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	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenwood Center for Nursing and Rehab	149 Lafayette Avenue Tamaqua, PA 18252

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21738 Based on clinical record review and resident and staff interviews, it was determined that the facility failed to provide care in a manner and environment that promotes each resident's quality of life by failing to respond timely to residents' requests for assistance as evidenced by four residents out of 18 sampled (Residents 3, 26, 40 and 79). Findings include: A clinical record review revealed that Resident 40 had diagnoses, which included congestive heart failure (a chronic condition in which the heart does not pump blood as well as it should) and diabetes mellitus. A review of a quarterly Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated April 12, 2024, revealed that Resident 40 is cognitively intact with a BIMS score of 15 (Brief Interview for Mental Status- a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 13-15 indicates cognition is intact). During an interview with Resident 40 on May 14, 2024, at 11:00 AM the resident stated that staff do not always answer call bells timely, especially on the 11:00 PM to 7:00 AM shift. Resident 40 stated that the wait time for the call bell to be answered is often greater than 45 minutes. Resident 40 said that she has reported her concern to the facility, regarding waiting too long for the staff to answer the call bell and provide needed care, but that nothing is done to solve the problem to date. A clinical record review revealed that Resident 26 was admitted on [DATE], and had diagnoses which included muscle weakness and difficulty walking. A review of a quarterly MDS dated [DATE], revealed that Resident 26 is cognitively intact with a BIMS score of 15. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395875	A. Building B. Wing	05/17/2024

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with Resident 26 on May 14, 2024, at 10:05 AM the resident indicated that residents rely on staff for pretty much everything and the resident has waited several hours to have staff answer the call bell to assist residents to the bathroom resulting in the residents sitting in their own feces for extended periods of time. The resident stated I feel like I ask for a lot, but I do not deserve to be neglected, I have been through a lot in my life, and I do not mean to make staff mad by ringing the bell, they seem like they are mad when I do so. A review of clinical record revealed that Resident 79 was admitted to the facility on [DATE], with diagnoses to include orthopedic after care following a surgical amputation (surgery to remove all or part of an extremity), acquired absence of right foot and gas gangrene (bacterial infection that produces tissue gas in gangrene causing death of body tissues due to lack of blood flow). A review of Grievance/Concern Form dated April 5, 2024, revealed that Resident 79's family member lodged a concern while visiting the facility on April 4, 2024, at approximately 10:30 AM. The complaint indicated that multiple staff walked by the resident's room while the call bell was on and never answered it She stated two nursing staff members did come in to change the resident and were very nice, but it is not always timely, she is more upset that the staff kept walking by without answering the call bell. The Nursing Home Administrator (NHA) explained that it would be hard to investigate who was walking by at this time. A Significant Change in Condition MDS dated [DATE], revealed that the resident had moderate cognitive impairment with a BIMS score of 10. During an interview with Resident 79 on May 14, 2024, at 11:51 PM the resident stated that the waits for staff to answer the call bell is up to two hours for staff to come in the resident's room and assist after ringing the call bell. The resident requires staff to assist to the bathroom and when the staff does not respond for hours, the resident explained that the resident is left to sit in their own urine and feces. A clinical record review revealed that Resident 3 was admitted on [DATE], and had diagnoses which morbid (severe) obesity due to excess calorie intake, muscle weakness and diabetes mellitus. A review of a quarterly MDS dated [DATE], revealed that Resident 3 is cognitively intact with a BIMS score of 15. During an interview with Resident 3 on May 14, 2024, at 12:02 PM the resident stated that she has waited a couple hours on the weekend for staff to respond to the call bell. The resident stated that the facility is short staffed all the time but the weekends are bad and that during the week she waits 30 minutes to one hour for assistance after ringing the call bell. During the survey, on May 17, 2024, the survey team received a concern that there is no means for residents to request assistance if they are the activity room and no staff is present. Observations on May 17, 2024, confirmed that there was no functioning call bell in the activity room. During a conversation with the Nursing Home Administrator, on May 20, 2024, it was confirmed that there was no way for residents to request assistance while unsupervised in activity room and the call bell in that room has been inoperable for quite a while, but was unable to confirm the duration. (continued on next page)

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	395875	A. Building B. Wing	05/17/2024

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on May 17, 20204, at at approximately 10:00 AM, the Nursing Home Administrator (NHA) verified that all residents at the facility should be treated with dignity and respect. The NHA was unable to explain why residents are reporting untimely staff responses to residents' requests for assistance, which is negatively affecting their quality of life in the facility. 28 Pa. Code 201.18 (e)(1) Management 28 Pa. Code 201.29 (a) Resident Rights 28 Pa. Code 211.12 (c)(d)(4)(5) Nursing Services.

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	395875	A. Building B. Wing	05/17/2024

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581 Based on observations and staff interview, it was determined that the facility failed to maintain a clean and orderly environment in resident areas on two of two resident units (West and East Nursing Units). Findings include: Observations on May 14, 2024, at approximately 11:10 AM of the [NAME] Nursing Unit revealed the following: Resident room [ROOM NUMBER] gouges in the surface of the wall were observed behind the resident's nightstand. Multiple small holes were in the wall by the resident's dressers. The paint on the wall was bubbling behind the toilet in the bathroom in this resident room and two holes in the hall near the toilet paper holder. Resident room [ROOM NUMBER] observations revealed that resident's dinner tray from the prior evening, Monday May 13, 2024, remained on the nightstand. There were dirty used gloves atop the dinner tray. The resident's breakfast tray from that morning was also still in the room on the over the bed table. There were food particles and wrappers on the floor. [NAME] stains were observed on the resident's pillowcase. Two urinals half filled with urine were observed on the floor. The bathroom door lock was broken. There were two holes in the bathroom wall by the toilet paper holder. [NAME] spots were observed on the privacy curtains. Resident room [ROOM NUMBER] observations revealed a dirty urinal coated with a dried white film inside was atop the bedside commode. Dirt and debris were observed on the floor throughout the room. Resident room [ROOM NUMBER] observations revealed chipped wood on the bathroom door. Two holes in the bathroom wall by the toilet paper holder. Gouges were observed on the surface of the wall behind the bed. The wall surface was chipped away around the heating and cooling unit. Observations on May 16, 2024, at approximately 9:00 AM of the [NAME] Nursing Unit revealed the following: Resident room [ROOM NUMBER] - brown drip spots were observed on the wall next to the bathroom door. A sticky substance, coated with dirt and dust was observed on the floor. The wood was chipped on the bathroom and closet doors. The wall was chipped around the heating and cooling unit. Observation on May 14, 2024, at 11:40 AM on the East Nursing Unit revealed an approximate 6 inch by 4 inch missing section of paint beneath the wall mounted hand sanitizer dispenser located outside Resident room [ROOM NUMBER]. Observation of Resident room [ROOM NUMBER] window bed on May 14, 2024, on East Unit,at 12:00 PM revealed the protective edge of over the bed table was removed revealing the cork underneath. (continued on next page)

