

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395875	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/14/2026
NAME OF PROVIDER OR SUPPLIER Greenwood Center for Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 149 Lafayette Avenue Tamaqua, PA 18252	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and staff interview, it was determined 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 Employee 9 (cook) on January 11, 2026, at 9:44 AM revealed the following unsanitary practices with the potential to introduce contaminants into food and increase the potential for food-borne illness: Employee 9 (cook) had a thick beard and was in the food preparation area without a beard restraint (effectively keeps facial hair from contacting food). There was a pair of snow boots placed directly on top of an opened box of grease pan liners (disposable pan liners used to reduce scrubbing and prevent food items from sticking to pans) on a bottom shelf in the food preparation area. Three shelves in the reach in refrigerator located next to the tray line were heavily rusted. There were six cases of frozen buns placed directly on the floor in the walk in freezer. Observation of the walk in refrigerator revealed one container of honey thickened cranberry juice, one container of nectar thickened cranberry juice, and one container of nectar thickened orange juice which were not dated when opened. Review of the manufacturer label revealed directions to use within 10 days after opening. Further observation of the walk in refrigerator revealed nine thawed four ounce containers of Mighty Shakes (nutritional beverage) which did not have a thaw date. Review of the manufacturer label revealed directions to use within 14 days after thawing. Interview with Employee 10 (dietary aide) at this time confirmed the food items were not dated. Interview with the consultant dietitian on January 11, 2026, at 1:00 PM confirmed 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.		

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, observations, and resident and staff interviews, it was determined the facility failed to ensure residents who were dependent on staff for assistance with activities of daily living were provided showers as planned to maintain acceptable standards of personal hygiene for three of 26 residents sampled (Residents 5, 119, and 11). Findings include: A review of Resident 5's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses to include fracture of the left femur (thigh bone), fracture of the sixth cervical vertebrae (the sixth bone in the neck), and dementia (decline in mental ability severe enough to interfere with daily life, affecting memory, thinking, judgement, language and behavior, caused by brain cell damage). An admission Minimum Data Set Assessment (MDS, a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated December 22, 2025, indicated the resident required substantial/maximal assistance from staff for showering/bathing. The resident was cognitively impaired with a BIMS score of 6 (brief interview for mental status, a tool to assess the residents' attention, orientation, and ability to register and recall new information, a score of 0-7 indicates a resident is severely cognitively impaired). A review of Resident 5's task report (an electronic record used to outline and track planned resident-centered nursing tasks) revealed the resident was scheduled to receive showers twice weekly on Mondays and Thursdays during the 3:00 PM to 11:00 PM shift. However a review of Resident 5's Documentation Survey Report (reports that capture care-related tasks completed by nurse aides) for December 2025 and January 2026 revealed the resident did not receive any showers since admission to the facility on December 13, 2025, and only received bed baths during that time period. There was no documented evidence that the resident refused showers. There was no documented evidence that the resident preferred bed baths instead of showers. There was no documented evidence that the facility provided showers twice weekly as planned. A review of Resident 119's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses to include venous insufficiency (condition where leg veins struggle to send blood back to the heart causing swelling, pain, heaviness, cramping, and skin changes) and pulmonary hypertension (high blood pressure in the arteries that carry blood from the heart to the lungs, making the right side of the heart work harder to pump blood through narrowed or blocked lung vessels). An admission MDS dated [DATE], indicated the resident required moderate assistance from staff for showering/bathing. The resident was cognitively intact with a BIMS score of 14 (a score of 13-15 indicates a resident is cognitively intact). During an interview conducted on January 11, 2026, at 1:30 PM, Resident 119 reported that staff had not provided or offered a shower since admission. The resident stated a preference for showers over bed baths and reported his hair had not been washed since admission. Observation during the interview revealed the resident's hair appeared oily and unkempt. A review of Resident 119's task report indicated showers were scheduled twice weekly on Mondays and Thursdays during the 3:00 PM to 11:00 PM shift. Review of the Documentation Survey Report for January 2026 revealed the resident did not receive any showers since admission and only received bed baths. There was no documented evidence that the resident refused showers. There was no documented evidence that the resident preferred bed baths instead of showers. There was no documented evidence that the facility provided showers twice weekly as planned. A review of Resident 11's clinical record revealed the resident 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) and end stage renal disease (final, permanent stage of chronic kidney disease, where the kidneys can no longer function on their own). An admission MDS dated [DATE], indicated the resident required