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	07/01/2026

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of clinical records, facility policies, facility investigative documentation, video surveillance, and resident and staff interviews, it was determined that the facility failed to ensure the environment remained as free of accident hazards as possible by failing to provide adequate supervision and implement effective interventions to prevent an avoidable elopement for one of 12 residents reviewed (Resident CR1). This deficient practice placed Resident CR1 and other residents (Resident 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, & 12) identified by the facility as being at risk for elopement in Immediate Jeopardy due to the likelihood of serious injury, serious harm, impairment, or death.Findings include: A review of the facility policy titled Elopement, last reviewed January 28, 2026, revealed the facility's policy is to provide residents with a safe and secure environment and to proactively prevent resident elopement (when a resident leaves the facility or a designated safe area without staff knowledge or authorization). The policy directs staff to evaluate residents for elopement risk upon admission, readmission, quarterly, and following a significant change in condition. The policy required staff to assess residents with a history of substance use disorder, develop individualized care plan interventions to reduce the risk of elopement, redirect residents who attempt to leave the facility without supervision, and maintain a current photograph of each resident identified as being at risk for elopement. Observation of the facility's main entrance revealed two interior doors leading to the exit area. One interior door opened into an enclosed vestibule, and the second door opened directly to the outside. Neither interior door was locked from inside the building. During weekday daytime hours, a clerical employee was stationed in an office adjacent to the entrance with a direct line of sight to the main hallway and entrance doors. Observation revealed the exterior entrance operated through an alarmed electronic access system. Between 8:00 AM and 4:30 PM, individuals could enter the building from outside without staff assistance. After 4:30 PM, individuals seeking entry were required to press an exterior call button that signaled staff inside the clinical area to remotely unlock the exterior door. Residents could exit the building from the inside unless an electronic elopement prevention device activated the locking system. The facility utilized an electronic Wander guard system to help prevent elopement. Residents identified as being at risk for elopement wore an electronic device attached to the resident or mobility equipment, such as a wheelchair or walker. When a functioning electronic device approached a monitored exit, the system locked the interior exit door, activated an audible alarm at the doorway, and illuminated a red indicator light above the door. A review of facility records dated June 19, 2026, revealed the facility had identified 12 residents as being at risk for elopement, including Resident 1 through Resident 12 (Resident 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, and 12). These residents relied on the facility's elopement prevention system and staff supervision to prevent unauthorized exit from the building. A closed clinical record review revealed that Resident CR1 was admitted to the facility on [DATE], with diagnoses to include diabetes mellitus (sugar builds up in the bloodstream), anxiety (a mental health condition characterized by excessive worry or fear) and psychoactive substance use, in remission (an individual used to use mind-altering drugs or substances in the past). A review of a quarterly Minimum (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	preparation for leaving. On May 5, 2026, Resident CR1 requested information about obtaining an apartment. On June 17, 2026, the psychologist again documented Resident CR1 remained focused on leaving the facility and returning home. The clinical record demonstrated concerns regarding Resident CR1's use of mobility equipment. Progress notes documented that the Wander guard device was missing on May 17, 2026, and staff reapplied a functioning device on May 21, 2026. On June 10, 2026, the occupational therapist documented Resident CR1 was using another resident's wheelchair and expressed dissatisfaction with the facility issued wheelchair. The occupational therapist educated Resident CR1 that the assigned wheelchair contained resident specific safety interventions, including the Wander guard device, a wheelchair cushion, and equipment intended to reduce the risk of injury. Resident CR1 became upset, yelled at staff, and continued to insist the wheelchair was not hers. Nursing administration assisted Resident CR1 back into the assigned wheelchair. On June 11, 2026, the Social Services Director met with Resident CR1 regarding the wheelchair incident. Despite staff intervention, Resident CR1 continued