STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395318	A. BLDG: 00 B. WING:	12/13/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
GREEN HOME INC STATE LICENSE NUMBER: **072202**	**37 CENTRAL AVENUE** **WELLSBORO, PA 16901**

(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
F 0000	INITIAL COMMENT Based on a Medicare/Medicaid Recertification Survey, State Licensure Survey, and Civil Rights Compliance Survey completed on December 13, 2024, it was determined that The Green Home Inc., was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations as they relate to the Health portion of the survey process.	F 0000		
F 0568 SS=E		F 0568		

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.

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F 0568 SS=E	Continued from page 1 483.10(f)(10)(iii) Accounting and Records of Personal Funds §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. This REQUIREMENT is not met as evidenced by:	F 0568	The Facility submits this Plan of Correction under procedures established by the Department of Health in order to comply with the Department's directive to change conditions which the Department alleges is deficient under State and/or Federal Long Term Care Regulations. This Plan of Correction should not be construed as either a waiver of the facility's right to appeal or challenge the accuracy or severity of the alleged deficiencies or an admission of past or ongoing violation of State or Federal regulatory requirements. 1. Residents 19 and 40 received a copy of their most recent quarterly statement during survey. 2. All residents who signed a Resident's Personal Fund Agreement have been received a copy of their most recent quarterly statement. 3. Education will be provided to the business office manager to provide and document receipt of quarterly statements for all residents who have signed a Resident's Personal Fund Agreement.	Completion Date: **01/28/2025** Status: **APPROVED** Date: **12/26/2024**

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F 0568 SS=E	Continued from page 2	F 0568	4. Quarterly audits will be completed x4 to ensure residents received quarterly statement with results presented in QAPI. 5. Compliance date: January 28, 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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F 0568 SS=E	Continued from page 3 Based on a review of resident personal fund accounting, clinical record review, and resident, family, and staff interview, it was determined that the facility failed to provide a personal fund quarterly statement for two of two residents reviewed for personal funds concerns (Residents 19 and 40). Findings include: Interview with Resident 19 on December 10, 2024, at 1:41 PM revealed that she had an idea regarding how much money she had in her personal funds account; however, she does not receive a written statement at least quarterly with her personal funds accounting. Clinical record review for Resident 19 revealed a facility Resident Personal Fund Authorization (form signed by a resident to consent to the facility management of the resident's personal fund) with an undated signature by Resident 19 that did not address the facility's obligation to provide quarterly statements that would account for all transactions	F 0568		

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F 0568 SS=E	Continued from page 4 occurring with the resident's personal fund. The form did not designate who would receive the accounting statement for the fund. Interview with the Nursing Home Administrator and the Director of Nursing on December 12, 2024, at 10:30 AM indicated that staff from the activities department would report the process that ensured Resident 19 received her resident fund statement; however, no staff provided additional information regarding the provision of personal fund statements for Resident 19. Interview with Resident 40 on December 10, 2024, at 12:11 PM revealed that the facility holds money for her in the business office; however, she does not receive a statement on at least a quarterly basis to know how much money she has. Interview with Resident 40's mother who was present during the interview with Resident 40 indicated that she does not get a statement of Resident 40's personal funds. Clinical record review for Resident 40 revealed a	F 0568		

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F 0568 SS=E	Continued from page 5 "Resident's Personal Fund Agreement (updated version of the form signed by a resident to consent to the facility management of the resident's personal fund)," that noted a record of all transactions regarding the resident's funds will be maintained by the facility in accordance with generally accepted accounting principles ,and the resident will have access at any time upon request to the above record and will receive an itemized quarterly statement of his/her account. Resident 40 signed this form on April 19, 2023. Interview with the Nursing Home Administrator on December 12, 2024, at 10:25 AM confirmed that the facility has not provided Resident 40 a statement of her personal funds on at least a quarterly basis. Interview with the Nursing Home Administrator on December 12, 2024, at 2:06 PM confirmed that the facility had no evidence that quarterly statements were given to the resident/responsible party for Residents 19 and 40 until following the surveyor's questioning.	F 0568		

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F 0568 SS=E	Continued from page 6 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.29(a) Resident rights	F 0568		
F 0582 SS=D		F 0582		

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F 0582 SS=D	Continued from page 7 483.10(g)(17)(18)(i)-(v) Medicaid/Medicare Coverage/Liability Notice §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation	F 0582	The Facility submits this Plan of Correction under procedures established by the Department of Health in order to comply with the Department's directive to change conditions which the Department alleges is deficient under State and/or Federal Long Term Care Regulations. This Plan of Correction should not be construed as either a waiver of the facility's right to appeal or challenge the accuracy or severity of the alleged deficiencies or an admission of past or ongoing violation of State or Federal regulatory requirements. 1. Resident 76 was notified of remaining Medicare days. 2. Residents who discharged while still covered by Medicare A in the last two months were reviewed for issuance of CMS-10123 notice. 3. The RNACs were educated on providing notice to residents discharging with Medicare A days remaining. 4. Audits for CMS-10123 notice will be completed weekly x4 then monthly x2 with results presented in	Completion Date: **01/28/2025** Status: **APPROVED** Date: **12/26/2024**

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F 0582 SS=D	Continued from page 8 of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by:	F 0582	QAPI. 5. Compliance date: January 28, 2025	

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F 0582 SS=D	Continued from page 9 Based on clinical record review and staff interview, it was determined that the facility failed to provide the required notification to a resident whose payment coverage changed for one of three residents reviewed for beneficiary notices (Resident 76). Findings include: A review of the form "Instructions for the Notice of Medicare Non-Coverage (NOMNC) CMS-10123," (a notice that informs the recipient when care received from the skilled nursing facility is ending; and how to contact a Quality Improvement Organization (QIO) to appeal) revealed instructions that a Medicare provider must ensure that the notice is delivered at least two calendar days before Medicare covered services end. The provider must ensure that the beneficiary or their representative signs and dates the NOMNC to demonstrate that the beneficiary or their representative received the notice and understands the termination of services can be disputed. If the provider is personally unable	F 0582		

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F 0582 SS=D	Continued from page 10 to deliver a NOMNC to a person acting on behalf of an enrollee, then the provider should telephone the representative to advise him or her when the enrollee's services are no longer covered. Confirm the telephone contact by written notice mailed on that same date. Clinical record review for Resident 76 revealed census documentation that confirmed Resident 76's last covered day of Medicare A services ended June 27, 2024. The facility discharged Resident 76 to his home/self-care. Rehabilitation/Nursing Communication documentation dated June 24, 2024, at 7:52 AM revealed that Resident 76 was deemed independent in the building with an assistive device. Social services documentation dated June 25, 2024, at 10:31 AM revealed that Resident 76 set a date with skilled therapy staff that he would discharge from the facility to home on June 27, 2024. The documentation indicated that Resident 76 was	F 0582		

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F 0582 SS=D	Continued from page 11 independent in the facility and had no medical equipment or home health needs. There was no evidence that either skilled therapy or social services staff provided Resident 76 a CMS-10123 notice. Interview with the Nursing Home Administrator and the Director of Nursing on December 12, 2024, at 10:25 AM and 2:30 PM, confirmed that the facility had no evidence to indicate that staff provided the CMS-10123 form to Resident 76 whose Medicare A covered services were ending. The interview confirmed that the facility had no evidence that Resident 76 exhausted his available Medicare A covered days. The interview confirmed that Resident 76's discharge from the facility was a planned discharge; with a known plan at least two days before his discharge. 28 Pa. Code 201.18(b)(2)(e)(1) Management 28 Pa. Code 201.29(a) Resident rights	F 0582		