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	395875	A. Building B. Wing	05/17/2024

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Nursing Home Administrator on May 17, 2024, at approximately 1:15 PM confirmed the facility is to be maintained daily to provide a clean and sanitary environment for the residents. 28 Pa. Code 201.18 (e)(2.1) Management

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	395875	A. Building B. Wing	05/17/2024

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21738 Based on a review of clinical records and the Resident Assessment Instrument and staff interview, it was determined that the facility failed to ensure the Minimum Data Set Assessments (MDS - a federally mandated standardized assessment conducted at specific intervals to plan resident care) accurately reflected the status of one resident out of 18 sampled (Resident 17). Findings include: According to the RAI User's Manual dated October 2023, Section J0100 Pain Management reflects pain medication the resident received in the last 5 days. The quarterly MDS Assessment of Resident 17 dated March 12, 2024, revealed Section J0100 indicated the resident did not receive scheduled pain medication or as needed pain medication in the last 5 days. A review of Resident 17's March 2024 Medication Administration Record revealed that the resident received physician prescribed Acetaminophen as needed pain medication 5 times in the last 5 days. Review of Section J Other Orthopedic Surgery indicated under J2500 that Resident 17 had repair fractures of the shoulder or arm and no repair fractures of the pelvis, hip, leg, knee, or ankle (not foot). A nurses note dated, February 14, 2024, noted that the resident was transferred to the emergency room following a fall and a preliminary x-ray report which indicated the resident had a left ankle fracture. A nurses note dated March 5, 2024, noted that the resident was readmitted to the facility on [DATE], status post fracture dislocation of the left ankle with ORIF on March 1, 2024 (open reduction and internal fixation- a type of surgery used to stabilize and heal a broken bone). Interview with the administrator on May 17, 2024, at 10:00 AM confirmed that Resident 17's quarterly MDS dated [DATE], with respect to completion of Section J related to pain medication received and orthopedic surgery was inaccurate.

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	395875	A. Building B. Wing	05/17/2024

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21738 Based on review of clinical records and staff interview, it was determined that the facility failed to revise the residents' comprehensive plan in response to a change in condition for two residents out of 18 reviewed (Resident 77 and 17). Findings include: A review of Resident 77's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses which included malignant neoplasm of the prostate and obstructive and reflex uropathy. A review of the resident's comprehensive plan of care, last revised by the facility March 19, 2024, revealed that the resident had an indwelling catheter, a 16 French Foley catheter (a medical device place through your urethra into your bladder to drain urine) with a 30 cc balloon. A review of a progress note dated April 5, 2024 at 3:54 PM indicated the resident had a suprapubic catheter (a medical device that helps drain urine from your bladder. It enters your body through a small incision in your abdomen) placed. A review of physician's orders dated April 5, 2024, revealed the resident has a suprapubic catheter and the site is to be cleansed with normal saline and a dry dressing applied. The facility failed to revise and update the resident's indwelling catheter care plan with new interventions after the resident had a suprapubic catheter placed on April 5, 2024. An interview on May 17, 2024, at approximately 1:15 PM, with the Nursing Home Administrator confirmed the facility failed to revise and update the resident's plan of care. A review of the clinical record revealed that Resident 17 was admitted to the facility on [DATE], and had diagnoses which included COPD (chronic obstructive pulmonary disease- group of lung diseases that block airflow and make it difficult to breathe) and diabetes mellitus. A review of the resident's comprehensive plan of care, last revised by the facility February 23, 2024, indicated that the resident has back, shoulder, hip pain, foot pain related to arthritis, and Charcot's foot diagnosis (condition that affects the bones, joints, and soft tissue in the feet and ankles). The goal was for the resident to verbalize adequate relief of pain or ability to cope with incompletely relieved pain. A nurses note dated, February 14, 2024, indicated that the resident was transferred to the emergency room following a fall and a preliminary x-ray report, which indicated that the resident had a left ankle fracture. (continued on next page)

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	395875	A. Building B. Wing	05/17/2024

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nurses note dated March 5, 2024, revealed that the resident was readmitted to the facility on [DATE], status post fracture dislocation of the left ankle with ORIF on March 1, 2024 (open reduction and internal fixation- a type of surgery used to stabilize and heal a broken bone). The facility failed to revise and update the resident's care plan to identify the potential for pain and new interventions after the resident was readmitted to the facility on [DATE], with a fractured ankle. An interview on May 17, 2024, at approximately 10:30 AM, with the Nursing Home Administrator confirmed the facility failed to revise and update Resident 17's plan of care. 28 Pa. Code 211.12(c)(d)(1)(5) Nursing Services.

