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	07/24/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility's abuse policy, clinical records, and select investigative reports and staff interview it was determined the facility failed to assure that one resident (Resident 2) was free from sexual abuse/harassment perpetrated by another resident (Resident 1) and out of 9 residents sampled.Findings included: A review of the current facility policy titled Abuse Policy, last reviewed by the facility on September 2024, revealed the resident has the right to be free from abuse, neglect, and misappropriation of resident property. Residents must not be subject to abuse by anyone, including but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies, family members or legal guardians, or other individuals. Further review defined sexual abuse as non-consensual sexual contact of any type with a resident including sexual harassment, sexual assault. A review of Resident 1's clinical record revealed admission to the facility on April 22, 2024, with diagnoses to include dementia (a group of symptoms affecting memory, thinking and social abilities. The symptoms interfere with a person's daily life). A quarterly Minimum Data Set assessment (MDS-a federally mandated standardized assessment completed periodically to plan resident care) dated June 5, 2025, indicated the resident was severely cognitively impaired with a BIMS score of 5 (brief interview of mental status to a tool to assess the resident's attention, orientation and ability to register and recall new information 0-7 represents severe cognitive impairment). Facility documentation and behavior progress notes revealed that Resident 1 exhibited sexually inappropriate behaviors prior to the incidents involving Resident 2. A progress note dated February 8, 2025, indicated that Resident 1 attempted to inappropriately grab staff during care. Resident 1's care plan, initiated April 26, 2024, identified sexualized behaviors including making sexual comments and gestures toward staff. Interventions included two-person assistance for all care and a referral to psychiatric services. A review of Resident 2's clinical record revealed admission to the facility on May 23, 2025, with diagnoses including dementia. An admission MDS dated [DATE], documented a BIMS score of 1, also indicating severe cognitive impairment. Resident 2 lacked the mental capacity to consent to sexual contact or activity. A review of facility documentation dated July 4, 2025, revealed that during a scheduled activity, Resident 1 was observed wheeling himself toward Resident 2, who was seated in a chair. Resident 1 then reached out and made contact with Resident 2's chest and groin area. The staff witness, identified as Employee 1 (Activities Aide), provided a written statement on July 4, 2025, at 2:55 p.m., documenting that Resident 1 was seen touching Resident 2's breast and subsequently placing his hand between her legs in the genital area. Staff immediately intervened and separated the residents During an interview with Employee 1 on July 24, 2025, at approximately 11:30 a.m., she stated that during the activity on July 4, 2025, she looked up and saw Resident 1 grab Resident 2 in the breast area. She stated that as she was standing up, she told Resident 1 to stop it and before she could get to them, Resident 1 grabbed Resident 2 in the groin area. Employee 1 stated Resident 2 was upset and crying briefly after the incident. However, this incident was not reported to the Department of Health. In interviews, the Director of Nursing (DON) and the Nursing Home Administrator (NHA) stated they did not believe the event was reportable, as they did not perceive intent on Resident 1's part. The only intervention implemented was to increase supervision. A second incident occurred on July 14, 2025, during lunch hour in the dining room. Facility documentation revealed that at approximately 11:45 a.m., Resident 1 reached through the back of Resident 2's chair and touched her buttocks. The incident was witnessed by Employee 2 (cook), who provided a written statement and confirmed the contact. Resident 2 expressed discomfort and described Resident 1 as gross. Following this incident, the facility reported the matter to the Department of Health, Adult Protective Services, and local law enforcement. The facility also notified Resident 2's representative. Resident 1 was then placed on one-to-one supervision, and staff were instructed to ensure separation between the two residents. The above findings were reviewed with the NHA during an interview on July 24, 2025, at 1:15 PM, the NHA acknowledged that Resident 1 displayed sexually inappropriate behaviors and was unable to provide evidence the facility ensured that Resident 2 was free from sexual harassment perpetrated by Resident 1 and could provide no evidence the facility had implemented sufficient safeguards to protect Resident 2 from recurring sexual harassment or abuse. 28 Pa. Code 201.14 (a) Responsibility of licensee. 28 Pa. Code 201.18 (e)(1) Management. 28 Pa. Code 201.29 (a) Resident Rights. 28 Pa. Code 211.10 (d) Resident care policies. 28 Pa. Code 211.12 (d)(1)(5) Nursing Services

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of select facility policy, facility investigative reports, clinical records and staff interviews it was determined the facility failed to ensure a complete and accurate investigation into sexual abuse was completed for one resident out of 9 sampled (Resident 2). Findings included: A review of the current facility policy titled Abuse Policy, last reviewed by the facility on September 2024, revealed the resident has the right to be free from abuse, neglect, and misappropriation of resident property. Further review of the facility abuse policy revealed under the area of investigation all reports of resident abuse, neglect, exploitation, misappropriation, shall be promptly reported to local, state and federal agencies as defined by current regulations, and thoroughly investigated by the administrator and or designee. The administrator or his/her designee will provide appropriate agencies or individuals within five working days of the occurrence of the incident. A review of Resident 2's clinical record revealed admission to the facility on May 23, 2025, with diagnoses to include dementia (a group of symptoms affecting memory, thinking and social abilities. The symptoms interfere with a person's daily life). An admission MDS dated [DATE], revealed the resident was severely cognitively impaired with a BIMS score of 1 (brief interview of mental status to a tool to assess the resident's attention, orientation and ability to