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F 0641 SS=D	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by:	F 0641	The Facility submits this Plan of Correction under procedures established by the Department of Health in order to comply with the Department's directive to change conditions which the Department alleges is deficient under State and/or Federal Long Term Care Regulations. This Plan of Correction should not be construed as either a waiver of the facility's right to appeal or challenge the accuracy or severity of the alleged deficiencies or an admission of past or ongoing violation of State or Federal regulatory requirements. 1. Resident 59's MDS was corrected at the time of survey to reflect the Stage 3 pressure ulcer was not facility acquired. 2. All MDS for residents with facility acquired pressure ulcers in the last 2 months were reviewed for accuracy. 3. The RNACs were educated on accurate MDS coding of facility acquired pressure ulcers. 4. Audits will be completed for MDS coding of facility acquired pressure ulcers weekly x4 then monthly x2 with results reported to QAPI. 5. Compliance date: January 28, 2025	Completion Date: **01/28/2025** Status: **APPROVED** Date: **12/26/2024**

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GREEN HOME INC STATE LICENSE NUMBER: 072202	37 CENTRAL AVENUE WELLSBORO, PA 16901

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F 0641 SS=D	Continued from page 13 Based on clinical record review and staff interview, it was determined that the facility failed to ensure complete and accurate Minimum Data Set (MDS) assessments for one of 20 residents reviewed (Resident 59). Findings include: Review of Resident 59's clinical record revealed a Minimum Data Set Assessment (MDS, a form completed at specific intervals to determine care needs) dated July 11, 2024, that indicated the facility assessed her as having a Stage 3 (full thickness skin loss that might extend into underlying tissue) pressure ulcer that was present on admission. There were no other skin issues noted on the assessment. An MDS dated October 11, 2024, now indicated that the facility assessed her as having a Stage 3 pressure ulcer that was not present on admission. There were no other skin issues noted on the assessment.	F 0641		

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F 0641 SS=D	Continued from page 14 Interview with the Administrator on December 12, 2024, at 2:46 PM, confirmed that Resident 59's October 11, 2024, MDS was coded in error for her pressure ulcer status. 28 Pa. Code 211.5(f)(ix) Medical records 28 Pa. Code 211.12(d)(1)(5) Nursing services	F 0641		
F 0676 SS=D		F 0676		

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F 0676 SS=D	Continued from page 15 483.24(a)(1)(b)(1)-(5)(i)-(iii) Activities Daily Living (ADLs)/Mntn Abilities §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting,	F 0676	The Facility submits this Plan of Correction under procedures established by the Department of Health in order to comply with the Department's directive to change conditions which the Department alleges is deficient under State and/or Federal Long Term Care Regulations. This Plan of Correction should not be construed as either a waiver of the facility's right to appeal or challenge the accuracy or severity of the alleged deficiencies or an admission of past or ongoing violation of State or Federal regulatory requirements. 1. Residents 24 and 40 are on therapy caseload to address needs and evaluate for appropriate restorative nursing program. 2. All residents with a prosthetic were reviewed to ensure documented use of prosthetic. All residents on a RNP for ADLs were reviewed for completion of program and elevation to IDT for recommendations for those not completing their program requirements.	Completion Date: **01/28/2025** Status: **APPROVED** Date: **12/26/2024**

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F 0676 SS=D	Continued from page 16 §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by:	F 0676	3. The Restorative Nursing Coordinator was educated on reviewing program completion of RNP for ADLs and elevating to IDT for recommendations of any programs not completed. 4. Random audit of 5 RNP for ADLs will be completed weekly x4 then monthly x2 with results reported to QAPI. 5. Compliance date: January 28, 2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395318	A. BLDG: 00 B. WING:	12/13/2024

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F 0676 SS=D	Continued from page 17 Based on clinical record review and resident and staff interview, it was determined that the facility failed to provide care and services to maintain or improve the ability to perform activities of daily living for two of four residents reviewed for rehabilitation concerns (Residents 24 and 40). Findings include: Interview with Resident 24 on December 11, 2024, at 9:22 AM revealed that he was provided a prosthetic leg following his left leg amputation; however, he was not using it. Resident 24 stated that staff use a mechanical lift to assist him to transfer and he was not walking at all. Resident 24 stated that the skilled therapy department did not have parallel bars (parallel bars are commonly used during physical therapy and rehabilitation, they are used as a support tool to provide a safe way to work on skills like gait training and balance) like he used in another therapy department prior to his admission to this facility, which now prevented him from taking steps with the prosthetic.	F 0676		

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F 0676 SS=D	Continued from page 18 Discharge summary documentation from physical therapy staff dated August 25, 2023, listed discharge recommendations that included a restorative nursing program and continued use of prosthetic for assistance and increased safety with standing in Return 7500 (assistive mechanical lift device for sit-to-stand and transfer activities). Interview with Resident 24 and his wife on December 12, 2024, at 1:20 PM reiterated that staff never used his prosthetic leg during transfers with the mechanical lift. Resident 24 and his wife reiterated their experience of using parallel bars at another facility; however, the absence of this equipment at this facility has prevented his ability to walk with the prosthetic. Interview with Employee 7 (nurse aide who identified herself as the nurse aide assigned to Resident 24's care on this date) on December 12, 2024, at 1:28 PM revealed that she was not familiar with Resident 24's left lower leg prosthetic; she was	F 0676		

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F 0676 SS=D	Continued from page 19 not educated on donning it or using it. Employee 7 referenced the electronic plan of care for Resident 24 that would be utilized to determine his resident care needs and confirmed that his care needs indicated two staff should utilize a sit-to-stand lift; however, there was no intervention listed to use a prosthetic device on his left leg. The review confirmed that the directive for two staff to use the sit-to-stand lift started on August 11, 2023. Review of Resident 24's plan of care to address his risk for falls instructed two staff to utilize a sit-to-stand lift. The plan of care did not include the use of a prosthetic. Interview with the Nursing Home Administrator and the Director of Nursing on December 12, 2024, at 10:25 AM and 2:00 PM, revealed that there was no evidence that the facility implemented the physical therapy recommendation for a restorative nursing program with the continued use of a prosthetic limb for Resident 24's standing during transfers with the sit-to-stand lift.	F 0676		

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F 0676 SS=D	Continued from page 20 Interview with Resident 40 on December 10, 2024, at 12:24 PM indicated that she no longer receives the services of skilled therapy and does not receive restorative nursing services. A physical therapy discharge summary dated September 18, 2024, indicated that Resident 40's treatment included exercises to pull herself up to a standing position in the hallway to increase her functional mobility tolerance and increase her lower extremity functional strength. Recommendations upon discharge from skilled services included that Resident 40 would continue with a restorative nursing program. A plan of care entitled, "(Resident 40) is on a Restorative Nurse Program," (Resident 40) will participate daily in the RNP (restorative nursing program) with assistance. The goal is to maintain lower extremity strength to reduce fall risk. (Resident 40) will perform pull-to-stands using the hallway railing, making sure "nose over toes" during	F 0676		