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	395875	A. Building B. Wing	05/17/2024

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581 Based on a review of clinical records, and staff interview, it was determined that the facility failed to accurately assess bowel and bladder function and implement individualized approaches to restore normal bowel and bladder function to the extent possible for one out of 18 sampled residents (Resident 86). Findings include: A review of the clinical record revealed that Resident 86 was admitted to the facility on [DATE], with diagnoses which included chronic kidney disease, unsteadiness on feet, and muscle weakness. A review of the resident's three day bowel and bladder diary completed April 29, 2024, revealed that the resident was frequently incontinent of urine. However, a review of the resident's admission bowel and bladder assessment dated [DATE], indicated that the resident was continent of bowel and bladder. A review of Resident 86's Admission Minimum Data Set assessment (MDS- a federally mandated standardized assessment process conducted periodically to plan resident care) dated May 2, 2024, revealed that the resident was frequently incontinent of bowel and bladder. The facility failed to demonstrate an accurate assessment of the resident's status to ensure the necessary services were planned to meet the resident's toileting needs. An interview with the Director of Nursing on May 16, 2024, at approximately 11:00 AM revealed the resident's bowel and bladder assessment was incorrect, and the resident had mixed incontinence and a program should have been initiated. Interview with the Nursing Home Administrator on May 17, 2024, at approximately 1:15 PM confirmed that the facility failed to accurately assess bowl and bladder function and resident's toileting needs. 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services

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	395875	A. Building B. Wing	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581 Based on observations, a review of clinical records, and staff interviews, it was determined that the facility failed to provide supplemental oxygen administration as ordered for one of 18 residents reviewed (Resident 64). Findings include: A review of Resident 64's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses which included shortness of breath and chronic respiratory failure with hypoxia (low levels of oxygen in your body). The resident had physician's orders as follows: Oxygen at 2 liters per minute per nasal cannula every shift for shortness of breath initially dated March 8, 2023; Check oxygen humidification water level and replace as needed initially dated March 8, 2024; Change oxygen tubing, humidification bottle, clean oxygen filter, and inspect easy foam wraps every Saturday on night shift initially dated March 8, 2024. Observation of Resident 64 on May 14, 2024, at approximately 11:15 AM revealed the resident was in bed with his supplemental oxygen in place. The water canister (to provide humidification) was dated for May 4, 2024 and was empty. The oxygen was set at 5 liters per minute not the 2 liters as ordered. Observations of the resident on May 15, 2024, at 9:56 AM revealed the resident's oxygen was still running at 5 liters per minute and the humidification water bottle still dated May 4, 2024. Observations of Resident 64 on May 15, 2024, at 1:40 PM revealed the resident was receiving his supplemental oxygen therapy from an oxygen tank on the back of his wheelchair. The oxygen tubing was not dated. The oxygen was being delivered at 3 liters per minute and the oxygen tank was empty. An interview with Employee 6 LPN (license practical nurse) on May 15, 2024, at 1:45 PM revealed the employee acknowledged the resident's oxygen tank was empty and stated she would get him a new one. Observations of the resident on May 15, 2024, at 2:00 PM revealed the resident's oxygen tank was still empty and he was not receiving his ordered oxygen therapy. Observations of Resident 64 on May 16, 2024, at 9:00 AM revealed the resident oxygen tubing connected to the tank on his wheelchair was lying on the floor. The resident was receiving oxygen therapy from the concentrator in his room. The water canister was still dated May 4, 2024, and the resident's oxygen was running at 5 liters per minute. An interview with Employee 1 LPN at the time of the observation confirmed the resident's water canister was not changed as per the physician order. Further the employee confirmed the oxygen was running at the incorrect rate the physician's orders were not followed. (continued on next page)

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	395875	A. Building B. Wing	05/17/2024

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with Nursing Home Administrator and Director of Nursing on May 17, 2024, at approximately 1:15PM confirmed the facility failed to provide supplemental oxygen administration and care consistent with professional standards of practice. 28 Pa. Code 211.12 (c)(d)(1)(5) Nursing services

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	395875	A. Building B. Wing	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21738 Based on clinical record review and staff interview, it was determined that the facility failed to ensure that physician orders for individual pain management regimens were followed for five of 18 residents reviewed for pain management (Resident 54, 86, 64, 17 and 190). Findings include: A review of the clinical record revealed Resident 54 was admitted to the facility on [DATE], with diagnoses to include chronic pain disorder, rheumatoid arthritis ([RA] an autoimmune disorder that attack the joints and causes pain) and progressive neuropathy (nerve pain). A physician order dated February 6, 2024, at 3:27 PM was noted for Tramadol (pain medication) 50 milligrams (mg) by mouth every six hours as needed for severe pain related to chronic pain with a pain level 8-10. Review of the resident's Medication Administration Record (MAR) for the month of April 2024 revealed that nursing administered the prn opioid pain medication, Tramadol, to the resident on the following dates for pain rated lower than the physician prescribed level: April 3rd for a pain level of 4 April 5th for a pain level of 6 April 8th for a pain level of 5 April 12th for a pain level of 7 April 15th for a pain level of 7 April 17th for a pain level of 6 April 27th for a pain level of 7 Further review of MAR for the month of May 2024 revealed that nursing administered the prn opioid pain medication to the resident on the following dates for pain rated lower than the physician prescribed range: May 3rd for a pain level of 6 May 4th for a pain level of 3 May 6th for a pain level of 7 May 7th for a pain level of 7 (continued on next page)

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	395875	A. Building B. Wing	05/17/2024

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	May 11th for a pain level of 0 May 13th for a pain level of 6 May 14th for a pain level of 7 May 15th for a pain level of 7 A review of the clinical record revealed that Resident 86 was admitted to the facility on [DATE], with diagnoses which included chronic kidney disease, unsteadiness on feet, and muscle weakness. A review of physician's orders initially dated April 25, 2024, revealed an order for Oxycodone HCL (opioid pain medication) 5 mg tablet give one tablet by mouth every six hours for pain rated 8 to 10. A review of the April 2024 MAR revealed the nursing staff administered the prn opioid pain medication to the resident on the following dates for pain rated lower than the physician prescribed range: April 25, 2024, at 11:16 PM for a pain level of 7 April 26, 2024, at 11:00 AM for a pain level of 6 April 27, 2024, at 9:03 PM for a pain level of 4 April 28, 2024, at 8:51 PM for a pain level of 7 April 30, 2024, at 3:01 PM for a pain level of 7 A review of the May 2024 MAR revealed the nursing staff administered the prn opioid pain medication to the resident on the following dates for pain rated lower than the physician prescribed range: May 2, 2024, at 5:30 PM for a pain level of 6 May 3, 2024, at 12:51 AM for a pain level of 7 May 4, 2024, at 3:40 AM for a pain level of 7 May 4, 2024, at 9:56 PM for a pain level of 6 May 6, 2024, at 9:13 PM for a pain level of 7 May 9, 2024, at 9:21 PM for a pain level of 0 May 14, 2024, at 8:12 PM for a pain level of 7 During an interview with the Director of Nursing (DON) and Nursing Home Administrator (NHA) on May 17, 2024, at 12:30 PM confirmed that nursing staff failed to consistently administer pain medication according to the physician orders based on the assessed severity of the resident's pain. (continued on next page)