moderate assistance from staff for showering/bathing. The resident was moderately cognitively impaired with a BIMS score of 10 (a score of 7-12 indicates the resident is moderately cognitively impaired). During an interview conducted on January 11, 2026, (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	at 12:55 PM, Resident 11 stated he only received one shower since admission. He stated, Nobody will give me a shower. I'm so dirty and feel so grimy. Look at my hair, it's so greasy! I ask when I can have a shower and they say tomorrow, tomorrow, tomorrow, but tomorrow never comes. Observation revealed the resident had greasy, disheveled hair and beard. A review of Resident 11's task report indicated showers were scheduled twice weekly on Wednesdays and Saturdays during the 7:00 AM to 3:00 PM shift. Review of Resident 11's Documentation Survey Reports revealed the resident did not receive any showers in December 2025 and only received two sink baths on December 19, 2025, and December 31, 2025. Review of the January 2026 Documentation Survey Report revealed the resident did not receive any showers or bed baths during the month. There was documentation of one shower refusal on December 16, 2025; however, there was no additional evidence of refusal. There was no documented evidence that the resident preferred bed baths instead of showers. There was no documented evidence that the facility provided showers twice weekly as planned. During an interview conducted on January 13, 2026, at 9:40 AM, the Nursing Home Administrator (NHA) acknowledged that residents should have been provided with showers as scheduled. The NHA was unable to explain why showers were not consistently provided. 28 Pa. Code 211.12 (c)(d)(5) Nursing services.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, select facility policies, observations, and staff, resident, and family member interviews, it was determined the facility failed to provide nursing services consistent with professional standards of practice. Specifically, the facility failed to ensure licensed nurses accurately administered prescribed medication for one of 26 residents sampled (Resident 5), failed to ensure consistent implementation of a physician-ordered therapeutic positioning device for one of 26 residents sampled (Resident 106), and failed to provide appropriate wound care, treatment, and monitoring for one of 26 residents sampled (Resident 9). 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 January 30, 2025, revealed that medications are administered as prescribed and in a safe and timely manner. Medications are administered in accordance with prescriber orders, including any required time frame. A clinical record review revealed Resident 5 was admitted to the facility on [DATE], with diagnoses to include orthostatic hypotension (condition causing dizziness or fainting from a sudden drop in blood pressure upon standing), atrial fibrillation (an irregular, often rapid heart rate that causes poor blood flow), and supraventricular tachycardia (a type of arrhythmia where the heart beats abnormally fast due to electrical issues causing palpitations, dizziness or chest pain). Review of a physician's order dated December 19, 2025, revealed an order for Midodrine hydrochloride 10 mg, to be given by mouth three times daily for 14 days related to orthostatic hypotension, with instructions to hold the medication for systolic blood pressure greater than 120 mmHg (systolic blood pressure is the top number in the blood pressure reading representing the pressure in the arteries when the heart beats and pumps blood). Review of the Medication Administration Record (MAR) for December 2025 and January 2026 revealed that Midodrine was administered six times outside of the physician ordered parameters, as evidenced by the following documented blood pressure readings at the time of administration: December 22, 2025, at 10:00 AM BP 136/74 December 23, 2025, at 10:00 AM BP 125/64 December 24, 2025, at 10:00 AM BP 127/70 December 24, 2025, at 2:00 PM BP 130/74 January 1, 2026, at 10:00 AM BP 124/56 January 1, 2026, at 2:00 PM BP 124/56 These administrations occurred despite the physician's explicit hold parameters. During an interview on January 13, 2026, at 9:15 AM, the Nursing Home Administrator acknowledged that nursing staff did not follow acceptable standards of nursing practice related to medication administration. A clinical record review revealed Resident 106 was admitted to the facility on [DATE], with diagnosis to include chronic pain syndrome, intervertebral disc degeneration of the lumbar region (breakdown of the spinal discs in the lower back), and muscle weakness. Review of a physician's order dated October 1, 2025, revealed an order for Resident 106 to be positioned out of bed in a Broda chair (a specialized wheelchair designed to support residents with complex positioning needs) with a blue comfy cushion (pressure reducing cushion) and an additional gel cushion placed on top for pressure reduction. Review of Resident 106's care plan, initiated September 19, 2025, identified an activities of daily living (ADL) performance deficit and included interventions to position the resident out of bed in a Broda chair with a blue comfy cushion. An observation conducted on January 12, 2026, at 12:50 PM revealed Resident 106 was seated out of bed (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	in a Broda chair without the ordered blue comfy cushion in place. At the time of observation, a family member reported the blue comfy cushion had not been present on the resident's chair for at least one week. During an interview on January 12, 2026, at 1:30 PM, Employee 7 (Licensed Practical Nurse) confirmed that Resident 106 had a physician's order for the blue comfy cushion and acknowledged that the cushion was not present on the resident's chair at the time of observation. A review of the facility policy titled Skin and Wound Management System, last reviewed by the facility on January 