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F 0676 SS=D	Continued from page 21 both standing and sitting, and receive reminders to breathe. Review of documentation regarding the planned restorative nursing program indicated numerous days when staff documented that the program was not completed because the resident was resting. Staff documented that the program was not completed on 22 of 31 days in October 2024, on 18 of 30 days in November 2024, and on seven of 11 days in December 2024. Staff also documented zero repetitions for zero minutes on three of the nine remaining days in October 2024, on six of the 12 remaining days in November 2024, and one of the four remaining days in December 2024. Interview with the Nursing Home Administrator and the Director of Nursing on December 12, 2024, at 10:25 AM confirmed that the documentation reflected that staff did not consistently complete the restorative nursing program with Resident 40. The facility did not provide documentation that the licensed staff who oversaw the restorative nursing	F 0676		

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F 0676 SS=D	Continued from page 22 programs identified that Resident 40's restorative nursing program was not completed consistently. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services	F 0676		
F 0688 SS=E		F 0688		

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F 0688 SS=E	Continued from page 23 483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by:	F 0688	The Facility submits this Plan of Correction under procedures established by the Department of Health in order to comply with the Department's directive to change conditions which the Department alleges is deficient under State and/or Federal Long Term Care Regulations. This Plan of Correction should not be construed as either a waiver of the facility's right to appeal or challenge the accuracy or severity of the alleged deficiencies or an admission of past or ongoing violation of State or Federal regulatory requirements. 1. Residents 11, 14 and 71 have been evaluated by therapy to provide needed services and identify appropriate restorative program. 2. Whole house audit of residents discharged from therapy in the last 2 months with an ambulation and ROM program to ensure programs are on Kardex. Audit of previous month of MDSs to review for any residents with a decline in ROM and ensure appropriate intervention occurred.	Completion Date: **01/28/2025** Status: **APPROVED** Date: **12/26/2024**

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F 0688 SS=E	Continued from page 24	F 0688	3. Education to Restorative Nurse Coordinator about ensuring all RNPs are added to Kardex. Education to RNACs to elevate any coded declines of ROM to IDT. 4. Random audit of 3 residents coming off therapy caseload weekly x4 then monthly x2 to confirm ordered RNP on Kardex. Random audit of 3 MDS weekly x4 then monthly x2 to monitor for any decline in resident ROM. 5. Compliance date: January 28, 2025	

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F 0688 SS=E	Continued from page 25 Based on clinical record review and resident and staff interview, it was determined that the facility failed to provide physician ordered services to maintain a resident's mobility for one of four residents reviewed (Resident 71), maintain a resident's range of motion program for one of four residents reviewed (Resident 14), and failed to provide services to prevent a decline in a resident's range of motion for one of four resident's reviewed (Resident 11). Findings include: Observation and interview with Resident 71 on December 10, 2024, at 1:09 PM revealed she was lying on her bed. Resident 71 stated she was planning on returning home and had finished therapy, but thought she was going to do more therapy to keep her strength to return home, such as walking. Resident 71 indicated she is not to try to walk on her own and needs to use a walker and rely on staff. Resident 71 stated she lies around a lot. Resident 71 stated staff need to walk her to her bathroom.	F 0688		

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F 0688 SS=E	Continued from page 26 Clinical record review for Resident 71 revealed a request for the resident to have physical and occupational therapy dated October 25, 2024he. The request was then noted to discontinue physical and occupational therapy orders as the resident had just completed 12 weeks of therapy on October 21, 2024, and is on a restorative nursing program for continued ambulation and lower extremity exercises. A review of Resident 71's physical therapy discharge summary dated October 18, 2024, noted the resident had reached maximum potential and resident and caregiver training with written communication was provided to nursing for both a restorative nursing program for ambulation and standing lower extremity exercises. The discharge recommendations included a restorative nursing program for ambulation in the hallway with a rolling walker and standing exercises at the hallway rail for heel raises, hip abduction, slow marches, and mini squats of two sets of 20 repetitions. The prognosis to maintain the resident's current level of function	F 0688		

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F 0688 SS=E	Continued from page 27 was good with consistent staff follow-through. A "Rehab Services Restorative Nursing/Functional Maintenance Referral" form dated October 16, 2024, by the therapist with services to begin on October 22, 2024, noted Resident 71 was to have an ambulation program to maintain the highest functional mobility level and decreased fall risk with special instructions noting the resident was to ambulate with a rolling walker in the hallway 200-300 feet with supervision and contact guard depending on her balance and awareness of surroundings that particular day. It was also noted the resident still has days with unsteadiness, decreased safety awareness, and needs close supervision/contact guard with ambulation. A physician's order dated October 22, 2024, indicated Resident 71 would ambulate with a rolling walker in the hallway 200-300 feet with one assist of supervision/contact guard depending on balance and awareness of surroundings that day, two times daily. There was no evidence of an order for the	F 0688		

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F 0688 SS=E	Continued from page 28 standing exercises noted above. A review of Resident 71's mobility/ambulation program documentation for October 2024, revealed no documentation of completion for October 22, October 29, and 30, 2024, as staff indicated "resident resting." From October 25, 26, 27 28, and 31, 2024, staff documented zero to 50 feet for ambulation and only one time a day was reflected. There was only one time from October 22 - 31, 2024, that Resident 71 was documented as receiving 200 feet of ambulation. Review of Resident 71's mobility ambulation program for November 2024, revealed the resident was documented as only receiving the program one time a day from November 1 -3, 2024, with only five feet in distance for November 1 and 3. The resident was only ambulated 200-300 feet five times from November 1-30, 2024, with only six documented resident refusals or resident not being available. One occurrence on November 29, 2024, was again noted as "resident resting." The remaining	F 0688		

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F 0688 SS=E	Continued from page 29 scheduled ambulation was documented as zero, five, 10, or 15 feet, with an occasional 50 or 100 feet documented. Review of Resident 71's December 2024, ambulation/mobility program documentation for twice a day revealed the resident was documented as "resting" on December 1, and 6, 2024, with zero, five and 10 feet documented completion, with only one instance of 25 feet, and one of 50 feet. The resident did ambulate 200 feet on December 1, 2024. There was no evidence to indicate Resident 71's ambulation program to maintain her mobility was completed as ordered as recommended by physical therapy in October 2024. There was no evidence Resident 71's exercise program to maintain her mobility was ordered or completed as recommended by physical therapy in October 2024. There was no evidence to indicate any communication was provided by facility staff to indicate Resident 71 could not complete the	F 0688		

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F 0688 SS=E	Continued from page 30 program as ordered. A quarterly MDS (minimum data set, an assessment completed at periodic intervals of time to assess resident care needs), dated November 4, 2024, revealed facility staff assessed Resident 71's sections of "walking 150 feet" was not attempted due to medical condition or safety concerns. There was no evidence Resident 71 had any medical or safety concerns inhibiting her from staff completing the ordered program. The above information regarding Resident 71 was reviewed with the Nursing Home Administrator and Director of Nursing on December 12, 2024, at 10:45 AM. Review of Resident 11's clinical record revealed that the facility readmitted her from a hospital stay on August 28, 2024. A physician's order was obtained for the facility to complete a physical and occupational therapy screen to determine what her care needs were regarding therapy after being in the	F 0688		

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F 0688 SS=E	Continued from page 31 hospital. There was no documented evidence in Resident 11's clinical record to indicate that the facility completed the screens as ordered by her physician. Review of Resident 11's clinical record revealed an MDS dated August 31, 2024, that indicated the facility assessed her as having no range of motion limitations to either her upper or lower extremities. An MDS dated December 1, 2024, indicated that the facility now assessed Resident 11 as having limited range of motion to both sides of her upper and lower extremities. There was no documented evidence in Resident 11's clinical record to indicate that the facility implemented interventions after identifying her decline in range of motion. Interview with the Administrator on December 13, at 10:52 AM confirmed the above findings for Resident 11. Interview with Resident 14 on December 10, 2024,	F 0688		

