATE] revealed that Resident CR1 had a BIMS score of 12 (a score of 8 to 12 indicates moderate cognitive impairment) and required staff assistance for activities of daily living. A review of physician's orders dated [DATE] indicated the resident was ordered to have vital signs (measurements of the body's most basic functions, such as temperature, pulse rate, respiration rate, and blood pressure) taken every shift. A review of admission nursing documentation dated [DATE], at 7:30 PM indicated Resident CR1 arrived at facility from a hospital stay. While at the hospital he was diagnosed with Covid 19 after having increased weakness and fatigue at home. The resident was placed on the facility's designated COVID-19 isolation hallway. Resident CR1 was the only COVID-19 positive resident in the facility at the time of his admission and was housed in this hallway unit. The residents door as well as the hallway exit doors were kept closed at all times. (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

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 10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A review of a nursing assessment completed on [DATE], revealed the resident's vital signs were stable. The resident was noted to have diminished lung sounds but did not complain of any shortness of breath at that time. The facility's certified registered nurse practitioner (CRNP) examined the resident on [DATE], at 10:16 AM. The CRNP noted at the time of the assessment, the resident had a mild productive cough, denied increased shortness of breath, had bilateral rales (an abnormal lung sound), and was exhibiting diarrhea. It was documented the resident was not in any acute distress. A review of nursing documentation, contained in the clinical record, dated [DATE], at 8:26 AM revealed the resident's condition had deteriorated. The resident's daughter notified nursing the resident was having trouble breathing. Facility staff were unable to obtain an oxygen saturation level (blood oxygen saturation level which is the amount of oxygen circulating in the blood. A normal resting pulse oximetry reading for oxygen saturation is between 95% and 100%. This shows that blood has an appropriate amount of oxygen. If oxygen saturation level drops below 95%, it may suggest a potential issue with the lung or heart function. Levels below 92% are considered low and may require medical attention. Seek immediate medical attention for a reading of 88% or lower) using pulse ox (a small, electronic device that measures the amount of oxygen in your blood) on each finger with multiple attempts. The resident was noted to be using accessory muscles (muscles that are not primarily responsible for respiration but can assist in the act of breathing when there is increased demand, or when the primary muscles of respiration are not sufficient to achieve adequate gas exchange) while breathing. The resident stated he was having difficulty breathing at that time. Nursing contacted the CRNP via telephone, and new orders were received for oxygen, 5 L/min via nasal cannula to keep the resident's oxygen level at 90% or above and Ipratropium-Albuterol Solution (respiratory treatment) 0XXX,d+[DATE].5 (3)MG/3ML,3 ml inhale orally via nebulizer every 6 hours for shortness of breath/Wheezing for 5 Days. Nursing documentation indicated they continued to be unable to obtain pulse oximetry levels. A review of the clinical record revealed the nurse practitioner failed to examine or evaluate the resident after the resident had a change in condition and was experiencing difficulty breathing and had an unobtainable oxygen saturation level. A review of nursing documentation dated [DATE], at 12:54 PM indicated that Resident CR1 complained of difficulty breathing and was using his accessory muscles to assist with breathing. The facility staff at that time were unable to get pulse oximetry reading with multiple attempts on all fingers. A review of the resident's July Medication Administration Record (MAR) revealed on [DATE], Resident CR1 received a nebulizer treatment at 12:00 PM over three hours from when his symptoms of shortness of breath initially began. A review of nursing documentation revealed that the treatment was given after the CRNP's order was documented as received on [DATE], at 12:54 P.M. There was no documented evidence the facility staff had provided any further assessments or follow up vital signs after the resident had difficulty breathing and unobtainable oxygen level. The facility failed to document the resident's condition to show if the resident was improving or declining or if the CRNP's orders were effective. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	An interview with the NHA [DATE], at 2:00 PM indicated the CRNP was in the facility on [DATE], at 10:30 AM but failed to assess the resident. A review of nursing documentation dated [DATE], 5:38 PM indicated the resident's daughter ran to the nurse's station at 4:50 PM and stated, I think my father stopped breathing! The nurse immediately ran to room to check the resident after instructing nurse aide to get another nurse immediately. The CPR cart was brought into the room. Staff were unable to detect a pulse. The resident's breathing ceased. The AED (automated external defibrillator, a portable device used to treat a person whose heart has suddenly stopped working) initiated and started by nursing staff. EMS(emergency medical services personal) was called by nursing staff and and facility staff were instructed to begin CPR. CPR was started by the facility staff. EMS arrived within 5 minutes and took over CPR. The Physician was in the facility and called into the room. CPR was not effective, and the resident expired on [DATE], at 5:00 PM. There was no evidence at the time of the survey that staff timely responded to this resident's immediate medical needs. During an interview [DATE], at 2:00 PM, the Nursing Home Administrator and the Director of Nursing confirmed that Resident CR1 was not timely assessed after a change in condition. She confirmed the nurse practitioner and the Physician could not see the resident in the same 24 hour period for payment purposes. Only one practitioner would get paid for the visit therefore delaying treatment. 28 Pa Code 211.2(d)(3) Medical Director 28 Pa Code 211.12 (d)(1)(3)(5) Nursing Services.