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	395875	A. Building B. Wing	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenwood Center for Nursing and Rehab	149 Lafayette Avenue Tamaqua, PA 18252

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the clinical record revealed that Resident 17 had diagnoses which included which included congestive heart failure (a chronic condition in which the heart does not pump blood as well as it should) and diabetes mellitus. A nurses note dated, February 14, 2024, noted that the resident was transferred to the emergency room following a fall and a preliminary x-ray report which indicated the resident had a left ankle fracture. A nurses note dated March 5, 2024, noted that the resident was readmitted to the facility on [DATE], status post fracture dislocation of the left ankle with ORIF on March 1, 2024 (open reduction and internal fixation- a type of surgery used to stabilize and heal a broken bone). A physician order dated March 5, 2024, was noted for Acetaminophen 325 mg one tablet by mouth every 4 hours as needed for mild pain 1-3 do not exceed 3000 mg acetaminophen per 24 hours; Acetaminophen 325 mg two tablets by mouth every 4 hours as needed for moderate pain 4-6 do not exceed 3000 mg acetaminophen per 24 hours; and Acetaminophen 1000 mg by mouth every 6 hours as needed for severe pain 8-10 do not exceed 3000 mg acetaminophen per 24 hours. A physician order dated March 12, 2024, was noted for Hydrocodone-Acetaminophen Tablet 5-325 MG one tablet by mouth every 4 hours as needed for pain. The physician order lacked the pain level range for administration. The physician order did not identify when to administer the Acetaminophen initially prescribed on March 5, 2024, versus the Hydrocodone-Acetaminophen, prescribed March 12, 2024. Review of Resident 17's March 2024 MAR from March 12, 2024, through March 31, 2024, revealed that Hydrocodone-Acetaminophen 5-325 mg was administered for pain levels varying from pain level 3 to pain level 9. Review of Resident 17's April 2024 MAR revealed that Hydrocodone-Acetaminophen 5-325 mg was administered for pain levels varying from pain level 3 through pain level 8. Review of Resident 17's May 2024 MAR from May 1, 2024, through May 13, 2024, revealed that Hydrocodone-Acetaminophen 5-325 mg was administered for pain levels varying from pain level 2 through 8. Interview with the administrator and director of nursing on May 17, 2024, at 9:30 AM confirmed that the physician order failed to specify the pain level range for the Hydrocodone-Acetaminophen 5-325 mg and that only one as needed medication should be prescribed for each pain range on the 1-10 pain scale. Review of Resident 190 clinical record revealed she was admitted to the facility on [DATE], with diagnoses to include a cholesectomy (gallbladder) tube. Review of Resident 190's care plan developed March 1, 2024, in place until resident discharged from facility March 23, 2024, revealed that the resident had no individualized plan for pain management. A review of Resident 190's admission MDS dated [DATE], revealed the resident had frequent pain that occasionally interrupted her sleep. (continued on next page)

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	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of Resident 190's clinical record revealed the resident had severe pain from the drainage site of her cholesectomy tube daily. A nursing progress note dated March 13, 2024, revealed that the resident was crying in pain. Tylenol was given without effect for pain. Review of Resident 190's Medication Administration Record for March 2024, revealed an order for Tramadol HCL Oral Tablet 25 MG for severe pain of 8-10. The resident was consistently reporting a pain level of 8 or higher. There was no evidence that the facility had addressed the resident's pain management on the resident's care plan with the individualized measures planned for the resident to meet the resident's pain management needs, which was confirmed during interview with Nursing Home Administrator and Director of Nursing on May 16, 2024 at approximately 2:00 p.m. 28 Pa. Code 211.5(f) Medical records 28 Pa. Code 211.12 (d)(d)(1)(3)(5) Nursing Services

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	395875	A. Building B. Wing	05/17/2024

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581 Based on observation, review of clinical records, and staff interview, it was determined that the facility failed to provide person-centered care for one resident receiving hemodialysis services out of 18 sampled (Resident 80). Findings include: A review of the clinical record revealed that Resident 80 was admitted to the facility on [DATE], with diagnoses to include stage 4 chronic kidney disease and dependence on renal dialysis (a procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly). A review of a progress note dated May 6, 2024, at 10:00 AM revealed that the resident was on a leave of absence from the facility to go to dialysis. A review of a progress note dated May 8, 2024, at 10:30 AM indicated the resident left for dialysis in stable condition. A review of a progress note dated May 10, 2024, at 9:50 AM revealed the resident left the facility in stable condition to go to dialysis services. A review of a progress note dated May 15, 2023, at 10:00 AM indicated the resident left for dialysis in stable condition. A review of the resident's current physician's orders revealed no documented orders for the resident to receive dialysis treatment. There were no orders identifying the schedule/frequency for the resident to receive dialysis treatments. A review of the resident's current plan of care for chronic renal failure requiring dialysis, initially dated March 27, 2024, revealed the resident's care plan did not identify the resident's dialysis days, any emergency care and what supplies are needed for the resident's dialysis access it, an AV fistula (a connection that's made between an artery and a vein for dialysis access), and the resident's transportation plan to and from dialysis treatments. Interview with the Nursing Home Administrator on May 17, 2024, at approximately 1:15 PM confirmed the facility failed to demonstrate person-centered care planning for a resident receiving dialysis. 28 Pa. Code 211.12 (d)(3)(5) Nursing services

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	395875	A. Building B. Wing	05/17/2024