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F 0688 SS=E	Continued from page 32 at 2:06 PM revealed that she had a CVA (stroke, brain damage secondary to abnormal blood supply or trauma in the brain) approximately six months earlier that resulted in deficits to her left arm and leg. Resident 14 said that she does not receive services from skilled therapy. Resident 14 stated that, "they (nursing staff) say they're going to (perform exercises with her) but they never do." Clinical record review of a care plan developed by the facility for Resident 14 indicated that she has the potential for injury, trauma, and falls related to cognitive impairment and history of CVA with left weakness. Interventions listed in the care plan included: to encourage participation in therapy for strengthening and maintain function, assist Resident 14 to attain/maintain her highest practicable level of physical or psychological well-being, and provide appropriate restorative nursing programs (RNP) as indicated. A physical therapy (PT) discharge summary dated November 22, 2024, listed recommendations that	F 0688		

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F 0688 SS=E	Continued from page 33 included an RNP for lower extremity AROM (active range of motion) and AAROM (active assisted range of motion) to maintain knee and ankle flexibility range for proper sitting. The surveyor requested any evidence that the RNP program for Resident 14's range of motion was implemented per the PT discharge summary recommendations during interviews with the Nursing Home Administrator on December 12, 2024, at 2:00 PM, and December 13, 2024, at 10:10 AM and 12:15 PM. Interview with the Nursing Home Administrator on December 13, 2024, at 12:15 PM confirmed that the facility had no evidence that the RNP program was implemented for Resident 14. 28 Pa. Code 211.10(a)(c)(d) Resident care policies 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services	F 0688		

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	395318	A. BLDG: 00 B. WING:	12/13/2024

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F 0695 SS=D	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by:	F 0695	The Facility submits this Plan of Correction under procedures established by the Department of Health in order to comply with the Department's directive to change conditions which the Department alleges is deficient under State and/or Federal Long Term Care Regulations. This Plan of Correction should not be construed as either a waiver of the facility's right to appeal or challenge the accuracy or severity of the alleged deficiencies or an admission of past or ongoing violation of State or Federal regulatory requirements. 1. Resident 15's orders were changed by the physician to a titrate order. There was no harm to resident 15. 2. All residents with supplemental oxygen orders were reviewed and confirmed for wean vs titrate. 3. Education to licensed staff on titrate vs wean orders for supplemental oxygen. 4. Random audit of 5 residents on supplemental oxygen to ensure their oxygen setting follows their order. 5. Compliance date: January 28, 2025	Completion Date: **01/28/2025** Status: **APPROVED** Date: **12/26/2024**

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F 0695 SS=D	Continued from page 35 Based on clinical record review, observation, and resident and staff interview, it was determined that the facility failed to ensure the application of physician ordered supplemental oxygen consistent with professional standards of practice for one of two residents reviewed for supplemental oxygen concerns (Resident 15). Findings include: Observation of Resident 15 on December 10, 2024, at 11:41 AM revealed that she wore supplemental oxygen via a nasal canula (flexible tubing with small prongs on one end that are positioned in the nares to administer a supply of oxygen) that was attached to a wall flow meter (metered device used to control the flow of compressed medical oxygen from a wall supply) that was set at three liters per minute. Interview with Resident 15 on the date and time of the observation indicated that she believed her oxygen liter flow was to be set at three liters per minute.	F 0695		

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F 0695 SS=D	Continued from page 36 Clinical record review for Resident 15 revealed an active physician order for staff to administer supplemental oxygen at two liters per minute, to check oxygenation saturations (SPO2, pulse oximeter, an assessment done by a small device applied to the tip of a finger to assess the amount of oxygen in the blood) three times daily, and to keep saturations at or above 90 percent. A plan of care developed by the facility to address Resident 15's risk for ineffective breathing related to a recent hospitalization and her diagnoses of chronic respiratory failure (lungs cannot remove enough carbon dioxide or take in enough oxygen) and COPD (damage to airways with inflammation that limits airflow into and out of the lungs) listed interventions that included to check and record oxygen saturations every eight hours and as needed when oxygen was in use and to administer oxygen per the physician's order. Observation of Resident 15 on December 12, 2024, at 1:35 PM revealed her supplemental	F 0695		

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F 0695 SS=D	Continued from page 37 oxygen supply via the wall flow meter was set at three liters per minute. Interview with Employee 8 (licensed practical nurse) on December 12, 2024, at 1:35 PM indicated that she believed Resident 15's physician orders for supplemental oxygen permitted her to titrate the liter flow based on Resident 15's oxygen saturation assessments. Review of Resident 15's physician orders confirmed that the active physician order did not permit staff to titrate the oxygen liter flow. Employee 8 went to Resident 15's room to correct the liter flow to two liters per minute as her physician orders directed. The surveyor reviewed the above concerns regarding Resident 15's oxygen administration during an interview with the Nursing Home Administrator and the Director of Nursing on December 12, 2024, at 2:00 PM. 28 Pa. Code 211.12(d)(1)(5) Nursing services	F 0695		

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F 0725 SS=D		F 0725		

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F 0725 SS=D	Continued from page 39 483.35(a)(1)(2) Sufficient Nursing Staff §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and 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 and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by:	F 0725	The Facility submits this Plan of Correction under procedures established by the Department of Health in order to comply with the Department's directive to change conditions which the Department alleges is deficient under State and/or Federal Long Term Care Regulations. This Plan of Correction should not be construed as either a waiver of the facility's right to appeal or challenge the accuracy or severity of the alleged deficiencies or an admission of past or ongoing violation of State or Federal regulatory requirements. 1. Facility is meeting all DOH staffing ratio and PPD guidelines. Residents 38 and 71 will be interviewed weekly x4 weeks then monthly x2 months to monitor call bell response satisfaction. 2. The DON or designee will attend Resident Council monthly x3 to confirm satisfaction with call bell response time. 3. Staff was educated on responding to call bells within 15 minutes of activation.	Completion Date: **01/28/2025** Status: **APPROVED** Date: **12/26/2024**

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F 0725 SS=D	Continued from page 40	F 0725	4. Random audit of call bell reports for response times will be completed weekly x4 then monthly x2. Resident council response to call bell length and the random audit results will be reported to QAPI for review and recommendations. 5. Compliance date: January 28, 2025	

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F 0725 SS=D	Continued from page 41 Based on observations, clinical record review, and resident and staff interview, it was determined that the facility failed to have sufficient nursing staff to meet resident's needs related to call bell response time for two of 20 residents reviewed (Resident 38 and 71). Findings include: In an interview with Resident 71 on December 10, 2024, at 1:24 PM the resident stated she doesn't have much notice for needing to use the bathroom and relies on staff to get her there as she needs assistance to ambulate to the bathroom. Resident 71 stated it takes staff a long time to get there as she will ring the bell and wait. Resident 71 indicated she waited one hour and 5 minutes recently. A review of call bell activation logs for Resident 71 from November 27 - December 11, 2024, revealed the following (total minutes reflect time in seconds from reports):	F 0725		

