

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 06/17/2025
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 0559</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and resident and staff interviews, it was determined that the facility failed to ensure that written notice, including the reason for a room change, was provided to residents and/or their resident representatives prior to a facility-initiated room change for three of eight residents reviewed (Residents CR1, 3, and 4).</p> <p>Findings include:</p> <p>Federal regulatory guidance under &sect;483.10(e)(6) notes that moving to a new room or changing roommates is challenging for residents. A resident's preferences should be taken into account when considering such changes. When a resident is being moved at the request of facility staff, the resident, family, and/or resident representative must receive an explanation in writing of why the move is required. The resident should be provided the opportunity to see the new location, meet the new roommate, and ask questions about the move.</p> <p>At the time of the survey ending June 17, 2025, all beds in the facility were licensed and dually certified for participation in both the Medicare and Medicaid programs.</p> <p>A review of Resident CR1's clinical record revealed the resident was admitted on [DATE], and initially assigned to a room on the [NAME] wing. On March 1, 2025, the resident's room was changed to a room on the East wing. There was no documented evidence that the resident or the resident's representative was provided with written notice or an explanation for the room change prior to the move.</p> <p>A review of Resident 3's clinical record revealed the resident was admitted to the facility on [DATE], and provided a room on the [NAME] wing. On May 19, 2025, the resident's room was changed to a room on the East wing.</p> <p>During an interview with Resident 3, a cognitively intact resident, on June 17, 2025, at 12:10 PM the resident stated that her room was recently changed. She stated that the facility had not informed her of why her room needed to be changed. She expressed frustration stating, someone came in and told us (pointing to her roommate) that they were going to move us to different room on the other side of the building. She continued I was in that room for over a year, I didn't want to move. I liked it there. Resident 3 stated she was not informed of her right to refuse the room change. She stated that had she been informed of her right to refuse, she would have refused the room change. She also reported the facility did not provide any written notification of the reason for the room change.</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 0559</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>There was no documentation in Resident 3's clinical record indicating that a written notice or explanation of the room change was provided to the resident or the resident's representative.</p> <p>A review of Resident 4's clinical record revealed the resident was admitted to the facility on [DATE], and was provided a room on the [NAME] wing. On May 19, 2025, the resident's room was changed to a room on the East wing.</p> <p>Continued review of Resident 4's clinical record revealed the resident was moderately cognitively impaired with a BIMS score of 12 (Brief Interview for Mental Status-a tool to assess the resident's attention, orientation, and the ability to register and recall new information, a score of 8-12 equates to moderate cognitive impairment).</p> <p>There was no documented evidence that written notice, including the reason for the move, was provided to the resident or the resident's representative in advance of the room change.</p> <p>During an interview with the Nursing Home Administrator (NHA) on June 17, 2025, at 11:15 AM the NHA failed to provide documented evidence the facility provided any written explanation of the reasons for the facility-initiated room changes to the residents and/or their representatives.</p> <p>28 Pa Code 201.29 (a) Resident Rights</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, medication error reports, and staff interview it was determined that the facility failed to provide nursing services consistent with professional standards of practice by failing to follow physician's orders and assure that two residents out of eight reviewed were free of significant medication errors (Resident CR1 and Resident 2).</p> <p>Findings include:</p> <p>The Principles of Medication Administration, The Five Rights of Medication Administration indicate that when you are giving medication, regardless of the type of medication, you must always follow the five rights.</p> <p>Each time you administer a medication, you need to be sure to have the:</p> <ol style="list-style-type: none"> 1. Right individual 2. Right medication 3. Right dose 4. Right time 5. Right route <p>According to the Pennsylvania Code Title 49, Professional and Vocational Standards Department of State, Chapter 21 State Board of Nursing, Chapter 21.145 Functions of the LPN (Licensed Practical Nurse) requires the following: The LPN is prepared to function as a member of the health care team by exercising sound nursing judgement based on preparations, knowledge, skills, understandings and past experiences in nursing situations. The LPN participates in the planning, implementation and evaluation of nursing care in settings where nursing takes place. (b) The LPN administers medication and carries out the therapeutic treatment ordered for the patient in accordance with the following: (d) The Board recognizes codes of behavior as developed by appropriate practical nursing associations as the criteria for assuring safe and effective practice.