30, 2025, revealed it is the policy of the facility to identify and assess residents with wounds and/or pressure ulcers, as well as those at risk for skin compromise. Such residents are then provided with appropriate treatment to encourage healing and/or skin integrity. Ongoing monitoring and evaluation are then provided to ensure optimal resident outcomes. Further review of the facility policy revealed residents with identified skin impairments will have appropriate interventions, treatment, and services implemented to promote healing and impede infection. A clinical record review revealed Resident 9 was admitted to the facility on [DATE], with diagnoses that include diabetes (a chronic disease that occurs either when the pancreas does not produce enough insulin or when the body cannot effectively use the insulin it produces) and end-stage renal disease (the final stage of kidney decline where the kidneys are no longer able to function to meet the body's needs). A review of a quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated December 13, 2025, revealed that Resident 9 was cognitively intact with a BIMS score of 14 (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 to 15 indicates cognition is intact). A progress note dated January 8, 2026, at 3:54 PM, completed by Employee 12 (Physician Assistant), documented Resident 9's complaint of a wound on the right lateral foot, described as a small wound approximately one-fifth of an inch in size, with nursing staff notified. Further review of the clinical record revealed no additional documentation related to assessment, treatment, or monitoring of the right foot wound. During an interview on January 11, 2026, at 11:42 AM, Resident 9 explained that a wound on her right foot has been bothering her. A four-inch by four-inch bandage dated January 8, 2026, was observed covering the top of Resident 9's right foot. She explained that no one has looked at her wound since January 8, 2026. During an interview on January 11, 2026, at 1:30 PM, Employee 11, a Registered Nurse (RN), confirmed the presence of a wound on Resident 9's right foot. The wound is oval in shape, measuring one inch long and half an inch wide, with the center of the wound having a reddish-pink coloration. The skin surrounding the pink area is dry and flaky. No smell or drainage was noted. Employee 11, RN, was unable to provide documented evidence Resident 9 was receiving care or treatment regarding the wound on her right foot. During an interview on January 13, 2026, at 11:25 AM, the Director of Nursing (DON) was unable to provide documented evidence Resident 9 was receiving care or treatment regarding the wound on her right foot. The above information was reviewed with the DON. The facility failed to ensure Resident 9 received treatment, care, and monitoring in accordance with professional standards of practice for an identified wound. 28 Pa. Code 211.5(f)(ii)(ix) Medical records.28 Pa. Code 211.9 (a)(1)(d) Pharmacy services.28 Pa. Code 211.10(c)(d) Resident care policies.28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services.		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of clinical records, facility staffing records, and resident and staff interviews, it was determined the facility failed to provide sufficient nursing staff to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care, for eight out of 26 residents sampled (Residents 53, 76, 104, 87, 5, 119, 11, and 103). Findings include: A review of nurse staffing data from January 7, 2026, through January 13, 2026, revealed the facility failed to meet the state minimum requirement for nurse aides on 14 out of 21 shifts reviewed. During the same time period, the facility failed to meet the state minimum requirement for licensed practical nurses on two out of 21 shifts reviewed. Additionally, review of staffing records revealed the facility failed to meet the state minimum requirement for total direct care nursing hours on two out of seven days reviewed. A clinical record review revealed that Resident 104 was admitted to the facility on [DATE], with diagnoses that include heart failure (a condition that occurs when the heart can't pump enough blood to the body). A review of clinical records revealed Resident 104 was admitted on [DATE], with diagnoses including heart failure (a condition in which the heart is unable to pump enough blood to meet the body's needs). An annual Minimum Data Set (MDS, a federally mandated standardized assessment used to plan resident care) dated December 29, 2025, indicated the resident was cognitively intact with a Brief Interview for Mental Status (BIMS, a standardized tool used to assess cognition; scores of 13-15 indicate intact cognition) score of 15. Physician orders dated January 27, 2025, included tramadol hydrochloride 50 mg (an opioid pain medication) by mouth every 12 hours as needed for severe pain (pain level 8-10), with instructions to attempt non-pharmacological interventions prior to medication administration. During a resident group interview conducted on January 12, 2026, at 10:00 AM, Resident 104 reported experiencing waiting times of one to two hours to receive prescribed as-needed pain medication after notifying staff, which the resident stated occurred repeatedly over the prior month. A clinical record review revealed that Resident 76 was admitted to the facility on [DATE], with diagnoses that include chronic heart failure (a condition that occurs when the heart can't pump enough blood to the body). A quarterly MDS dated [DATE], indicated the resident was cognitively intact with a BIMS score of 14. Physician orders dated May 25, 2025, included tramadol hydrochloride 50 mg by mouth every six hours as needed for severe pain, with required use of non-pharmacological interventions (non-medication approaches used to help relieve pain such as repositioning, relaxation techniques or massage) prior to administration. During the resident group interview on January 12, 2026, Resident 76 reported