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F 0725 SS=D	Continued from page 42 December 3, 2024, call bell activated at 1:03 PM, response at 1:20 PM, 16 minutes. December 6, 2024, call bell activated at 9:24 PM, response at 9:46 PM, 21 minutes. December 8, 2024, call bell activated at 10:50 AM, response at 11:05 AM, 15 minutes. December 11, 2024, call bell activated at 6:52 AM, response at 7:27 AM, 34 minutes. Out of 91 activations. A call bell response time over an hour was not identified for Resident 71, although the resident did have wait times of 15 minutes or greater in the time frame noted above. In an interview with Resident 38 on December 11, 2024, at 12:09 PM the resident stated she has to wait for staff to get her a bed pan or to get changed, when she rings her bell, or if staff does come, in the morning she will sit in a soaked bed later. A review of call bell activation logs for Resident 38 from November 20 - December 11, 2024, revealed	F 0725		

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F 0725 SS=D	Continued from page 43 the resident has had several call bell response times greater than 15 minutes, or bell response where multiple activations completed and shut off in a short time frame, not meeting the resident needs, as follows (total minutes reflect the call duration which may have included seconds): November 22, 2024, call bell activated at 7:06 AM response at 7:21 AM, 15 minutes. November 22, 2024, call bell activated at 7:01 PM response at 7:54 PM, 53 minutes. November 25, 2024, call bell activated at 7:47 AM, response at 8:11 AM, 23 minutes. November 25, 2025, call bell activated at 6:22 PM, response at 6:39 PM, 16 minutes. November 28, 2024, call bell activated at 8:32 AM, response at 8:53 AM, 20 minutes. Call bell activations were also listed as 8:14 AM, with response at 8:20 AM, then 8:23 AM, response at 8:31 AM prior to the 20-minute bell at 8:32 AM. December 5, 2024, call bell activated at 2:56 PM, response at 3:18 PM, 22 minutes. December 6, 2024, call bell activated at 7:44 PM,	F 0725		

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F 0725 SS=D	Continued from page 44 response at 8:11 PM, 26 minutes. December 7, 2024, call bell activated at 7:31 AM, response at 7:53 AM, 22 minutes. December 7, 2024, call bell activated at 6:39 PM, with response at 7:40 PM, one hour and one minute. December 8, 2024, call bell activated at 7:46 AM, response at 8:02 AM, 16 minutes. Call bell had been activated directly before at 7:43 AM and shut off at 7:44 AM prior to being reactivated again at 7:46 AM. December 8, 2024, call bell activated at 11:24 AM, response at 12:01 PM, 37 minutes. December 8, 2024, call bell activated at 12:53 PM, response at 1:08 PM, 15 minutes December 9, 2024, call bell activated just after 1:00 PM, response at 1:16 PM, 15 minutes. December 10, 2024, call bell activated at 9:34 PM, response at 9:56 PM, 22 minutes. Although Resident 38's call bell activation could not be directly correlated to incontinence due to facility staff indicating timing of nurse aide documentation	F 0725		

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F 0725 SS=D	Continued from page 45 may not be directly at the time someone is toileted, several long call bell wait times were evident in the time frame reviewed above for the resident. The above call bell response times were reviewed with the Nursing Home Administrator and Director of Nursing on December 12, 2024, at 2:00 PM. 28 Pa. Code 201.18(b)(1)(3) Management 28 Pa. Code 211.12(d)(1)(3)(4)(5) Nursing services	F 0725		
F 0758 SS=E		F 0758		

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F 0758 SS=E	Continued from page 46 483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and	F 0758	The Facility submits this Plan of Correction under procedures established by the Department of Health in order to comply with the Department's directive to change conditions which the Department alleges is deficient under State and/or Federal Long Term Care Regulations. This Plan of Correction should not be construed as either a waiver of the facility's right to appeal or challenge the accuracy or severity of the alleged deficiencies or an admission of past or ongoing violation of State or Federal regulatory requirements. 1. Resident 12's physician reviewed Ativan orders. 2. All residents with PRN Ativan orders written for greater than 14 days were reviewed to confirm appropriate documentation, timeframe, and dosing. 3. Consultant pharmacist will review regulation on gradual dose reductions and limitations for timeframes of PRN Ativan use. 4. Audits of new PRN Ativan orders documentation, timeframes and total	Completion Date: **01/28/2025** Status: **APPROVED** Date: **12/26/2024**

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F 0758 SS=E	Continued from page 47 §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by:	F 0758	dose ordered will be completed weekly x4 then monthly x2 with results reported to QAPI. 5. Compliance date: January 28, 2025	

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F 0758 SS=E	Continued from page 48 Based on clinical record review and staff interview, it was determined that the facility failed to ensure a resident's medication regime was free from potentially unnecessary medications for one of two residents reviewed for behaviors(Resident 12). Findings include: Clinical record review for Resident 12 revealed the following current physician orders: Ativan 0.5 milligram (mg) PO (by mouth) BID (twice daily), initially ordered September 26, 2023 Ativan 2 mg PO q HS (hour of sleep), initially ordered December 16, 2023 Ativan 1 mg PO PRN (as needed) q 4 hours (every four hours) for restlessness/anxiety for 120 days, initially ordered on October 29, 2024 Antianxiety Drug Monitoring TID (three times daily) for anxiety/insomnia Resident 12 had the potential to receive 9 mg of Ativan in a 24-hour period after October 29, 2024.	F 0758		

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GREEN HOME INC STATE LICENSE NUMBER: **072202**	**37 CENTRAL AVENUE WELLSBORO, PA 16901**

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F 0758 SS=E	Continued from page 49 Task documentation dated September 16, 2024, revealed that the hospice social worker (SW) noted that Resident 12 was in her room (verbally) rambling, won't open her eyes, talk, or touch, and won't answer questions. On October 16, 2024, Resident 12's physician assessed her and indicated no significant change in her overall condition since last visit, with no staff concerns. On October 20, 2024, at 7:55 PM staff noted Resident 12 chanting during and after dinner. Staff found her feet over the side of bed. Resident 12 was repositioned and had no further concerns. On October 29, 2024, the hospice SW noted that Resident 12 was in the hall, restless, scooting out of her chair. The SW assisted with transferring Resident 12 back to bed with Resident 12 having a firm grip on the SW's hand. The SW noted no PRN Ativan, with the last dose of (routine Ativan) at	F 0758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395318	A. BLDG: __00_____ B. WING: _____	12/13/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
GREEN HOME INC STATE LICENSE NUMBER: **072202**	**37 CENTRAL AVENUE WELLSBORO, PA 16901**

(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
F 0758 SS=E	Continued from page 50 9:00 AM. The SW contacted a hospice registered nurse (RN) and added a PRN dose addition to what was in the facility chart. Review of facility antianxiety monitoring from October 2024, revealed the Resident 12 had no noted anxiety or anxiousness. There was no other documentation available between September 16, 2024, to October 29, 2024, which indicated Resident 12 had increased rambling, restlessness, and/or signs and symptoms potentially attributed to anxiety to justify adding the PRN Ativan medication on October 29, 2024. Review of Resident 12's October, November, and December 2024, MAR (medication administration record, a form to document medication administration) revealed that the facility administered routine Ativan and PRN Ativan on the following dates: October 31, 2024, at 12:12 PM staff administered	F 0758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395318	A. BLDG: 00 B. WING:	12/13/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
GREEN HOME INC STATE LICENSE NUMBER: **072202**	**37 CENTRAL AVENUE** **WELLSBORO, PA 16901**

