| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 395875 | A. Building<br>B. Wing | 11/25/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Greenwood Center for Nursing and Rehab | 149 Lafayette Avenue<br>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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>(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 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, select facility policy, state professional nursing standards, and staff interview, it was determined the facility failed to ensure nursing services were provided in accordance with professional standards of quality by not ensuring licensed nurses accurately administered a prescribed medication within the physician-ordered parameters for one of four sampled residents (Resident 1).Findings include:According to the Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.11 (a)(1)(2)(4) indicates the registered nurse was to carry out nursing care actions that promote, maintain, and restore the well-being of individuals.The Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.145 Functions of the Licensed Practical Nurse (LPN) (a) The LPN is prepared to function as a member of the health-care team by exercising sound judgement based on preparation, 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. 21.148 Standards of nursing conduct (a) A licensed practical nurse shall: (5) Document and maintain accurate records.Review of the facility policy titled Administering Medications last reviewed by the facility on June 1, 2025, revealed that medications are administered as prescribed and in a safe and timely manner. The policy requires staff to verify medication allergies and obtain vital signs (basic health measurements such as blood pressure, temperature, heart rate, and breathing rate), as applicable, prior to administering medications. A review of the clinical record revealed Resident 1 was admitted to the facility on [DATE], with diagnoses to include congestive heart failure (weakness of the heart that leads to build-up of fluid in the lungs and surrounding body tissues), respiratory failure with hypoxia (not enough oxygen passes from the lungs to the blood, making it difficult to breath), atherosclerotic heart disease (build-up of fats, cholesterol, and other substances in and on the artery walls which causes obstruction of blood flow), and hypertension (high blood pressure).A review of the physician's order dated September 26, 2025, directed staff to administer Norvasc (Amlodipine Besylate, a medication used to treat high blood pressure) 10 mg by mouth once daily, and to hold the medication for systolic blood pressure less than 120 millimeters of mercury (mm/Hg). Systolic blood pressure is the top number in a blood pressure reading and reflects the pressure when the heart is actively pumping.Review of the Medication Administration Records for October and November 2025 revealed Norvasc was administered 30 times outside the physician-ordered parameters (outside parameters means the medication was given when the blood pressure reading did not meet the hold instruction).The following blood pressure readings were documented at the time the medication was given:October 1: 100/66 mm/HgOctober 2: 106/60 mm/HgOctober 3: 106/70 mm/HgOctober 4: 105/40 mm/HgOctober 5: 108/62 mm/HgOctober 15: 118/24 mm/HgOctober 18: 107/57 mm/HgOctober 19: 110/64 mm/HgOctober 20: 108/64 mm/HgOctober 21: 110/70 mm/HgOctober 22: 108/66 mm/HgOctober 23: 108/70 mm/HgOctober 24: 108/70 mm/HgOctober 25: 110/68 mm/HgOctober 26: 112/70 mm/HgOctober 27: 110/72 mm/HgOctober 29: 118/70 mm/HgOctober 30: 116/70 mm/HgOctober 31: 118/70 mm/HgNovember 1: 116/70 mm/HgNovember 3: 118/74 mm/HgNovember 4: 116/70 mm/HgNovember 5: 118/68 mm/HgNovember 6: 116/70 mm/HgNovember 8: 118/68 mm/HgNovember 9: 116/70 mm/HgNovember 10: 118/68 mm/HgNovember 11: 118/60 mm/HgNovember 12: 118/64 mm/HgNovember 13: 116/66 mm/HgNovember 14: 118/70 mm/HgThese readings show the medication was administered repeatedly when systolic blood pressure was below the required 120 mm/Hg. During an interview on November 25, 2025, at 12:10 PM the Nursing Home Administrator confirmed that nursing staff failed to follow acceptable standards of nursing practice during medication administration resulting in multiple medication errors. 28 Pa. Code 211.9 (a)(1)(d) Pharmacy services28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services 28 Pa. Code 211.10(c) Resident care policies |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that residents are free from significant medication errors.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, select facility policy, pharmacy records and staff and resident interviews, it was determined that the facility failed to ensure a resident's medication regime was free from significant medication errors for one of four residents reviewed (Resident 2). Findings include: Review of the facility policy titled Administering Medications last reviewed by the facility on June 1, 2025, revealed that medications are administered as prescribed and in a safe and timely manner. The policy required staff to verify medication allergies and obtain vital signs, as applicable, prior to administering medications. A review of the clinical record revealed Resident 2 was admitted to the facility on [DATE], with diagnoses to include Type 2 Diabetes (a chronic condition in which the body has difficulty controlling blood sugar and using it for energy), congestive heart failure (weakness of the heart that leads to build-up of fluid in the lungs and surrounding body tissues), and nausea and vomiting. The resident's documented allergies and intolerances included: NSAIDs (intolerance, a non-steroidal anti-inflammatory drug, a class of medications used to reduce pain, fever, and swelling),Celecoxib (intolerance, a type of NSAID used for pain and inflammation), Ciprofloxacin (intolerance, an antibiotic used to treat infections ),Codeine (intolerance, an opioid pain medication),Gabapentin (allergy, a medication used for seizures and nerve pain),Meperidine (intolerance, an opioid pain medication ),Ondansetron (allergy, a medication used to prevent nausea and vomiting), Oxycodone (allergy, an opioid pain medication),Prochlorperazine (intolerance, a medication used for nausea and certain mental health symptoms ),Rofecoxib (allergy, a pain and anti-inflammatory medication that is a type of NSAID),Tramadol (intolerance, an opioid-like pain medication), andCompazine (intolerance. brand name for prochlorperazine, used for nausea) An allergy refers to a harmful immune response to a substance. An intolerance refers to an adverse reaction that does not involve the immune system but still causes unwanted effects.A review of the physician's order dated September 26, 2025, revealed an order for Ondansetron HCl oral tablet 4 mg (an anti-nausea and anti-vomiting medication), give 4 mg by mouth every 8 hours as needed for nausea. Despite a documented allergy to Ondansetron, a review of the resident's Medication Administration Records (MARs) for October and November 2025 revealed the resident was administered Ondansetron on October 3, October 7, October 11, October 12, October 15, October 17, and November 3, November 4, November 5, November 16, 2025, for a total of 10 administrations.During an interview on November 25, 2025, at 12:00 PM, Resident 2 stated she was aware she had an allergy to Zofran (brand name for Ondansetron) and reported that when she takes it, it makes me puke. She stated she had previously informed her physician about this effect and was unaware the facility had administered it. She stated, that explains why it didn't work, and I kept feeling sick. A review of the physician's order dated July 4, 2025, revealed an order for Gabapentin 100 mg by mouth at bedtime. Gabapentin is an anti-epileptic medication used to treat seizures and certain types of nerve pain. Despite Gabapentin being listed as an allergy for Resident 2, a review of the September 2025 MAR revealed the resident received the medication daily from September 1 through September 15, 2025, with documentation of refusal beginning on September 16, 2025.The facility was unable to provide documentation showing that the physician justified prescribing or continuing Ondansetron or Gabapentin despite the medications appearing on the resident's allergy list. A review of the consultant pharmacist's monthly recommendations for Resident 2 revealed no documentation indicating that the pharmacist identified the use of the contraindicated medications or recommended discontinuation.During an interview on November 25, 2025, at 11:00 PM, the Nursing Home Administrator acknowledged the facility administered Ondansetron and Gabapentin to Resident 2 despite the documented allergies and acknowledged the facility could not provide evidence of physician justification.28 Pa. Code 211.9(a)(1)(k) Pharmacy services28 Pa. Code 211.10(c) Resident care policies28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services |