waiting between ten minutes and three hours to receive as-needed pain medication after notifying staff and stated that she waited over one hour on four occasions in the prior 30 days. A clinical record review revealed Resident 53 was admitted to the facility on [DATE], with diagnoses that include chronic respiratory failure (a condition where the respiratory system is unable to remove carbon dioxide from or provide oxygen to the body) and with bilateral above-knee amputations (surgery to remove the leg above the knee). A quarterly MDS dated [DATE], indicated the resident was cognitively intact with a BIMS score of 15. The resident's care plan identified dependence on staff for toileting and the need for two staff members for transfers (assistance moving from one surface to another, such as bed to wheelchair). Physician orders dated November 26, 2025, included orders to receive acetaminophen oral tablets with directions to give 1000 mg by mouth every eight hours as needed for severe pain. Directions include implementation of non-pharmacological interventions prior to administration and to not administer more than 3000 mg in 24 hours. A physician's order for Resident 53 to receive acetaminophen oral tablets with directions to give 650 mg by mouth every six hours as needed for moderate pain. Directions include implementation of non-pharmacological interventions prior to administration and to not administer more than 3000 mg (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	in 24 hours. A physician's order for Resident 53 to receive acetaminophen oral tablets with directions to give 325 mg by mouth every six hours as needed for mild pain. Directions include implementation of non-pharmacological interventions prior to administration and to not administer more than 3000 mg in 24 hours. During a resident group interview conducted on January 12, 2026, Resident 53 reported experiencing multiple episodes over the prior month in which she waited over one hour to receive pain interventions after notifying staff, which she stated caused her pain to worsen. The resident further reported frequent delays in being assisted out of bed in the morning, despite her stated preference to get out of bed after breakfast. An observation conducted on January 13, 2026, at 10:10 AM revealed Resident 53 remained in bed. At that time, the resident stated she was frustrated because she had not been assisted out of bed since breakfast. During an interview conducted on January 13, 2026, at 10:12 AM, Employee 5, Nurse Aide (NA), assigned to Resident 53, confirmed the resident remained in bed and stated that the resident's preferred time to get out of bed had not been discussed. Employee 5 further indicated that residents with scheduled appointments were prioritized due to assignment size. An observation conducted on January 14, 2026, at 10:00 AM revealed Resident 53 remained in bed. The resident stated that staff had not yet been around to assist her out of bed that morning. During an interview conducted on January 14, 2026, at 10:05 AM, Employee 6, Nurse Aide (NA), confirmed Resident 53 remained in bed and stated that she did not ask the resident her preferred time to get out of bed. Employee 6 further indicated she was assigned to 15 residents and prioritized residents with appointments to get out of bed first. During an interview conducted on January 14, 2026, at 10:10 AM, Employee 7, Licensed Practical Nurse (LPN), indicated there were no residents with appointments in Resident 53's hallway. Employee 7 was unable to explain why Resident 53 remained in bed after 10:00 AM. A clinical record review revealed Resident 87 was admitted to the facility on [DATE], with diagnoses which include congestive heart failure (a condition where the heart cannot pump blood enough blood) and diabetes (chronic condition that happens when blood sugar is too high). A review of a significant change MDS dated [DATE], revealed that Resident 87 is cognitively intact with a BIMS score of 15 (a score of 13 to 15 indicates cognition is intact), incontinent of bladder and bowel, and dependent on staff for toileting and hygiene. An observation conducted on January 12, 2026, at 2:05 PM revealed the resident's call bell was activated. Interview with the resident at this time revealed that the resident often waits an extended amount of time (longer than 15 minutes) for her call bell light to be answered. The resident stated that her call bell light was on since 1:20 PM and had not yet been answered. The resident stated that she was incontinent of urine and needed her brief changed. The resident further stated that she watches the clock on the wall in front of her bed to track how long it takes for her call bell light to be answered. At 2:10 PM (a wait time of 50 minutes) Employee 8 (nurse aide) entered the room to provide assistance to Resident 87. A clinical record review revealed Resident 5 was admitted to the facility on [DATE], with diagnoses to include fracture of the left femur (thigh bone), fracture of the sixth cervical vertebrae (the sixth bone in the neck), and dementia (decline in mental ability severe enough to interfere with daily life, affecting memory, thinking, judgement, language and behavior, caused by brain cell damage). An admission MDS dated [DATE], indicated the resident required substantial/maximal assistance from staff for showering/bathing. The resident was cognitively impaired with a BIMS score of 6 (a score of 0-7 indicates the resident was severely cognitively impaired). A review of Resident 5's task report (an electronic record used to outline and track planned resident-centered nursing tasks) revealed the resident was scheduled to receive showers twice weekly on Mondays and Thursdays during the 3:00 PM to 11:00 PM shift. A review of Resident 5's Documentation Survey Report (reports that capture care-related tasks completed by nurse aides) for December 2025 and January 2026 revealed the resident did not receive any showers since admission to the