(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
F 0758 SS=E	Continued from page 51 Ativan 1 mg PRN. October 31, 2024, at 5:00 PM staff administered Ativan 0.5 mg routine BID medication. October 31, 2024, at 7:29 PM staff administered Ativan 1 mg PRN October 31, 2024, at 8:00 PM staff administered Ativan 2 mg routine HS medication. Resident 12 received 4.5 mg of Ativan within 7 hours, 48 minutes, and 3.5 mg of Ativan within 3 hours on October 31, 2024. November 27, 2024, at 5:00 PM staff administered Ativan 0.5 mg routine BID medication. November 27, 2024, at 6:00 PM staff administered Ativan 1 mg PRN medication. November 27, 2024, at 8:00 PM staff administered Ativan 2 mg routine HS medication. Resident 12 received 3.5 mg of Ativan within three hours on November 27, 2024. December 2, 2024, at 4:00 PM staff administered Ativan 1 mg PRN medication. December 2, 2024, at 5:00 PM staff administered	F 0758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395318	A. BLDG: __00_____ B. WING: _____	12/13/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
GREEN HOME INC STATE LICENSE NUMBER: **072202**	**37 CENTRAL AVENUE WELLSBORO, PA 16901**

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F 0758 SS=E	Continued from page 52 Ativan 0.5 mg routine BID medication. December 2, 2024, at 8:00 PM staff administered Ativan 1 mg PRN medication. December 2, 2024, at 8:00 PM staff also administered Ativan 2 mg routine HS medication. Resident 12 received 4.5 mg of Ativan within 4 hours on December 2, 2024. December 3, 2024, at 5:00 PM staff administered Ativan 0.5 mg Ativan routine BID medication. December 3, 2024, at 7:18 PM staff administered Ativan 1 mg PRN medication. December 3, 2024, at 8:00 PM staff administered Ativan 2 mg routine HS medication. Resident 12 received 3.5 mg of Ativan within 3 hours on December 3, 2024. December 4, 2024, at 4:00 PM staff administered Ativan 1 mg PRN medication. December 4, 2024, at 5:00 PM staff administered Ativan 0.5 mg routine BID medication. December 4, 2024, at 8:00 PM staff administered Ativan 2 mg routine HS medication.	F 0758		

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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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
GREEN HOME INC STATE LICENSE NUMBER: **072202**	**37 CENTRAL AVENUE WELLSBORO, PA 16901**

(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
F 0758 SS=E	Continued from page 53 December 4, 2024, at 8:40 PM staff administered Ativan 1 mg PRN medication. Resident 12 received 4.5 mg of Ativan within 4 hours, 40 minutes on December 4, 2024. December 5, 2024, at 3:30 PM staff administered Ativan 1 mg PRN medication. December 5, 2024, at 5:00 PM staff administered Ativan 0.5 mg routine BID medication. December 5, 2024, at 7:30 PM staff administered Ativan 1 mg PRN medication. December 5, 2024, at 8:00 PM staff administered Ativan 2 mg routine HS medication. Resident 12 received 4.5 mg of Ativan within 4 hours, 30 minutes on December 5, 2024. December 8, 2024, at 4:00 PM staff administered Ativan 1 mg PRN medication. December 8, 2024, at 5:00 PM staff administered Ativan 0.5 mg routine BID medication. December 8, 2024, at 8:00 PM staff administered Ativan 2 mg routine HS medication. Resident 12 received 3.5 mg of Ativan within 4	F 0758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395318	A. BLDG: 00 B. WING:	12/13/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
GREEN HOME INC STATE LICENSE NUMBER: **072202**	**37 CENTRAL AVENUE** **WELLSBORO, PA 16901**

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F 0758 SS=E	Continued from page 54 hours on December 8, 2024. December 11, 2024, at 5:00 PM staff administered Ativan 0.5 mg routine BID medication. December 11, 2024, at 8:00 PM staff administered Ativan 1 mg PRN medication. December 11, 2024, at 8:00 PM staff administered Ativan 2 mg routine HS medication. Resident 12 received 2.5 mg of Ativan within 3 hours on December 11, 2024. December 12, 2024, at 4:29 PM staff administered Ativan 1 mg PRN medication. December 12, 2024, at 5:00 PM staff administered Ativan 0.5 mg routine BID medication. December 12, 2024, at 8:00 PM staff administered Ativan 2 mg routine HS medication. Resident 12 received 3.5 mg of Ativan within 3 hours, 31 minutes on December 12, 2024. There was no documentation that staff provided justification for Resident 12's PRN Ativan administration or that non-medicinal interventions	F 0758		

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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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
GREEN HOME INC STATE LICENSE NUMBER: 072202	37 CENTRAL AVENUE WELLSBORO, PA 16901

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F 0758 SS=E	Continued from page 55 were attempted prior to administering the PRN Ativan medications. Review of November and December 2024, pharmacy medication regimen reviews revealed no documentation that identified or addressed the PRN Ativan 1 mg order for 120 days with Resident 12's physician or requested that the physician review Resident 12's PRN Ativan for a potential gradual dose reduction The surveyor reviewed the above for Resident 12 during an interview with the Director of Nursing on December 13, 2024, at 12:15 PM and 1:55 PM. 28 Pa. Code 211.9(a)(1)(k) Pharmacy services 28 Pa. Code 211.10(a) Resident care policies 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services	F 0758		
F 0761 SS=D		F 0761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395318	A. BLDG: __00_____ B. WING: _____	12/13/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
GREEN HOME INC STATE LICENSE NUMBER: **072202**	**37 CENTRAL AVENUE WELLSBORO, PA 16901**

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F 0761 SS=D	Continued from page 56 483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 0761	The Facility submits this Plan of Correction under procedures established by the Department of Health in order to comply with the Department's directive to change conditions which the Department alleges is deficient under State and/or Federal Long Term Care Regulations. This Plan of Correction should not be construed as either a waiver of the facility's right to appeal or challenge the accuracy or severity of the alleged deficiencies or an admission of past or ongoing violation of State or Federal regulatory requirements. 1. No residents were harmed. 2. Employee 10 was immediately educated on proper storing of medications. 3. All licensed staff were educated on proper storing of medications. 4. A random audit of storing of medications will be conducted weekly x4 then monthly x2 with results reported to QAPI. 5. Compliance date: January 28, 2025	Completion Date: **01/28/2025** Status: **APPROVED** Date: **12/26/2024**

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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F 0761 SS=D	Continued from page 57 Based on observation and staff interview, it was determined that the facility failed to ensure locked storage of medication during medication administration pass for one of six residents observed for medication administration (Resident 7). Findings include: Observation of a medication administration pass on December 11, 2024, at 8:38 AM revealed Employee 10 (licensed practical nurse) administered medications to Resident 7. Resident 7 refused to take her Metoprolol medication (medication used to lower blood pressure) because she feared that it would lower her blood pressure excessively. Employee 10 removed the Metoprolol medication from the cup that contained the remainder of Resident 7's scheduled medications. Observation of Employee 10 on December 11, 2024, at 8:42 AM revealed that she put the tab of Resident 7's Metoprolol medication in an open plastic cup on top of the medication cart and stated	F 0761		