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39929 Based on a review of select facility reports and clinical records and staff interview it was determined that the facility failed to assure that nursing staff possessed the necessary knowledge, competencies, and skill sets to provide care to meet a resident's individualized needs as identified in the resident's current plan of care for one resident out of 18 sampled (Resident 22). Findings include: A review of the clinical record of Resident 22 revealed admission to the facility on [DATE], with diagnoses including Lennox-Gas taut Syndrome (a rare and severe form of epilepsy (seizure - a period of abnormally excessive neuronal activity in the brain) that starts in childhood and causes multiple types of seizures), intractable with status epilepticus, localization -related (focal)(partial) symptomatic epilepsy and epileptic syndromes with simple partial seizures, intractable with status epilepticus and anoxic (without oxygen) brain damage. A quarterly MDS assessment dated [DATE], revealed that the resident was severely cognitively impaired, requiring extensive assistance with ADLs. A review of the resident's care plan initially dated January 19, 2015, with revision on June 21, 2022, revealed that the resident had a seizure disorder with interventions to not change any neurological-related medications prior to notifying the neurologist, monitor for seizure activity every shift, if seizure persists over three minutes may send to the emergency room (ER), and to utilize vagal nerve stimulator if seizure persists over one minute; see chart for protocol on how to use magnet: Hold magnet in left hand and swipe across the resident's skin at the right side of her chest below the clavicle (collar bone) (her left) you can see the stimulator is implanted it looks like a flattened golf ball. Swipe the magnet in a way that you would swipe a credit card at the store, do this in the space of one second, count to one thousand, DO NOT HOLD THE MAGNET OVER THE DEVICE, wait one minute, if seizure is still going on swipe the magnet across the residents skin again, repeat again in one minute if seizure continues, continue repeating in intervals of one minute up to five minutes, if seizure continues call for emergency help, see chart for protocol for turning off the implant only if ordered by the physician. Give seizure medication as ordered by the physician and monitor and document side effects and effectiveness. Seizure documentation includes location of seizure activity, type of seizure activity (jerks, convulsive movements, trembling) duration, level of consciousness, any incontinence (involuntary passing of urine or feces) sleeping, dazed post-ictal state (state after a seizure), after seizure activity. A physician order dated December 10, 2023, at 2:58 PM was noted for Diazepam (Valium) Intensol Concentrate 5 milligrams (mg)/milliliters (ml) (controlled drug) give one ml via gastronomy tube (G-tube) as needed for seizures related to localization-related symptomatic epilepsy and epileptic syndromes with simple partial seizures, intractable, with status epilepticus if the resident has a seizure lasting more than three minutes then give one ml by G-tube and may repeat one ml if she continues to have seizure for more than 10 minutes. (continued on next page)

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	395875	A. Building B. Wing	05/17/2024

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician order dated December 10, 2023, at 4:04 PM was noted to monitor for seizure activity every shift use Vaso Nerve Stimulator ([VNS] a magnet used to stop seizure activity) if seizure is over one minute, if seizure persists over three minutes may send to the emergency room (ER). A physician order dated December 10, 2023, at 4:04 PM was note noted VNS left chest wall if seizure lasts more than three minutes apply magnet to left chest wall implant as needed for seizure disorder. A physician order dated December 10, 2023, at 4:04 PM indicated that per neurologist monitor and log seizures with duration, send with resident to appointments for review, if seizure activity noted document as needed response in the treatment administration record (TAR) with duration and type. A review of Monthly Staff Meeting dated January 2024, revealed licensed nurse updates and information included education on Resident 22's VNS magnet device. VNS left wall if seizures last more than three minutes, swipe magnet to left chest wall implant. Do not hold the magnet over device, swipe only. Manufacturers guidelines in medication cart with magnets. There was no documented evidence that this staff education included the specific instructions listed in the resident's care plan that included how often to use the magnet and when to send to the ER. A review of the Manufacturer's Instructions for VNS indicated to follow physician protocol and included instruction on how to clean and store the device. A review of the resident's clinical record revealed no documented evidence that licensed professional nursing staff fully assessed the resident, to include the location of seizure activity, type of seizure activity, duration, level of consciousness, any incontinence, sleeping, dazed post-ictal state, after seizure activity, the need to use the VNS, the proper use of as needed medication as noted in the resident's care plan. During an interview on May 16, 2024, at 1:37 PM, the Nursing Home Administrator (NHA) stated that staff were trained on the proper use of the VNS magnet device and provided documentation dated January 2024. She stated that it is the RN Supervisor's responsibility to train nursing staff on the proper use, and that staff are instructed to read the manufacturer's instructions, which are located with the magnets in the medication cart. During an interview on May 17, 2024, at 10:23 AM with Employee 1, LPN, the nurse stated revealed that they have worked in the facility for approximately four years and have taken care of Resident 22 in the past. Employee 1 stated that the resident has not had any seizure activity while this employee was caring for her, but stated that if the resident was having a seizure, they would call the physician and give the resident her as needed medication. Employee 1 confirmed receiving training on the magnet device approximately four years ago, but stated that the employee would have to read the pamphlet on the device before using it because they are unsure of the proper use. During an interview on May 17, 2024, at 10:25 AM with Employee 2, LPN, she stated she has worked in the facility for [AGE] years and they do not typically care for Resident 22 but is aware that she has a stimulator. Employee 2 stated that she unsure on the proper use, and does not recall having any trainings about the device. (continued on next page)

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	395875	A. Building B. Wing	05/17/2024

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on May 17, 2024, at 10:27 AM with Employee 3, Registered Nurse Supervisor (RNS), the nurse stated that she has worked in the facility for [AGE] years and has taken care of Resident 22. Employee 3, RNS, stated that the proper use of the VNS magnet is to swipe the resident's left upper chest after three minutes and then to give as needed Ativan (seizure medication) after the same time. Employee 3 RNS stated that she would document any abnormal movement, incontinence and how long the seizure lasted. Employee 3 RNS stated that the RN supervisor are not responsible for training staff on this device but will help as needed when agency staff are present. During an interview on May 17, 2024, at 10:29 AM with Employee 4, an agency LPN, who was caring for Resident 22 on this date revealed that she has worked at the facility for approximately four months. Employee 4 stated that the facility did not provide her training on the use of the device. Employee 4 LPN stated, I cannot tell you how to accurately use this device, if I had to use it now, I would have to read the pamphlet that is stored with the magnets. Interview with the DON and NHA on May 17, 2024, at approximately 12:15 PM confirmed that the facility was unable to provide documented evidence that licensed nursing staff possessed the necessary competency and skills to render care as planned and prescribed for this resident and that the facility had provided nursing staff with the necessary training and orientation to the resident's specific needs upon beginning work at the facility. 28 Pa. Code 201.20 (b)(d) Staff Development 28 Pa Code 211.12 (c)(d)(1)(5) Nursing services