register and recall new information 0-7 represents severe cognitive impairment). A review of the facility's investigative documentation dated July 4, 2025, revealed that Employee 1 (Activities Aide) reported observing Resident 1 grab Resident 2's breast and genital area during an activity in the activity room. The investigation summary, completed by the Director of Nursing (DON), referenced input from staff on duty and alert and oriented residents present at the time of the incident; however, no additional written statements or interview documentation from those individuals were included in the investigation file. The only written statement obtained was from Employee 1, which clearly described that she observed Resident 1 grab Resident 2's genital area over her clothing. Further review of the facility's investigative documentation revealed a written conclusion by the Director of Nursing (DON) dated July 4, 2025, which stated: After a full investigation, per reporting guidelines, if both residents are incapable and there is no injury, you do not have to report. At this point, there is no valid proof of any type of inappropriate touching or behaviors that happened. No injuries. Both residents cannot recall what happened. However, this rationale is inconsistent with federal regulatory guidance. Despite the DON's written conclusion, the facility did not document any efforts to interview other staff or alert, and oriented residents present during the incident, nor did it follow up on the eyewitness account from Employee 1, who documented that she observed Resident 1 grab Resident 2's genital area over her clothing. The incident was not reported to the Department of Health. In interviews on July 24, 2025, the DON and Nursing Home Administrator (NHA) stated they did not believe the incident was reportable due to a lack of intent by Resident 1.An interview conducted with the DON and NHA on July 24, 2025, at approximately 1:30 PM, revealed they were unable to provide evidence that the investigation into the potential sexual abuse of Resident 2 was complete or compliant with facility policy and federal reporting requirements. 28 Pa. Code 201.14 (a) Responsibility of licensee 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 201.29(a)(c) Resident Rights 28 Pa. Code 211. 10(d) Resident care policies. 28 Pa. Code 211.12(c)(d)(5) Nursing Services.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of the facility's plan of correction from the survey ending July 24, 2025, the outcome of the activities of the facility's quality assurance committee, a review of clinical records, and staff interviews, it was determined the facility failed to maintain compliance with nursing home regulations and ensure that plans to improve the delivery of care and services effectively addressed recurring deficiencies for one of six residents reviewed related to ensuring residents are free from sexual abuse (Resident 3) perpetrated by another resident (Resident 1). Findings include: As a result of the deficiencies cited under the requirements related to ensuring residents are free from sexual abuse during the survey of July 24, 2025, the facility developed a plan of correction to serve as their allegation of compliance, which included a quality assurance monitoring component to ensure that solutions were sustained. This corrective plan was to be completed and functional by August 19, 2025. However, during the survey ending August 28, 2025, continuing deficient facility practice was identified with these same requirements.According to the facility's plan of correction for the deficiency cited on July 24, 2025, relating to ensuring residents are free from sexual abuse, implemented to ensure deficient practice was corrected, included (1) The perpetrator is now 1:1 (level of staff to resident supervision) when out of bed. The recipient of sexual abuse was discharged from the facility. (2) The facility completed a baseline audit of abuse allegations for two weeks, and interventions have been implemented if applicable. (3) Facility educated staff regarding facility abuse policy. The facility will ensure that allegations of abuse will follow a facility policy that includes safeguards to be in place to protect residents from abuse. (4) The Nursing Home Administrator (NHA) or designee will audit the allegation of abuse to ensure facility policy is followed weekly for four weeks and then monthly for two months. (5) Audits will be submitted to the quality assurance performance improvement committee for review.A clinical record review revealed Resident 3 was admitted to the facility on [DATE]. A clinical record review revealed that Resident 1 was admitted to the facility on [DATE], with a history of known maladaptive behaviors such as inappropriate sexual comments to staff, touching staff inappropriately, wandering into female residents' rooms, and grabbing residents' wheelchairs. Further clinical record review revealed on August 27, 2025, Resident 1 sexually abused another resident when he was witnessed by facility staff touching Resident 3's genital area over her clothing without consent. A review of QAPI documentation revealed no evidence that the facility's performance improvement plan identified or addressed Resident 1's known maladaptive behaviors as risk factors requiring specific interventions. The QAPI plan focused only on the incident identified during the July 24, 2025, survey, without examining whether systemic failures in supervision, behavioral monitoring, or abuse-prevention interventions contributed to the current event. During an interview on August 28, 2025, at 11:00 AM, the Nursing Home Administrator (NHA) reviewed the concern regarding the August 27, 2025, incident in which Resident 1 was witnessed touching Resident 3 over her clothing without consent. The NHA did not provide documented evidence the facility's internal audits conducted after the July 24, 2025, survey identified Resident 1's history of maladaptive behaviors or that he was included in the audits intended to monitor and prevent recurrence of sexual abuse incidents.Further review revealed no documented evidence the Quality Assurance and Performance Improvement (QAPI) committee evaluated Resident 1's behavioral history, implemented targeted prevention strategies, or monitored the effectiveness of corrective actions beyond the initial audits. As a result, the facility's QAPI activities did not identify or correct the underlying causes of the original deficiency, contributing to the recurrence of resident-to-resident sexual abuse under the same regulatory requirement. Cross Refer to F600 28 Pa. Code 201.18(e)(4) Management.28 Pa. Code 211.12 (d)(5) Nursing services.