to state an intention to leave the facility and maintained the belief that the assigned wheelchair did not belong to her. Documentation entered by the Director of Nursing on June 17, 2026, revealed Resident CR1 experienced a fall on June 11, 2026, while using a personal wheelchair brought into the facility that did not contain the resident's prescribed safety interventions, including the Wander guard device. Staff subsequently removed the personal wheelchair and reissued the facility wheelchair. A review of the June 2026 electronic treatment administration record (eTAR), an electronic record used to document treatments provided to residents, indicated staff documented verification of the Wander guard device placement and function each shift before the elopement on June 19, 2026. A review of facility investigative documentation completed by the Director of Nursing (DON) on June 19, 2026, revealed Resident CR1 exited the facility without staff knowledge or supervision. According to the investigative documentation, video surveillance showed Resident CR1 holding the exterior entrance door open for an ambulance attendant at 6:35 PM. At 6:37 PM, Resident CR1 independently propelled the wheelchair through the exit, traveled along the sidewalk, and entered the facility parking lot. The investigative documentation revealed that at 6:38 PM, Employee 1, Nurse Aide (NA), observed Resident CR1 in the parking lot while leaving the building for a scheduled break and immediately summoned assistance. At 6:40 PM, Employee 8, Registered Nurse Supervisor (RNS), responded to the parking lot, assisted Resident CR1 back into the facility, notified the Director of Nursing, and initiated continuous one to one observation. On June 30, 2026, at 11:15 AM, the surveyor reviewed the video surveillance in the presence of the Director of Nursing. The video confirmed the facility's investigative findings, and Resident CR1 had a cigarette in her mouth throughout the recording. During an interview conducted on June 30, 2026, at 12:00 PM, the Nursing Home Administrator (NHA), Director of Nursing, and regional consultant were unable to explain how Resident CR1 obtained the cigarette or other smoking materials despite the facility operating as a smoke free facility. During a telephone interview conducted by the surveyor on June 30, 2026, at 11:53 AM, Employee 1, Nurse Aide, stated that on June 19, 2026, while leaving the building for a scheduled break, Employee 1 observed Resident CR1 propelling the wheelchair into the center of the parking lot with a cigarette in the resident's mouth. Employee 1 reported Resident CR1 appeared to be looking for a way to light the cigarette and stated she was looking for her husband. Employee 1 immediately requested assistance from an ambulance attendant returning another resident to the facility, who contacted staff inside the building. Employee 1 stated Resident CR1 frequently expressed the desire to leave the facility, return home, and smoke cigarettes. A written witness statement completed by Employee 1 and included in the facility's investigative documentation confirmed Resident CR1 was using the assigned facility wheelchair at the time of the elopement. The statement documented that the prescribed Wander guard device was not attached to the wheelchair. Employee 1 documented staff searched Resident CR1's room but were unable to locate the missing Wander guard device. Employee 1 also reported asking Resident CR1 where the cigarette had been obtained; however, Resident CR1 did not provide an answer. Although the June 2026 eTAR (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	documented staff verified the Wander Guard device every shift. The facility was unable to determine when the device was removed or how Resident CR1 exited the building without the prescribed electronic device attached to the assigned wheelchair or her person. During a telephone interview conducted on June 30, 2026, at 1:45 PM, Employee 2, the ambulance attendant, stated that on June 19, 2026, the exterior entrance door was unlocked remotely after Employee 2 pressed the entrance call button. As Employee 2 opened the exterior door to assist another resident into the building, Resident CR1 independently exited the facility. Employee 2 stated Resident CR1 had a cigarette in her mouth and initially believed Resident CR1 intended to smoke outside because other residents were observed smoking in designated outdoor areas. Video surveillance confirmed Resident CR1 independently opened the first interior door before exiting through the exterior entrance as Employee 2 entered the building. Additional facility investigative documentation showed Employee 3, Licensed Practical Nurse (LPN), observed the Wander guard device attached to Resident CR1's wheelchair and functioning properly at 3:00 PM on June 19, 2026. Employee 6, Nurse Aide, documented Resident CR1 received the evening meal at 4:40 PM without unusual behaviors. Employee 5, Licensed Practical Nurse, observed Resident CR1 independently propelling the wheelchair to the resident's room