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39929 Based on a review of clinical records and staff interview, it was determined that the facility failed to develop and implement an effective individualized person-centered plan to address a resident's dementia-related behavioral symptoms for one out of 18 residents reviewed (Resident 20). Findings include: A review of Resident 20's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses to include vascular dementia (A condition caused by the lack of blood that carries oxygen and nutrient to a part of the brain. It causes problems with reasoning, planning, judgment, and memory.) A review of Resident 20's Quarterly Minimum Data Set Assessment (MDS - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated April 17, 2024, revealed the resident was severely cognitively impaired. A review of progress notes in the resident's clinical record dated from February 01, 2024 to May 16, 2024, revealed that the resident exhibited behaviors of exit-seeking, intrusive wandering, and agitation. The resident's current care plan, in effect at the time of the survey ending May 17, 2024, did not address her diagnosis of dementia. The facility failed to develop and implement an individualized person-centered plan to address, modify and manage this resident's dementia-related behaviors. The resident's care plan for dementia failed to include individualized interventions based on an assessment of the resident's preferences, social/past life history, customary routines, and interests in an effort to manage, modify or decrease the resident's dementia-related behavioral symptoms. The facility failed to demonstrate the provision of necessary care and services, including individualized interdisciplinary non-pharmacological approaches to care, purposeful and meaningful activities, that address the resident's customary routines, interests, preferences, and choices to enhance the resident's well-being. There was no evidence that the facility provided the resident with specialized services and supports, such specialized activities, nutrition, and environmental modifications, based on the individual's abilities and dementia related behaviors Interview with Nursing Home Administrator on May 17, 2024, at approximately 10:00 a.m., confirmed the facility was unable to provide evidence of the development and implementation of an individualized person-centered plan to address the resident's dementia-related behaviors. 28 Pa Code 211.12 (d)(3)(5) Nursing services

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	395875	A. Building B. Wing	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581 Based on a review of clinical records and controlled drug medication sheets, and staff interview, it was determined that the facility failed to implement procedures to promote accurate accounting of controlled medications for three of four residents sampled (Resident 64, 54, and 52). Findings include: A review of Resident 64's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses which included lower back pain and abdominal pain. A review of the resident's clinical record revealed that Resident 64 had a physician order initially dated March 27, 2024, and revised on April 4, 2024, for Oxycodone HCL (a narcotic opioid pain medication) 5 mg tablet every 6 hours as needed for pain level 8 to 10. A review of the resident's controlled substance records accounting for the above controlled medication revealed on April 8, 2024, at 12:00 AM, April 18, 2024, at 12:00 AM, and May 10, 2024, at 11:00 PM revealed that nursing staff signed out a dose of the resident's supply of Oxycodone 5 mg. However, the administration of the controlled drug to the resident was not recorded on the resident's Medication Administration Record on those dates and times. A review of Resident 52's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses which included Parkinson's disease, left knee pain, and intervertebral disc degeneration. A review of the resident's clinical record revealed that Resident 52 had a physician order initially dated February 15, 2024, for Oxycodone HCL 5 mg tablet every 8 hours as needed for pain level 8 to 10. A review of the resident's controlled substance records accounting for the above controlled medication revealed on April 3, 2024, at 9:00 PM, April 4, 2024, at 9:00 PM, April 7, 2024, at 8:00 PM, April 15, 2024, at 9:00 PM, April 18, 2024, at 9:00 PM, April 20, 2024, at 9:00 PM, April 23, 2024, at 9:00 PM, April 24, 2024 at 9:00 PM, April 28, 2024, at 11:00 PM, April 29, 2024, at 10:33 AM, and May 1, 2024, at 9:00 PM revealed that nursing staff signed out a dose of the resident's supply of Oxycodone 5 mg. However, the administration of the controlled drug to the resident was not recorded on the resident's Medication Administration Record on those dates and times. A review of the clinical record revealed Resident 54 was admitted to the facility on [DATE], with diagnoses to include post traumatic stress disorder ([PTSD] a mental health condition that develops following a traumatic event causing distress and anxiety) and anxiety (fear characterized by behavioral disturbances). (continued on next page)

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	395875	A. Building B. Wing	05/17/2024

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A physician order dated January 7, 2024, at 9:43 AM was noted for the resident to receive Lorazepam (Ativan) 0.5 milligram (mg) by mouth give one tablet every 12 hours related to anxiety disorder (standing order dose). A physician order dated May 10, 2024, at 6:37 PM was noted for Lorazepam (Ativan) 0.5 milligram (mg) by mouth give one tablet every 24 hours, as needed, for anxiety related to anxiety disorder, not to be given within two hours of standing order dose (as needed dose). A review of medication administration record (MAR) for the month of May 2024 revealed staff administered the prn (as needed) Ativan to the resident on the following dates: May 11th at 3:27 PM May 12th at 4:27 PM May 13th at 4:47 PM May 14th at 4:47 PM A review of Controlled Substance Record for Resident 54 revealed that controlled drug record was maintained for Ativan 0.5 mg take one tablet by mouth every 12 hours (straight order) and did not include the physician prn Ativan order to account for the doses removed. The controlled substance record revealed that both orders for Ativan were being recorded on the straight order Controlled Substance Record. Employee 5 Licensed Practical Nurse (LPN) and the Nursing Home Administrator (NHA) confirmed the observation that both orders, prn and straight, for the Ativan were being recorded on the same controlled substance record and staff used the same blister pack failing to have an accurate record of both orders for this medication. An interview on May 17, 2024, at approximately 1:15 PM the Nursing Home Administrator confirmed the inconsistencies in the accounting and administration of the opioid pain medications for Resident 64 and Resident 52, and the lack of a controlled drug record for Resident 54's prn Ativan supply. Refer F761 28 Pa Code 211.12 (d)(3)(5) Nursing services 28 Pa Code 211. (c)(k) Pharmacy services 28 Pa Code 211.5(f) Medical records