facility on December 13, 2025, and only received bed baths during that time. A clinical record review revealed Resident 119 was admitted to the facility on [DATE], with diagnoses to include venous insufficiency (condition where leg veins struggle to send blood back to the heart causing (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	swelling, pain, heaviness, cramping, and skin changes) and pulmonary hypertension (high blood pressure in the arteries that carry blood from the heart to the lungs, making the right side of the heart work harder to pump blood through narrowed or blocked lung vessels). An admission MDS dated [DATE], indicated the resident required moderate assistance from staff for showering/bathing. The resident was cognitively intact with a BIMS score of 14 (a score of 13-15 indicates the resident is cognitively intact). During an interview on January 11, 2026, the resident reported that no showers had been provided since admission despite scheduled showers twice weekly. Observation revealed the resident's hair appeared oily and unkempt. A review of Resident 119's task report indicated showers were scheduled twice weekly on Mondays and Thursdays during the 3:00 PM to 11:00 PM shift. Review of the Documentation Survey Report for January 2026 revealed the resident did not receive any showers since admission and only received bed baths. A clinical record review revealed Resident 11 was admitted to the facility on [DATE], with diagnoses to include neuromuscular dysfunction of the bladder (a condition in which the nerves and muscles that control bladder function doesn't work together properly. As a result, a person may have trouble storing urine, emptying the bladder, or both) and end stage renal disease (the final stage of kidney decline where the kidneys are no longer able to function to meet the body's needs). An admission MDS dated [DATE], indicated the resident required moderate assistance from staff for showering/bathing. The resident was moderately impaired with a BIMS score of 10 (a score of 7-12 indicates the resident is moderately cognitively impaired). During an interview conducted on January 11, 2026, at 12:55 PM, Resident 11 stated he only received one shower since admission. He stated, Nobody will give me a shower. I'm so dirty and feel so grimy. Look at my hair, it's so greasy! I ask when I can have a shower and they say tomorrow, tomorrow, tomorrow, but tomorrow never comes. Observation revealed the resident had greasy, disheveled hair and beard. Resident 11 also reported that the bandage covering the stoma (small, surgically created opening in the lower abdomen where a tube/catheter is inserted directly into the bladder to drain urine) for his suprapubic catheter (thin tube that drains urine from the bladder through a small opening in the lower abdomen, just above the pubic bone, instead of the urethra (a long fibromuscular tube that serves as the final pathway for urine to exit the body) had not been changed in three days. Resident 11 reported that he waits an excessively long time for his call bell to be answered. He stated I push the call button, and they don't come in for 45 minutes to 1.5 hours. Sometimes I have to go out in my wheelchair to get help. They don't have enough staff. A review of Resident 11's task report indicated showers were scheduled twice weekly on Wednesdays and Saturdays during the 7:00 AM to 3:00 PM shift. Review of Resident 11's Documentation Survey Reports revealed the resident did not receive any showers in December 2025 and only received two sink baths on December 19, 2025, and December 31, 2025. Review of the January 2026 Documentation Survey Report revealed the resident did not receive any showers or bed baths during the month. A review of physician orders dated December 23, 2025, revealed Resident 11 had an order to cleanse the suprapubic catheter site with normal saline solution and apply a dry dressing every day and as needed. Observation of Resident 11's suprapubic catheter insertion site was conducted on January 11, 2026, at 1:24 PM, in the presence of Employee 13, (Licensed Practical Nurse). The observation revealed the dressing covering the suprapubic catheter site was dated January 8, 2026. Employee 13 confirmed the date on the dressing and further confirmed Resident 11 had a physician's order requiring the dressing to be changed daily. A clinical record review revealed Resident 103 was admitted to the facility on [DATE], with diagnosis to include fracture of the left tibia (lower leg) and hypertension (high blood pressure). An admission MDS dated [DATE], indicated the resident was moderately cognitively impaired with a BIMS score of 9. During an interview conducted on January 11, 2026, at 12:00 PM, Resident 103 stated that she frequently waited over 30 minutes for her call bell to be answered. A family member, who was present at the time of the interview, added that the facility is understaffed, especially on weekends and holidays. The family member noted that staff are nice but there aren't enough of them, and they seemed rushed all the time. Yesterday, the girl went on (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Greenwood Center for Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 149 Lafayette Avenue Tamaqua, PA 18252	
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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	lunch and left my mother on the bed pan for over thirty minutes. During an interview on January 14, 2026, at 11:00 AM, the above information was reviewed with the Nursing Home Administrator (NHA). The facility failed to ensure residents were provided with sufficient nursing staff to attain or maintain the highest practicable physical, mental, and psychosocial wellbeing of each resident, as determined by resident assessments and individual plans of care. Cross refer F 677 F 684 28 Pa. Code 201.18 (b)(1)(3)(e)(1)(6) Management. 28 Pa. Code 201.29 (a) Resident rights. 28 Pa. Code 211.12 (c)(d)(1)(4)(5) Nursing services.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, observations, and resident and staff interviews, it was determined the facility failed to consistently implement infection prevention and control practices and failed to ensure that reusable medical equipment intended for oral use was stored in a manner that prevented contamination for one of 26 sampled residents (Resident 16). The facility also failed to evaluate infection surveillance data to determine potential contributing factors and identify the need for corrective actions. Findings include: Clinical record review revealed that Resident 16 was admitted to the facility on [DATE], with a diagnosis of cancer of the throat and tracheostomy (surgically created opening in the throat for purposes of breathing). An admission Minimum Data Set assessment dated [DATE], (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated November 11, 2025, indicated the resident was cognitively intact with a BIMS score of 13 (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). An observation of Resident 16 conducted on January 11, 2026, at 10:00 a.m., and again on January 12, 2026, at 9:15 a.m., revealed that a Yankauer suction device, (a reusable medical device used to remove saliva and secretions from the mouth), was observed in direct contact with the floor in the resident's room. The floor is considered a non-clean surface, and contact with it increases the risk that bacteria or germs may contaminate an item intended to be placed in the mouth. During both observations, no storage method was observed that would prevent the device from contacting the floor. An interview with Resident 16 conducted on January 11, 2026, revealed that the resident independently uses the Yankauer suction device and reported that there was no designated place to store the device when finished. The resident stated that the device sometimes falls to the floor and that he continues to use it for oral suctioning even after it has contacted the floor. The resident further stated that he attempts to place the device on his abdomen to keep it clean; however, it does not consistently remain there. An interview with the Nursing Home Administrator revealed that staff had not identified or reported concerns regarding storage of the Yankauer suction device prior to surveyor observation and that no preventative solution had been implemented until after surveyor notification. A review of the facility's infection control logs for October, November, and December 2025 revealed documented cases of urinary tract infections (infections that occur when bacteria enter and multiply in the urinary system, including the bladder or kidneys). Review of the infection data revealed that approximately 50 percent of the documented urinary tract infections were caused by Escherichia coli or Proteus mirabilis, which are types of bacteria commonly found in the digestive system and are known to cause urinary tract infections when introduced into the urinary tract through hygiene-related factors. An interview with the Assistant Director of Nursing/Infection Control Preventionist conducted on January 14, 2026, revealed the facility was unable to provide evidence that it evaluated or analyzed the infection data to determine potential contributing factors or trends requiring intervention. This included the absence of documentation demonstrating review of staff hand hygiene practices, glove use between residents, provision of timely incontinence care, performance of perineal care, which is cleaning of the genital and anal areas to reduce the spread of bacteria, or evaluation of toileting practices for residents who were independent. The absence of such evaluation limited the facility's ability to determine whether additional staff education or corrective actions were needed to reduce the recurrence of urinary tract infections. The interview with the Assistant Director of Nursing/Infection Control Preventionist on January 14, 2026, at 1:00 p.m., was unable to provide evidence that the facility evaluated/audited potential causes for the infections specific to E. coli and Proteus mirabilis in relation to the urinary tract infections, such as confirmation that staff were washing their hands upon entering and exiting resident rooms, changing gloves between residents, providing timely incontinence care, and providing (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	adequate perineal care (cleaning genital and anal areas) to determine any potential links that would require staff education to reduce the percentages of occurrence. In addition, if any of these infections were in residents who were independent for toileting, the individual resident practices would need to be evaluated. 28 Pa. Code 211.10 (c) Resident care policies. 28 Pa. Code 211.12(d)(3) (5) Nursing services.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of clinical records, and staff interview, it was determined that the facility failed to develop and implement a comprehensive, person-centered care plan to address the identified medical and treatment needs of one out of 26 residents sampled (Resident 5). Findings include: Clinical record review revealed Resident 5 was admitted to the facility on [DATE], with diagnoses to include fracture of the left femur (thigh bone), fracture of the sixth cervical vertebrae (the sixth bone in the neck), and dementia (decline in mental ability severe enough to interfere with daily life, affecting memory, thinking, judgement, language and behavior, caused by brain cell damage). An observation of Resident 5 conducted on January 11, 2026, at approximately 12:40 PM revealed the resident was wearing a Vista cervical collar, an adjustable neck brace designed to immobilize the cervical spine following injury or surgery. A review of the physician's orders dated December 18, 2025, revealed an active order for Resident 5 to wear a Vista cervical collar at all times except during showering, with instructions to change to a Sierra (peach) cervical collar, a shower-safe cervical collar, during bathing. A review of Resident 5's comprehensive care plan, in effect at the time of the survey, identified an intervention addressing altered musculoskeletal status related to fracture. However, the care plan failed to identify the resident's ordered use of a Vista cervical collar, failed to address the use of an alternate cervical collar during showering, and failed to outline staff responsibilities for monitoring, applying, or ensuring consistent use of the prescribed cervical collars in accordance with physician orders. An interview with the Nursing Home Administrator conducted on January 13, 2026, at approximately 9:30 AM confirmed that the facility failed to ensure Resident 5's comprehensive care plan was developed and implemented in a manner that fully addressed the resident's medical and treatment needs related to cervical spine stabilization. 28 Pa. Code 211.12 (d)(5) Nursing services.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, select facility policies, observations, and staff interviews, it was determined that the facility failed to consistently implement planned measures to prevent the development or worsening of pressure ulcers for one of 26 residents sampled (Resident 27). Findings include: According to the US Department of Health and Human Services, Agency for Healthcare Research & Quality, the pressure ulcer best practice bundle incorporates three critical components in preventing pressure ulcers: comprehensive skin assessment, standardized pressure ulcer risk assessment, and care planning and implementation to address the areas of risk. The American College of Physicians (ACP) is a national organization of internists who specialize in the diagnosis, treatment, and care of adults. The largest medical specialty organization and second-largest physician group in the United States, Clinical Practice Guidelines indicate that the treatment of pressure ulcers should involve multiple tactics aimed at alleviating the conditions contributing to ulcer development (i.e., support surfaces, repositioning, and nutritional support); protecting the wound from contamination and creating and maintaining a clean wound environment; promoting tissue healing via local wound applications, debridement, and wound cleansing; using adjunctive therapies; and considering possible surgical repair. A review of the facility Skin and Wound Management System Policy last reviewed January 30, 2025, indicated it is the policy of the facility to assess residents with wounds and, or pressure ulcers, as well as those at risk for skin compromise. Such residents are then provided with appropriate treatment to encourage healing and, or integrity. Ongoing monitoring and evaluation are then provided to ensure optimal resident outcomes. Preventative intervention will be implemented for residents identified at risk as appropriate, for example beds, wheelchair cushions, nutrition, therapy, etc. An Interdisciplinary Care Plan will be developed, and will identify the contributing risks for breakdown, or the actual skin impairment and the interventions implemented and updated as needed. The Interdisciplinary Care Plan should address (as appropriate) hydration, nutrition, preventative devices, physical activity, as well as positioning requirements, redistribution (techniques to remove pressure and maintain skin integrity), and proper body alignment. A review of the clinical record revealed that Resident 27 was admitted to the facility on [DATE], with diagnoses that included dementia (chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning). A review of a quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated October 7, 2025, revealed that Resident 27 was severely cognitively impaired, dependent on staff for mobility and transfers, was non-ambulatory, and at risk for pressure ulcers (localized injury to the skin and underlying tissue, usually over a bony area, caused by prolonged pressure). A review of the resident's current care plan, initially dated January 23, 2025, identified the resident as having the potential for pressure ulcer development related to immobility. Planned interventions included use of a pressure-reduction mattress, transfer out of bed to a Geri Lounger chair (a padded reclining chair with wheels designed for individuals with limited mobility) as tolerated, and an intervention dated September 17, 2025, indicating the use of bilateral heel protectors (devices designed to suspend the heels off the surface to relieve pressure and reduce the risk of skin breakdown) at all times. A physician order dated September 17, 2025, noted an order for bilateral heel protectors to be applied at all times. During observations of Resident 27 on January 11, 2026, at 12:30 PM and again at 1:15 PM, the resident was observed seated in a Geri Lounger chair without the bilateral heel protectors in place. During an additional observation on January 12, 2026, at 2:00 PM, Resident 27 was again observed seated in the Geri Lounger chair without the heel protectors in place. At that time, an interview with Employee 8 (nurse aide) confirmed that the heel protectors were not in place. An interview with the Nursing Home Administrator (NHA) on January 15, 2026, at 10:00 AM confirmed the facility did not consistently (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	implement the planned intervention for heel protectors to prevent pressure ulcers for Resident 27. 