STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395262	A. BLDG: __--_____ B. WING: _____	01/23/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
GREENFIELD HEALTHCARE AND REHABILITATION CENTER STATE LICENSE NUMBER: **490802**	**1521 WEST 54TH STREET ERIE, PA 16509**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
E 0000	INITIAL COMMENT Based on an Emergency Preparedness Survey completed on January 23, 2025, at Greenfield Healthcare and Rehabilitation, it was determined there were no deficiencies identified with the requirements of 42 CFR 483.73.	E 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE: (X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

Certified End Page

GREENFIELD HEALTHCARE AND REHABILITATION CENTER

STATE LICENSE NUMBER: 490802

SURVEY EXIT DATE: 01/23/2025

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeanne Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen MD
Debra L. Bogen, MD, FAAP
Secretary of Health

Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY

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K 0000	INITIAL COMMENT Facility ID #490802 Component 01 Main Building Based on a Medicare/Medicaid Recertification Survey completed on January 23, 2025, it was determined that Greenfield Healthcare and Rehabilitation was not in compliance with the following requirements of the Life Safety Code for an existing health care occupancy. Compliance with the National Fire Protection Association's Life Safety Code is required by 42 CFR 483.90(a). This is a one-story, Type III (200), unprotected, ordinary building, with a basement, that is fully sprinklered.	K 0000		

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K 0291 SS=F	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by:	K 0291	An annual 90 -minute battery back-up lighting test was completed January 30, 2025. Education was provided to the Maintenance Director by the Administrator on January 24, 2025 regarding the annual 90-minute battery back-up lighting test. An audit will be completed annually by the Maintenance Director to ensure that the annual 90-minute battery back-up lighting test is completed and will be monitored by the Administrator. Results of the audit will be presented at the quarterly QAPI meeting and recommendations will be implemented.	Completion Date: **02/28/2025** Status: **APPROVED** Date: **02/07/2025**

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K 0291 SS=F	Continued from page 2 Based on document review and interview, the facility failed to provide documentation of functional tests for battery-powered emergency lighting, affecting the entire component. Findings include: Document review on January 23, 2025, at 1:10 p.m., revealed the facility lacked documentation for the annual 90-minute battery back-up lighting test. Interview with the maintenance supervisor on January 23, 2025, at 1:10 p.m., confirmed the facility could not provide documentation that an annual test had been conducted.	K 0291		
K 0324 SS=E		K 0324		

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K 0324 SS=E	Continued from page 3 NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by:	K 0324	A semi-annual kitchen exhaust hood cleaning will be scheduled no later than February 14, 2025. Education was provided to the Maintenance Director by the Administrator on January 24, 2025 regarding kitchen semi-annual exhaust hood cleaning. An audit will be completed no less than quarterly by the Maintenance Director to ensure that the semi-annual kitchen exhaust hood cleaning is completed and will be monitored by the Administrator. Results of the audit will be presented at the quarterly QAPI meeting and recommendations will be implemented.	Completion Date: **02/28/2025** Status: **APPROVED** Date: **02/07/2025**

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K 0324 SS=E	Continued from page 4 Based on document review and interview, the facility failed to ensure kitchen exhaust hood cleanings were conducted at required intervals, affecting one of two inspections. Findings include: Document review on January 23, 2025, at 1:00 p.m., revealed the facility lacked documentation the kitchen exhaust hood cleaning was conducted on a semi-annual basis. Interview with the maintenance supervisor on January 23, 2025, at 1:00 p.m., confirmed a semi-annual kitchen hood cleaning had not been conducted within the required time frame.	K 0324		
K 0347 SS=F		K 0347		

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K 0347 SS=F	Continued from page 5 NFPA 101 Smoke Detection Smoke Detection 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2 This REQUIREMENT is not met as evidenced by:	K 0347	Monthly testing and battery replacements were completed for the facility battery operated smoke detectors January 30, 2025. Education was provided to the Maintenance Director by the Administrator on January 24, 2025, regarding the monthly testing and semi-annal battery replacement of the facility battery-operated smoke detectors. An audit will be conducted monthly for 4 months by the Maintenance Director to ensure that the monthly testing and semi-annual battery replacement for the facility battery-operated smoke detectors are completed. The audit will be monitored by the Administrator. Results of the audit will be presented at the quarterly QAPI meeting and recommendations will be implemented.	Completion Date: **02/28/2025** Status: **APPROVED** Date: **02/07/2025**

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K 0347 SS=F	Continued from page 6 Based on document review and interview, the facility failed to maintain smoke detectors for all battery-operated smoke detectors within the facility. Findings include: Document review on January 23, 2025, at 12:40 p.m., revealed the facility could not provide documentation for the following battery-operated smoke detector testings/maintenance: A. (12:40 p.m.) Monthly testing; B. (12:40 p.m.) Semi-annual battery replacement. Interview with the maintenance supervisor on January 23, 2025, at 12:40 p.m., confirmed the battery-operated smoke detector deficiencies at the time of the survey.	K 0347		
K 0371 SS=C		K 0371		