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	395875	A. Building B. Wing	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenwood Center for Nursing and Rehab	149 Lafayette Avenue Tamaqua, PA 18252

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39929 Based on clinical record review and staff interview it was determined that the facility failed to ensure accurate medication labeling for one of 18 residents sampled (Resident 54). Findings include: Review of Pa Code Chapter 27. State Board of Pharmacy, 27.18 Standards of Practice, (d) The container in which a prescription drug or device is sold or dispensed to the ultimate consumer shall bear a label which shall be written in ink, typed or computer generated and shall contain the following information: (1) The name, address, telephone number and DEA number of the pharmacy. (2) The name of the patient. (3) Full directions for the use of its contents. (4) The name of the prescriber. (5) The serial number of the prescription and the date originally filled. (6) The trade of brand name of the drug, strength, dosage form and quantity dispensed, the manufacturer's name shall also be shown. (7) On controlled substances, the statement: Caution: Federal law prohibits the transfer of this drug to any person other than the patient for whom it was prescribed. A review of the clinical record revealed Resident 54 was admitted to the facility on [DATE], with diagnoses to include post traumatic stress disorder ([PTSD] a mental health condition that develops following a traumatic event causing distress and anxiety) and anxiety (fear characterized by behavioral disturbances). A physician order dated January 7, 2024, at 9:43 AM was noted for the resident to receive Lorazepam (Ativan) 0.5 milligram (mg) by mouth give one tablet every 12 hours related to anxiety disorder (standing order dose). A physician order dated May 10, 2024, at 6:37 PM was noted for Lorazepam (Ativan) 0.5 milligram (mg) by mouth give one tablet every 24 hours, as needed, for anxiety related to anxiety disorder, not to be given within two hours of standing order dose (as needed dose). A review of medication administration record (MAR) for the month of May 2024 revealed staff administered the prn (as needed) Ativan to the resident on the following dates: May 11th at 3:27 PM May 12th at 4:27 PM May 13th at 4:47 PM May 14th at 4:47 PM A review of Controlled Substance Record for Resident 54 revealed that controlled drug record was maintained for Ativan 0.5 mg take one tablet by mouth every 12 hours (straight order) and did not include the physician prn Ativan order to account for the doses removed. (continued on next page)

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	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenwood Center for Nursing and Rehab	149 Lafayette Avenue Tamaqua, PA 18252

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The controlled substance record revealed that both orders for Ativan were being recorded on the straight order Controlled Substance Record. Employee 5 Licensed Practical Nurse (LPN) and the Nursing Home Administrator (NHA) confirmed the observation that both orders, prn and straight, for the Ativan were being recorded on the same controlled substance record and staff used the same blister pack failing to have an accurate record of both orders for this medication. Interview with the NHA on May 17, 2024, at 12:00 PM confirmed that the resident had two different physician orders for Ativan but there were ot two separate pharmacy labels attached to the controlled substance records. There was not blister pack of medication with the correct pharmcy label to reflect the current active physician order. Refer F 755 28 Pa. Code 211.9 (a)(1)(e)(j) Pharmacy Services

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	05/17/2024

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39929 Based on clinical record review and staff interview it was determined that the facility failed to timely obtain prescribed laboratory services for one resident out of 18 sampled (Resident 39). Findings included: A review of clinical record revealed Resident 39 was admitted to the facility on [DATE], with diagnoses, which included dementia. A CRNP (certified registered nurse practitioner) note dated May 10, 2024, revealed that the CRNP examined the resident. The CRNP noted that the resident was complaining of burning upon urination and had increased agitation. The CRNP was requesting a repeat U/A C&S (urinalysis and culture and sensitivity) before starting Bactrim (antibiotic). Review of Resident 39's clinical record during survey ending May 17, 2024, revealed no documented evidence that the CRNP's request for a repeat U/A C&S had been completed. There was no documented evidence that the facility completed the lab studies as the CRNP had requested. During an interview with the Director of Nursing (DON) on May 16, 2024, at approximately 2:45 PM the DON confirmed that the lab studies were not completed timely as ordered by the CRNP. 28 Pa. Code 211.12 (d)(3)(5) Nursing services

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	395875	A. Building B. Wing	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenwood Center for Nursing and Rehab	149 Lafayette Avenue Tamaqua, PA 18252