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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F 0761 SS=D	Continued from page 58 that she would dispose of it at the nurses' station when she was completed with her morning medication administration pass. Employee 10 then began preparing medications for the next resident on her schedule. Observation of Employee 10 on December 11, 2024, at 8:54 AM revealed that she left the medication cart unattended in the hallway to administer medication to Resident 7's roommate. The medication cart (with the unsecured tablet of Metoprolol) was not in Employee 10's view from December 11, 2024, at 8:54 AM to 8:58 AM, while she administered medications and washed her hands in Resident 7's room. Interview with Employee 10 upon her return to the medication cart on December 11, 2024, at 8:58 AM confirmed that she left the unsecured tablet of Metoprolol on top of the med cart while administering medications to Resident 7's roommate. The surveyor reviewed the above concerns regarding medication security during an interview with the Nursing Home Administrator and the	F 0761		

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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F 0761 SS=D	Continued from page 59 Director of Nursing on December 11, 2024, at 1:45 PM. 28 Pa. Code 211.12(d)(1)(5) Nursing services	F 0761		
F 0791 SS=D		F 0791		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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F 0791 SS=D	Continued from page 60 483.55(b)(1)-(5) Routine/Emergency Dental Srvcs in NFs §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(f) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay;	F 0791	The Facility submits this Plan of Correction under procedures established by the Department of Health in order to comply with the Department's directive to change conditions which the Department alleges is deficient under State and/or Federal Long Term Care Regulations. This Plan of Correction should not be construed as either a waiver of the facility's right to appeal or challenge the accuracy or severity of the alleged deficiencies or an admission of past or ongoing violation of State or Federal regulatory requirements. 1. Resident 40 was seen by a dentist on December 13, 2024. 2. All residents were reviewed for required dental visits. 3. Education was provided to the medical records tech regarding required dental services. 4. Random audit of dental visits will be completed monthly x3 with results reported to QAPI. 5. Compliance date: January 28, 2025	Completion Date: **01/28/2025** Status: **APPROVED** Date: **12/26/2024**

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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F 0791 SS=D	Continued from page 61 §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by:	F 0791		

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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F 0791 SS=D	Continued from page 62 Based on clinical record review and resident and staff interview, it was determined that the facility failed to ensure routine dental services for one of two residents reviewed for dental concerns (Resident 40). Findings include: Interview with Resident 40 on December 10, 2024, at 12:16 PM revealed that she had natural teeth; however, had not received services from dental professionals in the past year (e.g., for routine prophylactic cleaning of her teeth). The surveyor requested any evidence that Resident 40 received routine dental services in the past year during an interview with the Nursing Home Administrator and the Director of Nursing on December 11, 2024, at 1:45 PM. Clinical record review for Resident 40 revealed a summary report from the facility's contracted dental provider that indicated that Resident 40 last	F 0791		

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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F 0791 SS=D	Continued from page 63 received services from the professional dentist on October 4, 2022 (more than two years ago). The summary report indicated that Resident 40 received professional dental hygienist services on April 26, 2023 (approximately one and one-half years ago). Interview with the Nursing Home Administrator on December 12, 2024, at 10:25 AM confirmed that the facility did not provide routine dental services for Resident 40 in accordance with the State plan. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services	F 0791		
F 0842 SS=E		F 0842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395318	A. BLDG: 00 B. WING:	12/13/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
GREEN HOME INC STATE LICENSE NUMBER: **072202**	**37 CENTRAL AVENUE** **WELLSBORO, PA 16901**

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F 0842 SS=E	Continued from page 64 483.20(f)(5), 483.70(h)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;	F 0842	The Facility submits this Plan of Correction under procedures established by the Department of Health in order to comply with the Department's directive to change conditions which the Department alleges is deficient under State and/or Federal Long Term Care Regulations. This Plan of Correction should not be construed as either a waiver of the facility's right to appeal or challenge the accuracy or severity of the alleged deficiencies or an admission of past or ongoing violation of State or Federal regulatory requirements. 1. Interview with employee 9 reveals resident 12 received medications as ordered. 2. Employee 9 was coached on medication documentation at time of administration. 3. All licensed staff were educated to document at time of administration of ordered medications. 4. A random audit of documented medication administration times for five residents will be completed weekly x4 then monthly x2 with	Completion Date: **01/28/2025** Status: **APPROVED** Date: **12/26/2024**

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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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
GREEN HOME INC STATE LICENSE NUMBER: **072202**	**37 CENTRAL AVENUE WELLSBORO, PA 16901**

(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
F 0842 SS=E	Continued from page 65 (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.	F 0842	results reported to QAPI. 5. Compliance date: January 28, 2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395318	A. BLDG: __00_____ B. WING: _____	12/13/2024

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GREEN HOME INC STATE LICENSE NUMBER: **072202**	**37 CENTRAL AVENUE** **WELLSBORO, PA 16901**

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F 0842 SS=E	Continued from page 66 This REQUIREMENT is not met as evidenced by:	F 0842		

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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F 0842 SS=E	Continued from page 67 Based on clinical record review and staff interview, it was determined that the facility failed to ensure complete and accurate clinical documentation for one of 20 residents reviewed (Resident 12). Findings include: Clinical record review for Resident 12 revealed the following current physician orders: Ativan 0.5 milligram (mg) PO (by mouth) BID (twice daily at 8:30 and 5:00 PM), initially ordered September 26, 2023 Ativan 2 mg PO q HS (hour of sleep, 8:00 PM), initially ordered September 26, 2023 Ativan 1 mg PO PRN (as needed) q 4 hours (every four hours) for restlessness/anxiety for 120 days, initially ordered on October 29, 2024 Morphine 100 mg/5 ml (20 mg/ml) 5 mg/0.25 ml PO q 2 hours for moderated pain 4-7, initially ordered on March 30, 2023 Review of Resident 12's October, November, and	F 0842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395318	A. BLDG: 00 B. WING:	12/13/2024

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F 0842 SS=E	Continued from page 68 December 2024's MAR (medication administration record, a form to document medication administration) revealed that Employee 9, licensed practical nurse, documented the following: On October 30, 2023, at 8:28 PM Employee 9 documented that she administered Resident 12's Ativan 0.5 mg routine BID medication at 5:00 PM, 3 hours, 28 minutes after the administration occurred. On October 31, 2024, at 7:29 PM Employee 9 documented that she administered Ativan 1 mg PRN. At 7:31 PM, 2 minutes later, Employee 9 documented that Resident 12's PRN Ativan administration was effective but indicated that it was effective for 8:29 PM, 58 minutes after the documentation occurred. Employee 9 pre-documented the outcome of Resident 12's PRN Ativan dose. On November 27, 2024, at 6:13 PM Employee 9 documented that she administered Ativan 1 mg	F 0842		

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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F 0842 SS=E	Continued from page 69 PRN medication at 6:00 PM. At 6:14 PM, 1 minute later, Employee 9 documented that Resident 12's PRN Ativan administration was effective but indicated that it was effective for 7:00 PM, which was 46 minutes after the documentation occurred. Employee 9 pre-documented the outcome of Resident 12's PRN Ativan dose. On December 2, 2024, at 10:50 PM Employee 9 documented that she administered Ativan 1 mg PRN medication at 4:00 PM 6 hours, 50 minutes prior. At 10:51 PM, 1 minute later, Employee 9 documented that Resident 12's 4:00 PM PRN Ativan administration was effective as of 5:00 PM, 5 hours 51 minutes prior. At 10:51 PM Employee 9 documented that she administered Ativan 1 mg PRN medication at 8:00 PM, 2 hours, 51 minutes prior. At 10:51 PM, Employee 9 documented that Resident 12's 8:00 PM PRN Ativan administration was effective as of 9:00 PM, one hour, 51 minutes prior. Employee 9 failed to timely document Resident 12's PRN Ativan administration.	F 0842		