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K 0371 SS=C	Continued from page 7 NFPA 101 Subdivision of Building Spaces - Smoke Compar Subdivision of Building Spaces - Smoke Compartments 2012 EXISTING Smoke barriers shall be provided to form at least two smoke compartments on every sleeping floor with a 30 or more patient bed capacity. Size of compartments cannot exceed 22,500 square feet or a 200-foot travel distance from any point in the compartment to a door in the smoke barrier. 19.3.7.1, 19.3.7.2 Detail in REMARKS zone dimensions including length of zones and dead-end corridors. This REQUIREMENT is not met as evidenced by:	K 0371	The completion of smoke barriers throughout the facility was completed February 2, 2025. The Maintenance Director was educated by the Administrator on January 24, 2025 regarding the requirement for the facility to have complete smoke barriers throughout the building. An audit will be completed monthly for 4 months by the Maintenance Director to ensure that the smoke barriers throughout the facility are complete and will be monitored by the Administrator. Results of the audit will be presented at the quarterly QAPI meeting and recommendations will be implemented.	Completion Date: **02/28/2025** Status: **APPROVED** Date: **02/07/2025**

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K 0371 SS=C	Continued from page 8 Based on observation and interview, the facility failed to install and maintain smoke barriers, per regulations, on two of two building levels. Findings include: Observation on January 23, 2025, at 9:05 a.m., revealed the facility had incomplete smoke barriers throughout the building. Interview with the maintenance supervisor on January 23, 2025, at 9:05 a.m., confirmed the facility had incomplete smoke barriers throughout the building.	K 0371		
K 0712 SS=D		K 0712		

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K 0712 SS=D	Continued from page 9 NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by:	K 0712	A quarterly fire drill was conducted February 3, 2025 on first shift. Second and third shift drills will be conducted no later than February 27, 2025. The Maintenance Director was educated on January 24, 2025 by the Administrator regarding the requirement that quarterly fire drills must be completed on each shift. A monthly audit will be conducted for 4 months by the Maintenance Director to ensure that quarterly fire drills are completed on each shift and will be monitored by the Administrator. Results of the audit will be presented at the quarterly QAPI meeting and recommendations will be implemented.	Completion Date: **02/28/2025** Status: **APPROVED** Date: **02/07/2025**

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K 0712 SS=D	Continued from page 10 Based on document review and interview, the facility failed to meet fire drill requirements for seven of twelve required drills. Findings include: Document review on January 23, 2025, at 11:30 a.m., revealed the facility failed to provide documentation for the following fire drills: A. (11:30 a.m.) First quarter, first shift; B. (11:30 a.m.) Second quarter, first shift; C. (11:30 a.m.) Second quarter, second shift; D. (11:30 a.m.) Second quarter, third shift; E. (11:30 a.m.) Third quarter, third shift; F. (11:30 a.m.) Fourth quarter, second shift; G. (11:30 a.m.) Fourth quarter, third shift. Interview with the maintenance supervisor on January 23, 2025, at 11:30 a.m., confirmed the facility failed to provide the documentation at the time of the survey.	K 0712		

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K 0912 SS=C	NFPA 101 Electrical Systems - Receptacles Electrical Systems - Receptacles Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, play rooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover. If used in patient care room, ground-fault circuit interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.2.4.2 (NFPA 99) This REQUIREMENT is not met as evidenced by:	K 0912	Ground fault circuit interrupter receptacles were placed in the basement laundry rooms February 4, 2025. Education was provided to the Maintenance Director by the Administrator January 24, 2025 regarding the replacement of an interrupter receptacle to be placed within 6 feet of a water source. An audit will be conducted by the Maintenance Director to ensure that all receptacles that are located within 6 feet of a water source will be GFCI receptacles. The audit will be conducted by the Maintenance Director monthly for 4 months. The audit will be monitored by the Administrator. Results of the audit will be presented at the quarterly QAPI meeting and recommendations will be implemented.	Completion Date: **02/28/2025** Status: **APPROVED** Date: **02/07/2025**

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K 0912 SS=C	Continued from page 12 Based on observation and interview, the facility failed to maintain the protection of electrical systems in wet locations, affecting one of two floors. Findings include: Observation on January 23, 2025, at 1:25 a.m., revealed the basement laundry room had an electrical outlet located within six feet of the washing machines that was not a ground fault circuit interrupter (GFCI) receptacle. Interview with the maintenance supervisor on January 23, 2025, at 1:25 a.m., confirmed the receptacle deficiency.	K 0912		
K 0914 SS=F		K 0914		