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 21738 Based on observation, resident and staff interviews, and test tray results it was determined that the facility failed to serve meals that are palatable, attractive, and at a safe and appetizing temperature. Findings include: According to the federal regulatory guidance at 483.60(i)-(2) Food safety requirements - the definition of Danger Zone, found under the Definitions section, is food temperatures above 41 degrees Fahrenheit and below 135 degrees Fahrenheit that allow rapid growth of pathogenic microorganisms that can cause foodborne illness. During an interview with Resident 40 on May 14, 2024, at 11:00 AM the resident stated that the food is often not hot enough when served. During an interview with Resident 45 on May 14, 2024, at 11:33 PM the resident states that the food served in the facility could taste better. During an interview with Resident 79 on May 14, 2024, at 11:51 PM the resident states that the food tastes lousy here and is never hot when served. During an interview with Resident 3 on May 14, 2024, at 12:02 PM the resident stated that the food is not served hot and does not taste good. The resident stated I live on sandwiches because the food that is served is very low in quality. Observation of Resident 40's lunch meal on May 14, 2024, at 12:30 PM revealed that the resident received a bowl of cream of vegetable soup on her meal tray. Resident 40 stated that the soup did not look or taste appetizing. Upon surveyor observation, the soup was a white semi-translucent (semitransparent) color and lumpy consistency. A test tray performed for the B Hall Nursing Unit on May 15, 2024, at 12:05 PM revealed that the planned hot meal served was chicken noodle soup, chicken parmesan, penne pasta with marinara, Italian blend vegetables, bread stick, and mandarin oranges. At 12:25 PM, at the time the last resident was served, a test tray was completed and yielded the following results: chicken noodle soup was 125 degrees Fahrenheit, chicken parmesan was 116 degrees Fahrenheit, penne pasta was 112 degrees Fahrenheit, and Italian vegetables were at 115 degrees Fahrenheit. The hot food tasted lukewarm and was not palatable at the temperatures served. The Italian vegetables were soggy and soft. Interview with the employee 8 (registered dietitian) on May 15, 2024, at 12:30 PM confirmed that food was to be palatable, attractive, and served at safe and appetizing temperatures.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 21738 Based on observation, a review of the facility's planned menus and grievances submitted to the facility, and resident and staff interview it was determined that the facility failed to provide preferred food as planned and accommodate individual food preferences to the extent possible to increase satisfaction with meals for seven residents out of 18 sampled (Residents 40, 3, 28, 69, 45, and 19). Findings include: A review of the facility's 2 Gram Sodium Diet revealed that this diet is a strict sodium restriction omitting the use of saltshaker at the table and cooking. Salted food items and foods of sodium content are eliminated or replaced with a low-sodium alternate unless otherwise calculated into the diet by the dietitian. The diet can be individualized. Review of Grievance/Concern Form dated March 25, 2024, revealed that Resident 3 had a concern related to her lunch. She had selected a steak sub on her meal ticket but received baked ziti. The resident indicated that the kitchen said I knew they did not have steak subs left, but I was not informed of this, I also did not get a tea bag for the lukewarm water I received. The kitchen keeps giving me high sodium food that I can not have. Pertinent information from this grievance was noted that the kitchen was out of steak subs on this day and the dietary manager spoke with the resident, sodium in food has been addressed multiple times in the past. Corrective action: Resident 3 will be notified when the kitchen is out of something she ordered. Interview with Resident 40 on May 14, 2024, at 11:00 AM revealed that the facility provides a menu for her to choose from but that often the food items she is served differs from her chosen selections or food items are missing from the meal tray. Resident 40 stated that the other day the facility did not have buns for the planned cheesesteak alternate. Interview with Resident 3 on May 14, 2024, at 12:02 PM revealed that the facility has failed to provide her a diet low in sodium. The resident states that all the food she receives is processed and very high in salt, she has filed grievances and discussed her concerns with multiple staff members without a resolution to date. She stated that she has gained 30 pounds since being admitted and wishes that they offered items lower in sodium. She has been told that they offer a liberal diet, but she stated that all the diet consists of is greasy and fatty food without healthier options. She stated, as a result, she is forced to make a poor selection from the substitute menu if it is available and mostly eats tomato sandwiches or peanut butter and jelly sandwiches. The resident stated that dietary staff have told her that the facility does not have a low sodium diet. Observation of Resident 40's lunch meal on May 14, 2024, at 12:30 PM revealed that the resident received a ham steak instead of the meatball sandwich which was selected by the resident for that meal. Observation of Resident 3's lunch meal on May 15, 2024, at 12:40 PM revealed that the resident's menu selection was penne pasta. However, the penne pasta was not provided. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with Employee 7, Registered Dietician (RD), on May 16, 2024, at 12:41 PM revealed that the facility does have a low sodium diet. Employee 7 RD stated that Resident 3's food preferences were updated to include lower sodium options, but the facility does not carry a lot of low sodium foods. During a group meeting with five alert and oriented residents (40, 28, 69, 45, and 19) on May 15, 2024 at 10:30 a.m., all five residents in attendance revealed that their food preference were not always honored by the facility. The residents stated that the facility's planned alternates offered at meals aren't always available. The residents gave an example, as meatball and cheesesteak sandwiches, which the residents were unable to receive because no sandwich rolls were available. Interview with the dietary manager on May 17, 2024, at 11:30 AM confirmed that cheesesteaks and meatball sandwiches were planned alternates for residents, but the buns for the cheesesteaks were not available and that a substitution was made. The dietary manager confirmed that on occasion substitutions are needed for menu items not received with the facility's food order. The dietary manager confirmed that the facility did not have a substitution list to monitor the amount of menu substitutions that were occurring and to ensure appropriate substitutions when a planned menu item is not available for residents' meals. The dietary manager confirmed that residents' meal trays were to be checked for accuracy to ensure selected menu items are provided. The dietary manager confirmed that residents were to be informed ahead of a meal if chosen preferences were not available. 28 Pa. Code 211.6 (a) Dietary services

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 21738 Based on observation and staff interview, it was determined that the facility failed to maintain acceptable practices for the storage and service of food to prevent the potential for contamination and microbial growth in food, which increased the risk of food-borne illness in the food and nutrition services department. Findings include: Food safety and inspection standards for safe food handling indicate that everything that comes in contact with food must be kept clean and food that is mishandled can lead to foodborne illness. Safe steps in food handling, cooking, and storage are essential in preventing foodborne illness. You cannot always see, smell, or taste harmful bacteria that may cause illness according to the USDA (The United States Department of Agriculture, also known as the Agriculture Department, is the U.S. federal executive department responsible for developing and executing federal laws related to food). Observation during the initial tour of the kitchen conducted with the facility's dietary manager on May 14, 2024, at 9:00 AM revealed the following unsanitary practices with the potential to introduce contaminants into food and increase the potential for food-borne illness: There was a build-up of dirt and debris on the perimeter area of the kitchen floor throughout the kitchen. There was a plastic crate filled with half pint containers of milk stored directly on the floor of the walk-in freezer. There were two bags of frozen vegetables on the shelf of the walk-in freezer which were not dated. Observation on May 15, 2024, at 12:00 PM revealed an accumulation of dust on the fins of the fan located in the dishroom. Interview with the dietary manager on May 15, 2024, at 12:30 PM, confirmed that the dietary department was to be maintained in a sanitary manner and that foods should be dated and stored in a manner to prevent potential contamination of food and foodborne illness. 28 Pa. Code 201.18 (e)(2.1) Management 28 Pa. Code 211.6 (f) Dietary Services