</p> <p>A review of the clinical record revealed that Resident CR1 was admitted to the facility on [DATE], with diagnosis to include Type 2 diabetes (body has trouble controlling blood sugar and using it for energy), and falls with fracture of the let humerus (upper arm).</p> <p>A quarterly Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated May 4, 2025, revealed the resident was cognitively intact with a BIMS score of 15 (Brief Interview for Mental Status - a tool to assess the resident's attention, orientation, and ability to register and recall new information, a score of 13-15 equates to being cognitively intact).</p> <p>(continued on next page)</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Nurse documentation dated June 1, 2025, at 1:40 PM, revealed that Resident CR1 received Hydralazine 75 mg and Clonidine 0.2 mg (both medications used to treat high blood pressure) in error. RN assessment documented the resident as alert and awake, with clear speech, warm and dry skin, and no signs of distress. Her blood pressure was noted to be 80/52 (low reading). She denied dizziness, chest pain, weakness, nausea, or headache. The resident was transferred back to bed with the assistance of two staff members. Fluids were encouraged, and lower extremities were elevated. A call was placed to the on-call physician, and an order was received to send the resident to the emergency room for evaluation. Emergency medical services were dispatched, and the resident's daughter was notified.</p> <p>A review of the facility's Medication Error report dated June 1, 2025, indicated that Employee 2, a Licensed Practical Nurse, had administered the medications in error. According to the error report and subsequent root cause analysis, the error occurred when Employee 2 was preparing medications for Resident 5 and Resident CR1 approached the nurse requesting a pain pill. Employee 2 placed Resident CR1's pain pill into Resident 5's cup and inadvertently administered Hydralazine and Clonidine to Resident CR1. As a corrective measure, Employee 2 received re-education on the Five Rights of Medication Administration and minimizing distractions during medication pass.</p> <p>A review of the clinical record revealed that Resident 2 was admitted to the facility on [DATE], with diagnoses to include Alzheimer's disease (a progressive brain disease that destroys memory and other important mental functions), depression, and fall with fracture of the upper end of the right humerus (upper arm).</p> <p>A quarterly MDS dated [DATE], revealed the resident was severely cognitively impaired with a BIMS score of 0 (a score of 0-7 equates to severe cognitive impairment).</p> <p>Review of a psychiatry note from Employee 1 (nurse practitioner) dated May 8, 2025, indicated Resident 2's current medication list was as follows: Trazadone 100 mg, give one tablet by mouth at bedtime related to depression; Risperidone 1 mg, give one tablet by mouth at bedtime related to dementia; Duloxetine 30 mg, give 1 capsule by mouth related to depression; Memantine 10 mg, give one tablet by mouth two times a day related to Alzheimer's; and Donepezil 10 mg, give one tablet by mouth at bedtime related to Alzheimer's.</p> <p>Continued review of Employee 1's note recommended a Gradual Dose Reduction (GDR a structured process of slowly reducing a resident's medication dosage over time to evaluate the need for continued use) of Risperidone from 1 mg to 0.75 mg nightly. A physician's order dated May 9, 2025, reflected the change to Risperidone 0.75 mg at bedtime.</p> <p>Review of a physician's order dated May 9, 2025, revealed an order for Risperdal (Risperidone) oral tablet, give 0.75 mg by mouth at bedtime for agitation related to dementia.</p> <p>Continued review of physician orders revealed an order dated December 17, 2024, for Risperidone oral tablet 1 mg, give one tablet by mouth at bedtime related to dementia.</p> <p>A review of facility provided document titled Medication Error dated May 22, 2025, at 12:09 AM indicated a GDR of Risperidone was to be started on May 9, 2025, from 1 mg at bedtime to 0.75 mg at bedtime. The nurse added the new order for 0.75 mg but did not discontinue the 1 mg order. The resident received 1.75 mg of Risperidone from May 9, 2025, until May 22, 2025, when the error was noted.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A medication error report dated May 22, 2025, documented that the nurse had entered the new 0.75 mg order into the electronic system but failed to discontinue the existing 1 mg order. As a result, Resident 2 received a combined total of 1.75 mg of Risperidone nightly from May 9, 2025, through May 22, 2025. The root cause analysis identified a transcription error during the medication reconciliation process as the source. Although no adverse effects were noted, corrective actions included staff education on transcribing provider orders, disciplinary action for the responsible nurse, and implementation of 11 PM-7 AM chart checks to verify order accuracy.</p> <p>During an interview with the Nursing Home Administrator (NHA) on June 17, 2025, at approximately 2:00 PM, the NHA confirmed the occurrence of significant medication errors involving both Resident CR1 and Resident 2.</p> <p>The facility failed to ensure residents were free of significant medication errors and failed to ensure that nursing services were provided in accordance with professional standards of practice and physician orders.</p> <p>28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing Services.</p> <p>28 Pa. Code 211.10(c) Resident care policies.</p> <p>\</p>		