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K 0914 SS=F	Continued from page 13 NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by:	K 0914	Electrical receptacles in resident care rooms were tested February 4, 2025 for visual inspection of physical integrity, correct polarity of the hot and neutral connections and retention force of the grounding blade which shall be not less than 115g (4oz.). Education was provided to the Maintenance Director by the Administrator January 24, 2025 regarding the requirement for electrical receptacles in resident care rooms were tested for visual inspection of physical integrity, correct polarity of the hot and neutral connections and retention force of the grounding blade which shall be not less than 115g (4oz.) An audit will be conducted by the Maintenance Director to ensure that all receptacles in resident care rooms were tested for non-hospital grade receptacles at intervals not exceeding 12 months. The audit will be conducted monthly for 4 months and will be monitored by the	Completion Date: **02/28/2025** Status: **APPROVED** Date: **02/07/2025**

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K 0914 SS=F	Continued from page 14	K 0914	Administrator. Results of the audit will be presented at the quarterly QAPI meeting and recommendations will be implemented.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395262	A. BLDG: __01_____ B. WING: _____	01/23/2025

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K 0914 SS=F	Continued from page 15 Based on document review and interview it was determined that the facility failed to perform an annual test and inspection on non-hospital grade electrical receptacles in resident sleeping rooms, throughout the entire facility. Findings include: Document review on January 23, 2025, at 1:13 p.m., revealed electrical receptacles in resident care rooms were not tested for non-hospital grade receptacles at intervals not exceeding 12 months. Receptacle testing should include the following: a. Patient care rooms; b. Visual inspection of physical integrity; c. Correct polarity of the hot and neutral connections; d. Retention force of the grounding blade (except locking-type receptacles) shall be not less than 115g (4 oz). Interview with the maintenance supervisor on January 23, 2025, at 1:13 p.m., confirmed the lack	K 0914		

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K 0914 SS=F	Continued from page 16 of documentation.	K 0914		
K 0918 SS=F		K 0918		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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K 0918 SS=F	Continued from page 17 NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10	K 0918	Weekly visual inspection and battery voltage/electrolyte levels and a monthly 30-minute load run and transfer switch operation was completed February 5, 2025. The annual fuel sample was taken January 30, 2025. Education was provided to the Maintenance Director by the Administrator on January 24, 2025 regarding the requirement for weekly visual inspection and battery voltage/electrolyte levels and a monthly 30-minute load run and transfer switch operation of the emergency generator, as well as an annual fuel sample. An audit will be conducted by the Maintenance Director to ensure that weekly visual inspection and battery voltage/electrolyte levels and a monthly 30-minute load run and transfer switch operation of the emergency generator, as well as an annual fuel sample is completed. A weekly audit will be conducted	Completion Date: **02/28/2025** Status: **APPROVED** Date: **02/07/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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K 0918 SS=F	Continued from page 18 (NFPA 70) This REQUIREMENT is not met as evidenced by:	K 0918	for visual inspection and battery voltage/electrolyte levels and a monthly audit will be conducted for 4 months for a 30-minute load run and transfer switch operation of the emergency generator. An annual audit will be conducted to ensure that a fuel sample is completed. These audits will be monitored by the Administrator. Results of the audits will be presented at the quarterly QAPI meeting and recommendations will be implemented.	

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K 0918 SS=F	Continued from page 19 Based on document review and interview, the facility failed to maintain the emergency generator, affecting the entire facility. Findings include: Document review on January 23, 2025, at 1:05 p.m., revealed the facility failed to provide documentation for the following tests: A. Weekly visual inspection and battery voltage/electrolyte levels; B. Monthly 30-minute load run and trasfer switch operation; C. Annual fuel sample. Interview with the maintenance supervisor on January 23, 2025, at 1:05 p.m., confirmed the documentation was unavailable at the time of the survey.	K 0918		
K 0923 SS=E		K 0923		

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K 0923 SS=E	Continued from page 20 NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders	K 0923	Full and empty cylinders signage were labeled to identify gas levels in the basement oxygen storage room January 24, 2025. Education was provided to the Maintenance Director by the Administrator on January 24, 2025 regarding the requirement for full and empty cylinders signage to identify gas levels in the basement oxygen storage room. An audit will be conducted by the Maintenance Director to ensure that signage is in the basement oxygen storage room to identify full and empty oxygen cylinders. The audit will be conducted 4 times a week for 4 weeks, 3 times a week for 3 weeks, 2 times a week for 2 weeks then weekly ongoing. The audit will be monitored by the Administrator. Results of the audits will be presented at the quarterly QAPI meeting and recommendations	Completion Date: **02/28/2025** Status: **APPROVED** Date: **02/07/2025**

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K 0923 SS=E	Continued from page 21 are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain medical gas cylinder storage in one location, affecting one of two building levels. Findings include: Observation on January 23, 2025, at 1:18 p.m., revealed the basement oxygen storage room had full and empty cylinders not properly labeled to identify gas levels. Interview with the maintenance supervisor on January 23, 2025, at 1:18 p.m., confirmed the medical gas cylinder storage deficiency.	K 0923		

Certified End Page

GREENFIELD HEALTHCARE AND REHABILITATION CENTER

STATE LICENSE NUMBER: 490802

SURVEY EXIT DATE: 01/23/2025

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeanne Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen MD
Debra L. Bogen, MD, FAAP
Secretary of Health

Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY