

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395262	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/24/2025
--	---	---	--

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
F 0000	<p>INITIAL COMMENT</p> <p>Based on a Follow-Up Survey completed on April 24, 2025, it was determined that Greenfield Healthcare and Rehabilitation Center corrected all the federal citations cited during the survey of February 4, 2025, under the requirements of the 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities; however, failed to correct all the state deficiencies and continued to be out of compliance with the following requirements of the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.</p>	F 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.

Pennsylvania Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395262	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/24/2025
--	---	---	--

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
P 5520		P 5520		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395262	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/24/2025	
NAME OF PROVIDER OR SUPPLIER: GREENFIELD HEALTHCARE AND REHABILITATION CENTER STATE LICENSE NUMBER: 490802		STREET ADDRESS, CITY, STATE, ZIP CODE: 1521 WEST 54TH STREET ERIE, PA 16509		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
P 5520	Continued from page 1 Nursing services. (3) Effective July 1, 2024, a minimum of 1 nurse aide per 10 residents during the day, 1 nurse aide per 11 residents during the evening, and 1 nurse aide per 15 residents overnight. This REGULATION is not met as evidenced by:	P 5520	The facility must maintain the minimum of one Nurse Aide for every 10 residents during the day shift, one Nurse Aide for every 11 residents during the evening and one Nurse Aide per 15 residents overnight. To ensure that these regulatory requirements are met the following action plan will be implemented: The scheduler was reeducated 4/28/25 to ensure that they understand the regulatory staffing requirements for nursing assistants. The nursing assistant schedule will be reviewed by the scheduler and Director of Nursing to ensure that nursing assistant ratios are met prior to posting of the schedule. In the event of call-offs by staff, all other staff will be contacted to cover any open shifts to ensure ratios are met. Bonuses will be offered as an incentive for employees to cover shifts. In addition, the facility utilizes a recruitment company to attract additional staff. An audit will be developed and completed by the Director of	Completion Date: 05/21/2025 Status: APPROVED Date: 05/02/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395262	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/24/2025
NAME OF PROVIDER OR SUPPLIER: GREENFIELD HEALTHCARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 1521 WEST 54TH STREET ERIE, PA 16509		
STATE LICENSE NUMBER: 490802				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
P 5520	Continued from page 2	P 5520	Nursing or Designee 3 times per week for 4 weeks, then 2 times a week for 3 weeks, then weekly ongoing, to ensure that nursing assistant ratios are met for all shifts. The audit will be monitored by the Administrator. Results of the audit will be presented at the Quality Assurance monthly meeting and recommendations will be implemented.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395262	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/24/2025
NAME OF PROVIDER OR SUPPLIER: GREENFIELD HEALTHCARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 1521 WEST 54TH STREET ERIE, PA 16509		
STATE LICENSE NUMBER: 490802				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
P 5520	Continued from page 3 Based on review of facility nursing staffing documents and staff interview, it was determined that the facility failed to meet the minimum Nurse Aide (NA) ratios of one NA per 10 residents on the day shift for ten of 21 days reviewed (3/31/25, 4/1/25, 4/3/25, 4/5/25, 4/6/25, 4/9/25, 4/14/25, 4/15/25, 4/16/25, and 4/17/25); failed to meet the minimum NA ratios of one NA per 11 residents on the evening shift for 17 of 21 days reviewed (3/29/25, 3/30/25, 3/31/25, 4/2/25, 4/3/25, 4/4/25, 4/5/25, 4/6/25, 4/7/25, 4/9/25, 4/10/25, 4/11/25, 4/13/25, 4/14/25, 4/15/25, 4/16/25, and 4/17/25); and failed to meet the minimum NA ratios of one NA per 15 residents on the overnight shift for five of 21 days reviewed (4/2/25, 4/10/25, 4/13/25, 4/16/25, and 4/18/25). Findings include: Review of facility nursing staffing documents for the time period from 3/29/25, through 4/18/25, revealed the following NA staffing shortages for the	P 5520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395262	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/24/2025
NAME OF PROVIDER OR SUPPLIER: GREENFIELD HEALTHCARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 1521 WEST 54TH STREET ERIE, PA 16509		
STATE LICENSE NUMBER: 490802				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
P 5520	Continued from page 4 day shift where the NA ratios were not met: 3/31/25 census of 88 residents worked and 8.80 were required 6.90 NAs 4/01/25 census of 88 residents worked and 8.80 were required 5.97 NAs 4/03/25 census of 87 residents worked and 8.70 were required 7.94 NAs 4/05/24 census of 86 residents worked and 8.60 were required 6.46 NAs 4/06/25 census of 86 residents worked and 8.60 were required 7.00 NAs 4/09/25 census of 84 residents worked and 8.40 were required 7.96 NAs 4/14/25 census of 83 residents worked and 8.30 were required 7.91 NAs 4/15/25 census of 84 residents worked and 8.40 were required 5.92 NAs 4/16/25 census of 84 residents worked and 8.40 were required 7.62 NAs 4/17/25 census of 84 residents worked and 8.40 were required 7.71 NAs	P 5520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395262	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/24/2025
NAME OF PROVIDER OR SUPPLIER: GREENFIELD HEALTHCARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 1521 WEST 54TH STREET ERIE, PA 16509		
STATE LICENSE NUMBER: 490802				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
P 5520	Continued from page 5 Review of facility nursing staffing documents for the time period from 3/29/25, through 4/18/25, revealed the following NA staffing shortages for the evening shift where the NA ratios were not met: 3/29/25 census of 88 residents 7.32 NAs worked and 8.00 were required 3/30/25 census of 88 residents 6.04 NAs worked and 8.00 were required 3/31/25 census of 88 residents 5.43 NAs worked and 8.00 were required 4/02/25 census of 87 residents 6.40 NAs worked and 7.91 were required 4/03/25 census of 87 residents 6.97 NAs worked and 7.91 were required 4/04/25 census of 87 residents 7.21 NAs worked and 7.91 were required 4/05/25 census of 86 residents 5.48 NAs worked and 7.82 were required 4/06/25 census of 85 residents 7.55 NAs worked and 7.73 were required 4/07/25 census of 86 residents 5.83 NAs worked and 7.82 were required	P 5520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395262	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/24/2025
NAME OF PROVIDER OR SUPPLIER: GREENFIELD HEALTHCARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 1521 WEST 54TH STREET ERIE, PA 16509		
STATE LICENSE NUMBER: 490802				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
P 5520	Continued from page 6 4/09/25 census of 84 residents worked and 7.64 were required 6.27 NAs 4/10/25 census of 84 residents worked and 7.64 were required 6.68 NAs 4/11/25 census of 84 residents worked and 7.64 were required 5.96 NAs 4/13/25 census of 83 residents worked and 7.55 were required 5.63 NAs 4/14/25 census of 83 residents worked and 7.55 were required 5.70 NAs 4/15/25 census of 84 residents worked and 7.64 were required 6.42 NAs 4/16/25 census of 84 residents worked and 7.64 were required 6.89 NAs 4/17/25 census of 84 residents worked and 7.64 were required 6.01 NAs Review of facility nursing staffing documents for the time period from 3/29/25, through 4/18/25, revealed the following NA staffing shortages for the overnight shift where the NA ratios were not met: 4/02/25 census of 87 residents 4.97 NAs	P 5520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395262	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/24/2025
NAME OF PROVIDER OR SUPPLIER: GREENFIELD HEALTHCARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 1521 WEST 54TH STREET ERIE, PA 16509		
STATE LICENSE NUMBER: 490802				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
P 5520	Continued from page 7 worked and 5.80 were required 4/10/25 census of 84 residents 5.00 NAs worked and 5.60 were required 4/13/25 census of 83 residents 4.00 NAs worked and 5.53 were required 4/16/25 census of 84 residents 5.05 NAs worked and 5.60 were required 4/18/25 census of 84 residents 3.81 NAs worked and 5.60 were required During a telephone interview on 4/24/25, at 3:30 p.m. the Nursing Home Administrator confirmed that the facility did not meet the minimum NA ratios for the above days and shifts.	P 5520		
P 5530		P 5530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395262	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/24/2025
NAME OF PROVIDER OR SUPPLIER: GREENFIELD HEALTHCARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 1521 WEST 54TH STREET ERIE, PA 16509		
STATE LICENSE NUMBER: 490802				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
P 5530	Continued from page 8 Nursing services. (4) Effective July 1, 2023, a minimum of 1 LPN per 25 residents during the day, 1 LPN per 30 residents during the evening, and 1 LPN per 40 residents overnight. This REGULATION is not met as evidenced by:	P 5530	The facility must maintain the minimum of one Licensed Practical Nurse (LPN) per 25 residents on the day shift, one Licensed Practical Nurse (LPN) per 30 residents for evening shift and one LPN for every 40 residents on the overnight shift. To ensure that these regulatory requirements are met the following action plan will be implemented: The scheduler was reeducated 4/28/25 to ensure that they understand the regulatory staffing requirements for Licensed Practical Nurses. The LPN schedule will be reviewed by the scheduler and Director of Nursing to ensure that LPN ratios are met prior to posting of the schedule. In the event of call-offs by staff, all other staff will be contacted to cover any open shifts to ensure ratios are met. The Director of Nursing and or the Scheduler are responsible for handling call offs on the off shifts and weekends. Bonuses will be offered as an incentive for employees to cover shifts. In	Completion Date: 05/21/2025 Status: APPROVED Date: 05/02/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395262	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/24/2025
NAME OF PROVIDER OR SUPPLIER: GREENFIELD HEALTHCARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 1521 WEST 54TH STREET ERIE, PA 16509		
STATE LICENSE NUMBER: 490802				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
P 5530	Continued from page 9	P 5530	<p>addition, the facility utilizes a recruitment company to attract additional staff.</p> <p>An audit will be developed and completed by the Director of Nursing or Designee 3 times a week for 4 weeks, then 2 times a week for 3 weeks, then weekly ongoing, to ensure that LPN ratios are met for the day, evening and overnight shifts. The audit will be monitored by the Administrator or Designee. Results of the audit will be presented at the Quality Assurance monthly meeting and recommendations will be implemented.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395262	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/24/2025
NAME OF PROVIDER OR SUPPLIER: GREENFIELD HEALTHCARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 1521 WEST 54TH STREET ERIE, PA 16509		
STATE LICENSE NUMBER: 490802				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
P 5530	Continued from page 10 Based on review of facility nursing staffing documents and staff interview, it was determined that the facility failed to meet the minimum of one Licensed Practical Nurse (LPN) per 25 residents on the day shift for one of 21 days (4/15/25); failed to meet the minimum of one LPN per 30 residents on the evening shift for six of 21 days (3/31/25, 4/9/25, 4/11/25, 4/12/25, 4/13/25, and 4/14/25); and failed to meet the minimum of one LPN per 40 residents on the overnight shift for 13 of 21 days reviewed (3/29/25, 3/30/25, 3/31/25, 4/2/25, 4/3/25, 4/4/25, 4/5/25, 4/7/25, 4/8/25, 4/10/25, 4/12/25, 4/13/25, and 4/14/25). Findings include: Review of facility nursing staffing documents for the time period from 3/29/25, through 4/18/25, revealed the following LPN staffing shortage for the day shift where the LPN ratios were not met: 4/15/25 census of 84 residents 3.31 LPNs	P 5530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395262	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/24/2025
NAME OF PROVIDER OR SUPPLIER: GREENFIELD HEALTHCARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 1521 WEST 54TH STREET ERIE, PA 16509		
STATE LICENSE NUMBER: 490802				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
P 5530	Continued from page 11 worked and 3.36 were required Review of facility nursing staffing documents for the time period from 3/29/25, through 4/18/25, revealed the following LPN staffing shortages for the evening shift where the LPN ratios were not met: 3/31/25 census of 88 residents 2.67 LPNs worked and 2.93 were required 4/09/25 census of 84 residents 2.78 LPNs worked and 2.80 were required 4/11/25 census of 85 residents 1.86 LPNs worked and 2.83 were required 4/12/25 census of 85 residents 1.85 LPNs worked and 2.83 were required 4/13/25 census of 83 residents 2.49 LPNs worked and 2.77 were required 4/14/25 census of 83 residents 2.72 LPNs worked and 2.77 were required Review of facility nursing staffing documents for the time period from 3/29/25, through 4/18/25, revealed the following LPN staffing shortages for the	P 5530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395262	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/24/2025
NAME OF PROVIDER OR SUPPLIER: GREENFIELD HEALTHCARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 1521 WEST 54TH STREET ERIE, PA 16509		
STATE LICENSE NUMBER: 490802				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
P 5530	Continued from page 12 overnight shift where the LPN ratios were not met: 3/29/25 census of 88 residents worked and 2.20 were required 1.16 LPNs 3/30/25 census of 88 residents worked and 2.20 were required 1.06 LPNs 3/31/25 census of 88 residents worked and 2.20 were required 2.06 LPNs 4/02/25 census of 87 residents worked and 2.18 were required 1.06 LPNs 4/03/25 census of 87 residents worked and 2.18 were required 1.06 LPNs 4/04/25 census of 87 residents worked and 2.18 were required 1.06 LPNs 4/05/25 census of 86 residents worked and 2.15 were required 1.05 LPNs 4/07/25 census of 86 residents worked and 2.15 were required 1.35 LPNs 4/08/25 census of 84 residents worked and 2.10 were required 1.46 LPNs 4/10/25 census of 84 residents worked and 2.10 were required 1.26 LPNs 4/12/25 census of 85 residents 2.03 LPNs	P 5530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395262	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/24/2025
NAME OF PROVIDER OR SUPPLIER: GREENFIELD HEALTHCARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 1521 WEST 54TH STREET ERIE, PA 16509		
STATE LICENSE NUMBER: 490802				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
P 5530	Continued from page 13 worked and 2.13 were required 4/13/25 census of 83 residents 1.74 LPNs worked and 2.08 were required 4/14/25 census of 83 residents 1.01 LPNs worked and 2.08 were required During a telephone interview on 4/24/25, at 3:30 p.m. the Nursing Home Administrator confirmed that the facility did not meet the minimum LPN ratios for the above days and shifts.	P 5530		
P 5640		P 5640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395262	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/24/2025
NAME OF PROVIDER OR SUPPLIER: GREENFIELD HEALTHCARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 1521 WEST 54TH STREET ERIE, PA 16509		
STATE LICENSE NUMBER: 490802				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
P 5640	Continued from page 14 Nursing services. (2) Effective July 1, 2024, the total number of hours of general nursing care provided in each 24-hour period shall, when totaled for the entire facility, be a minimum of 3.2 hours of direct resident care for each resident. This REGULATION is not met as evidenced by:	P 5640	The facility must maintain the minimum of 3.20 general nursing care hours for each 24-hour period. To ensure that this regulatory requirement is met the following will be implemented: The scheduler was reeducated 4/28/25, to ensure that they understand the regulatory requirement for general nursing care hours. The nursing schedule will be reviewed by the scheduler and Director of Nursing to ensure that general nursing care hours are met prior to posting of the schedule. In the event of call-offs by staff, all other staff will be contacted to cover any open shifts to ensure that general nursing care hours are met. Bonuses will be offered as an incentive for employees to cover shifts. In addition, the facility utilizes a recruitment company to attract additional staff. An audit will be developed and completed by the Director of Nursing or Designee 3 times per week for 4 weeks, then 2 times a	Completion Date: 05/21/2025 Status: APPROVED Date: 05/02/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395262	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/24/2025	
NAME OF PROVIDER OR SUPPLIER: GREENFIELD HEALTHCARE AND REHABILITATION CENTER STATE LICENSE NUMBER: 490802		STREET ADDRESS, CITY, STATE, ZIP CODE: 1521 WEST 54TH STREET ERIE, PA 16509		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
P 5640	Continued from page 15	P 5640	week for 3 weeks, then weekly ongoing, to ensure that the minimum of 3.20 general nursing care hours for 24-hour period is met. The audit will be monitored by the Administrator. Results of the audit will be presented at the Quality Assurance monthly meeting and recommendations will be implemented.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395262	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/24/2025
NAME OF PROVIDER OR SUPPLIER: GREENFIELD HEALTHCARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 1521 WEST 54TH STREET ERIE, PA 16509		
STATE LICENSE NUMBER: 490802				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
P 5640	Continued from page 16 Based on review of facility nursing staffing documents and staff interview, it was determined that the facility failed to meet the 3.2 minimum number of general nursing care hours for each 24-hour period for 14 of 21 days reviewed (3/29/25, 3/30/25, 3/31/25, 4/2/25, 4/3/25, 4/5/25, 4/7/25, 4/9/25, 4/10/25, 4/13/25, 4/14/25, 4/15/25, 4/16/25, and 4/17/25). Findings include: Review of facility nursing staffing documented for the time period from 3/29/25, through 4/18/25, revealed the following general nursing care hours was below the minimum 3.2 per patient day (PPD) on the following days: 3/29/25 3.18 PPD 3/30/25 3.09 PPD 3/31/25 2.85 PPD 4/02/25 2.96 PPD 4/03/25 3.08 PPD	P 5640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395262	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/24/2025
NAME OF PROVIDER OR SUPPLIER: GREENFIELD HEALTHCARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 1521 WEST 54TH STREET ERIE, PA 16509		
STATE LICENSE NUMBER: 490802				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
P 5640	Continued from page 17 4/05/25 2.99 PPD 4/07/25 3.15 PPD 4/09/25 3.09 PPD 4/10/25 3.13 PPD 4/13/25 3.00 PPD 4/14/25 3.07 PPD 4/15/25 2.84 PPD 4/16/25 3.14 PPD 4/17/25 3.03 PPD During a telephone interview on 4/24/25, at approximately 3:30 p.m. the Nursing Home Administrator confirmed the facility did not meet the 3.2 PPD minimum direct nursing care hours on the above dates.	P 5640		



Certified End Page

GREENFIELD HEALTHCARE AND REHABILITATION CENTER

STATE LICENSE NUMBER: 490802

SURVEY EXIT DATE: 04/24/2025

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, 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