at 5:20 PM. Employee 4, Nurse Aide, documented Resident CR1 remained in the room speaking with the roommate at 6:00 PM, and Employee 7, Nurse Aide, documented Resident CR1 continued speaking with the roommate at 6:20 PM. Employee 8 Registered Nurse Supervisor (RNS) provided a statement describing being called to the parking lot at 6:40 PM on June 19, 2026, via a phone call from the ambulance attendant, assisted Resident CR1 back into the facility, contacted the DON and initiated continuous individual observation for Resident CR1. Documentation completed by the Director of Nursing on June 20, 2026, summarized the elopement event, documented placement of a new Wander guard device on Resident CR1's left ankle, and noted plans to transfer Resident CR1 to a secured unit. Facility investigative documentation also included documentation identifying residents who required Wander guard devices on June 19, 2026. The record identified 12 residents as requiring electronic elopement prevention devices. During an interview conducted on June 30, 2026, at 12:30 PM, the Nursing Home Administrator and Director of Nursing confirmed Resident CR1 had a well documented history of wandering into resident rooms, lounges, and vacant rooms, taking items belonging to other residents, and using mobility devices that did not belong to the resident. Based on the clinical record, facility investigative documentation, video surveillance, staff interviews, and administrative interviews, the facility knew Resident CR1 had demonstrated persistent exit seeking behaviors, repeatedly expressed the intent to leave the facility, required an ordered Wander guard device, and had a history of using mobility devices that did not belong to the resident. Despite this knowledge, the facility failed to implement additional individualized interventions as Resident CR1's behaviors escalated, failed to ensure the prescribed Wander guard device remained in place, and failed to prevent Resident CR1 from exiting the facility without staff knowledge or supervision. As a result of the facility's noncompliance, Resident CR1 exited the facility without staff knowledge or supervision and entered the facility parking lot. Despite months of documented exit seeking behaviors, repeated unsuccessful attempts at redirection, repeated use of mobility devices that did not belong to Resident CR1, a previous incident in which the Wanderguard device was missing, and a physician's order requiring continued use of the Wanderguard device, the facility continued to rely primarily on the electronic Wanderguard system and routine redirection. The facility did not implement additional individualized interventions as Resident CR1's behaviors escalated and did not ensure the prescribed Wanderguard device remained in place before Resident CR1 exited the building without staff knowledge or supervision. Because the facility used the same electronic elopement prevention system and staff supervision to protect all residents it had identified as being at risk for elopement, the deficient practice placed Resident CR1 and other similarly situated residents in Immediate Jeopardy because it created a likelihood of serious injury, serious harm, impairment, or death. The survey team notified the facility of the Immediate Jeopardy on June 30, 2026, at 1:25 PM and provided (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the Immediate Jeopardy template at that time. In response, the facility submitted a written Immediate removal plan on June 30, 2026, at 3:43 PM, and revised plans at 4:37 PM and 5:47 PM. The corrective action plan submitted by the facility included the following measures: 1. Resident CR1 was placed on continuous one-to-one observation until discharge, applying a new Wanderguard device. Elopement evaluations were completed on all residents identified as being at risk for elopement2. Current residents at risk for elopement were reviewed to ensure electronic devices were in place and care plans had appropriate interventions. 3. Residents who have Wanderguards will be checked every hour for placement of the device after 4:30 PM until bedtime. Residents who refuse the Wanderguard device will have documentation of refusal and interdisciplinary team meeting will discuss alternative interventions. 4. Education will be provided to all staff on the elopement policy.5. Audits of corrective actions will be completed daily for seven days, weekly for three weeks, and monthly for two months and reported to the Quality Assurance Performance Improvement department.6. The individual responsible for overall monitoring of the individualized plan of correction is the NHA or designee. On June 30, 2026, at 10:30 AM, in the presence of the Assistant Director of Nursing (ADON), the surveyor verified the placement and function of the Wanderguard devices for the 12 residents the facility had identified as being at risk for elopement. The Assistant Director of Nursing demonstrated the testing process using the facility's electronic testing device, which displayed a green indicator confirming proper device function. At 5:15 PM on June 30, 2026, the facility identified five additional (Resident 13, 14, 15, 16, & 17) residents as being at risk for elopement. Surveyors again observed the Assistant Director of Nursing evaluated the placement and function of the Wanderguard devices. During this verification, the electronic testing device displayed a red indicator showing the Wanderguard devices assigned to Resident 16 and Resident 17 were not functioning properly. The malfunctioning devices were immediately replaced by facility staff. After verification of the facility's corrective actions, including observation of the placement and function of Wanderguard devices for all residents identified as being at risk for elopement, review of resident photographs maintained for elopement identification, staff interviews, verification of staff education, and observation of the facility's elopement prevention processes, the Immediate Jeopardy was determined to have been removed on July 1, 2026, at 12:15 PM. 28 Pa. Code 201.18 (e)(1) Management. 28 Pa Code 211.10 (a)(c) Resident care policies. 28 Pa Code 211.12 (d)(1)(2)(3)(5) Nursing services.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on observations, review of clinical records, select facility policies, job descriptions, facility-provided documentation, and interviews with residents and staff, it was determined the facility administration failed to effectively use available resources and provide the leadership, oversight, and coordination necessary to ensure residents attained or maintained their highest practicable physical, mental, and psychosocial well-being. Specifically, the facility failed to ensure effective administrative oversight and implementation of systems to protect residents identified as being at risk for wandering or elopement. As a result, one of twelve residents identified by the facility as being at risk for wandering (Resident CR1) exited the building without staff knowledge or supervision and entered an unsafe environment. This systemic failure placed Resident CR1 and other residents identified as being at risk for wandering or elopement in Immediate Jeopardy due to the likelihood of serious injury, serious harm, impairment, or death.Findings include: A review of the job description for the Nursing Home Administrator (NHA) dated and signed February 27, 2026, indicated the administrator will manage the facility in accordance with policies, procedures, and current federal, state, and local standards, guidelines, and regulations. The job description identified responsibilities that included directing overall facility operations, ensuring the physical environment is maintained, hiring, training, and developing department staff, and ensuring departmental operations comply with applicable regulatory requirements. A review of the Director of Nursing (DON) Services job description, dated and signed November 16, 2023, indicated the DON is responsible for directing nursing services in accordance with current federal, state, and local laws, regulations, and standards. The job description required the DON to collaborate with the Administrator and Medical Director to ensure the highest degree of quality of care for residents, determine staffing necessary to meet resident needs, conduct daily rounds to evaluate nursing services, review nursing documentation, monitor resident care, and assume responsibility for daily facility operations in the absence of the Administrator. The facility failed to ensure administrative systems were effectively implemented and monitored to protect residents identified as being at risk for wandering or elopement. On June 19, 2026, at approximately 6:35 PM. Resident CR1 exited the facility through an exterior door with a cigarette in her mouth without staff knowledge or supervision and entered an unsafe outdoor environment. The resident's ability to leave the building without staff intervention demonstrated that facility systems intended to identify and prevent unauthorized resident exits were not effectively implemented or monitored. Resident CR1 had a documented history of removing safety devices, including the electronic monitoring device intended to activate the facility's exit alarm system, and had repeatedly expressed an intent to leave the facility, smoke, and return home. Despite these known risk factors, administrative oversight did not ensure effective systems were in place to identify when required safety interventions were absent or to prevent the resident from exiting the building without staff awareness. The Nursing Home Administrator and Director of Nursing failed to fulfill their essential administrative duties to monitor departmental operations, identify systemic risks, and ensure the implementation of facility policies to maintain resident safety. This lack of oversight and failure to use available resources to identify and correct system problems resulted in conditions that placed residents in immediate jeopardy. 28 Pa. Code: 201.14 (a) Responsibility of licensee. 28 Pa. Code: 201.18 (e)(1) Management.