28 Pa. Code 201.18(b)(1) Management.28 Pa. Code 211.10(d) Resident care policies.28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on a review of clinical records, facility-provided investigative documentation, and staff interviews, it was determined the facility did not demonstrate consistent reassessment and modification of care interventions for one of 26 residents sampled (Resident 72) following the identification of an injury risk during routine care. Findings include: Clinical record review revealed that Resident 72 had a diagnosis of left hemiplegia (paralysis to the left side of the body) and atrophy to the same limb (decreasing size of muscle due to lack of use). A quarterly Minimum Data Set Assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) completed on November 9, 2025, revealed the resident was dependent on staff for moving in bed and dressing and was not interview able, with a BIMS of 10 (Brief Interview for Mental Status, a tool to assess cognitive function a score of 8-10 indicates moderate cognitive impairment). A nurse's progress notes dated December 23, 2025, at 2:00 PM documented the resident was evaluated by a nurse practitioner due to complaints of left shoulder pain, and diagnostic imaging was ordered. A subsequent nurse's note dated December 23, 2025, at 2:57 PM, documented the resident complained of left shoulder pain during the provision of morning care. Nursing documentation dated December 23, 2025, indicated the resident reported left shoulder discomfort during routine care activities. A nurse practitioner evaluation was completed, and diagnostic imaging was ordered to further assess the complaint. Review of facility-provided investigative documentation dated December 26, 2025, indicated that the resident was later identified as having an acute fracture of the distal left humerus (the lower portion of the upper arm bone near the elbow joint). The documentation described that the resident reported pain during assistance with dressing of the affected extremity. A physician progress note dated January 9, 2026, documented that the fracture was consistent with stress occurring during external rotation of the arm (movement in which the arm rotates outward from the body), a motion that can occur during upper-body dressing, particularly in individuals with limited range of motion. During an interview conducted on January 12, 2026, at 12:45 p.m., Employee 4, a nurse aide, described providing routine dressing assistance to Resident 72 on December 23, 2025. The staff member explained that additional difficulty was encountered when dressing the resident's left side due to reduced range of motion and increased stiffness related to the resident's underlying medical conditions. The staff member further indicated they were not aware of any changes to the resident's care approach, dressing technique, or specific safety guidance implemented following the occurrence. An interview with the nursing home administrator (NHA) on January 13, 2026, did not provide evidence that the facility completed a documented reassessment of the resident's dressing needs or implemented modified interventions tailored to the resident's limited mobility and vulnerability to injury following the identification of the fracture. 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, facility-provided documentation, and employee interviews, it was determined that the facility failed to ensure the accuracy and completeness of resident medical records for two of 26 residents sampled (Residents 90 and 102). Findings include: A clinical record review revealed Resident 90 was admitted to the facility on [DATE], with diagnoses that include anoxic brain damage (a serious type of injury characterized by a lack of oxygen to the brain) and chronic obstructive pulmonary disease (COPD, a condition caused by damage to the airways or other parts of the lung that blocks airflow and makes it hard to breathe). A clinical record review revealed Resident 102 was admitted to the facility on [DATE], with diagnoses that include dementia (a condition characterized by the loss of cognitive functioning such as thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities). A review of Resident 102's clinical record revealed a nursing progress note dated December 21, 2025, at 3:07 PM, completed by Employee 1, Registered Nurse (RN). The note documented that while Resident 102 was in the lounge and yelled help, Resident 90 wheeled over and slapped Resident 102 in the face. The note further documented that the RN separated the residents, completed a nursing assessment (an evaluation of the resident's physical and mental condition), initiated neurological checks (routine monitoring for signs of head or brain injury), provided emotional support, and notified the physician and the resident's emergency contact. A review of Resident 90's clinical record revealed a nursing progress note dated December 21, 2025, at 3:06 PM, also completed by Employee 1, RN. This note documented that Employee 1 observed Residents 90 and 102 in the lounge and then heard a slap. The note did not document Employee 1's direct observation of Resident 90 striking Resident 102. During an interview conducted on January 12, 2026, at 1:25 PM, Employee 1, RN, confirmed that the documentation in Resident 90's clinical record was not accurate. Employee 1 stated that she directly observed Resident 90 slap Resident 102. Employee 1 further stated that documentation involving resident-to-resident altercations is reviewed by the Director of Nursing (DON) or Assistant Director of Nursing, and that she was directed to change her documentation from saw Resident 90 slap Resident 102 to heard a slap so the note would align with information from the facility's internal investigative process. During an interview conducted on January 13, 2026, at 11:25 AM, the Director of Nursing (DON) confirmed that she directed Employee 1, RN, to document that the nurse heard a slap rather than saw Resident 90 slap Resident 102. The DON confirmed that the facility reviews documentation entered into residents' clinical records related to resident-to-resident altercations and acknowledged that the description of the incident differed between Resident 90's and Resident 102's medical records. Based on the above, the facility failed to ensure that resident clinical records accurately and completely reflected the nurse's direct observations of the incident. 28 Pa. Code 211.5 (f)(ii)(iii) Medical records.28 Pa. Code 211.12 (c)(d)(1)(5) Nursing services.		