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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F 0842 SS=E	Continued from page 70 On December 2, 2024, at 10:50 PM Employee 9 documented that she administered Morphine 5 mg PRN medication for a pain level of 4 at 4:00 PM, 6 hours, 50 minutes prior. At 10:50 PM Employee 9 documented that the PRN Morphine administration was effective at 5:00 PM, five hours, 50 minutes prior. Employee 9 failed to timely document Resident 12's 4:00 PM PRN Morphine administration. On December 3, 2024, at 7:21 PM Employee 9 documented that she administered Morphine 5 mg PRN medication for a pain level of 4 at 7:00 PM, 21 minutes prior. At 7:21 PM Employee 9 documented that the PRN Morphine administration was effective at 8:00 PM, which was 39 minutes after the documentation occurred. Employee 9 pre-documented the outcome of Resident 12's PRN Morphine dose. On December 4, 2024, at 8:40 PM Employee 9 documented that she administered Ativan 1 mg PRN medication at 4:00 PM 4 hours, 40 minutes	F 0842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395318	A. BLDG: __00_____ B. WING: _____	12/13/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
GREEN HOME INC STATE LICENSE NUMBER: **072202**	**37 CENTRAL AVENUE WELLSBORO, PA 16901**

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F 0842 SS=E	Continued from page 71 prior. At 8:40 PM Employee 9 documented that Resident 12's 4:00 PM PRN Ativan administration was effective as of 5:00 PM, 3 hours 40 minutes prior. At 8:41 PM Employee 9 documented that she administered Ativan 1 mg PRN medication at 8:40 PM, 2 hours, 1 minute prior. At 8:41 PM Employee 9 documented that Resident 12's 8:40 PM PRN Ativan administration was effective as of 9:40 PM, which was 59 minutes after the documentation occurred. Employee 9 failed to timely document Resident 12's 4:00 PM PRN Ativan administration and effectiveness and pre-documented the outcome of Resident 12's 8:40 PRN Ativan dose. On December 5, 2024, at 10:48 PM Employee 9 documented that she administered Ativan 1 mg PRN medication at 3:30 PM, 7 hours, 18 minutes prior. At 10:49 PM Employee 9 documented that she administered Ativan 1 mg PRN medication at 7:30 PM, 3 hours, 19 minute prior. Employee 9 failed to timely document Resident 12's 3:30 PM and 7:30 PRN Ativan administration.	F 0842		

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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F 0842 SS=E	Continued from page 72 On December 8, 2024, at 6:57 PM Employee 9 documented that she administered Ativan 1 mg PRN medication at 4:00 PM 2 hours, 57 minutes prior. At 6:59 PM Employee 9 documented that Resident 12's 4:00 PM PRN Ativan administration was effective as of 5:00 PM, 1 hour 59 minutes prior. Employee 9 failed to timely document Resident 12's PRN Ativan administration and effectiveness and pre-documented the outcome of Resident 12's 8:40 PRN Ativan dose. This surveyor reviewed the above information during an interview on December 13, 2024, at 1:55 PM with the Director of Nursing. 28 Pa. Code 211.5 (f) Medical records 28 Pa. Code 211.12(d)(1)(5) Nursing Services	F 0842		
F 0883 SS=E		F 0883		

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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GREEN HOME INC STATE LICENSE NUMBER: **072202**	**37 CENTRAL AVENUE** **WELLSBORO, PA 16901**

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F 0883 SS=E	Continued from page 73 483.80(d)(1)(2) Influenza and Pneumococcal Immunizations §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;	F 0883	The Facility submits this Plan of Correction under procedures established by the Department of Health in order to comply with the Department's directive to change conditions which the Department alleges is deficient under State and/or Federal Long Term Care Regulations. This Plan of Correction should not be construed as either a waiver of the facility's right to appeal or challenge the accuracy or severity of the alleged deficiencies or an admission of past or ongoing violation of State or Federal regulatory requirements. 1. Residents 11, 15, 46, and 59 or their responsible party have acknowledged they received education at the time of consenting/declining the influenza immunization. 2. The Infection Preventionist will review all current residents to ensure documentation of influenza education of risks and benefits of vaccination was provided to resident or responsible party. 3. Education for the Infection	Completion Date: **01/28/2025** Status: **APPROVED** Date: **12/26/2024**

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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F 0883 SS=E	Continued from page 74 (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by:	F 0883	Preventionist regarding documentation requirement for provided education of the influenza immunizations. 4. Audits for documented education for influenza and pneumococcal to residents or families will be conducted weekly x4 then monthly x2 with results reported in QAPI. 5. Compliance date: January 28, 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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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
GREEN HOME INC STATE LICENSE NUMBER: 072202	37 CENTRAL AVENUE WELLSBORO, PA 16901

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F 0883 SS=E	Continued from page 75 Based on review of select facility policies and procedures, clinical record review, and staff interview, it was determined that the facility failed to provide required immunization education for four of five residents reviewed for influenza immunizations (Resident 11, 15, 46, and 59). Findings include: Review of Resident 11's immunization listing revealed that the facility administered the influenza vaccination for the 2024-2025 season on November 21, 2024. There was no documented evidence in Resident 11's clinical record to indicate that the facility provided the resident or her responsible party education regarding the risks and benefits of the vaccination. Review of Resident 15's immunization listing revealed that the facility administered the influenza vaccination for the 2024-2025 season on October 29, 2024. There was no documented evidence in Resident 15's clinical record to indicate that the	F 0883		

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GREEN HOME INC STATE LICENSE NUMBER: **072202**	**37 CENTRAL AVENUE WELLSBORO, PA 16901**

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F 0883 SS=E	Continued from page 76 facility provided the resident or her responsible party education regarding the risks and benefits of the vaccination. Review of Resident 46's immunization listing revealed that the facility administered the influenza vaccination for the 2024-2025 season on October 29, 2024. There was no documented evidence in Resident 46's clinical record to indicate that the facility provided the resident or his responsible party education regarding the risks and benefits of the vaccination. Review of Resident 59's immunization listing revealed that the facility administered the influenza vaccination for the 2024-2025 season on October 29, 2024. There was no documented evidence in Resident 59's clinical record to indicate that the facility provided the resident or her responsible party education regarding the risks and benefits of the vaccination. Interview with Employee 6, infection control	F 0883		

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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F 0883 SS=E	Continued from page 77 preventionist, on December 13, at 10:05 AM confirmed the above findings. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.12(d)(1)(5) Nursing services	F 0883		
F 0887 SS=E		F 0887		

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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F 0887 SS=E	Continued from page 78 483.80(d)(3)(i)-(vii) COVID-19 Immunization §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision;	F 0887	The Facility submits this Plan of Correction under procedures established by the Department of Health in order to comply with the Department's directive to change conditions which the Department alleges is deficient under State and/or Federal Long Term Care Regulations. This Plan of Correction should not be construed as either a waiver of the facility's right to appeal or challenge the accuracy or severity of the alleged deficiencies or an admission of past or ongoing violation of State or Federal regulatory requirements. 1. Employees 1, 2, 3, and 4 were provided COVID-19 vaccination education and a list of nearby providers of the COVID-19 vaccination. 2. All new hires in the last two months were provided COVID-19 vaccination education and nearby providers of the vaccination. 3. Education provided to SDC of requirements to document COVID-19 screening, providing education on the COVID-19 vaccination and a list	Completion Date: **01/28/2025** Status: **APPROVED** Date: **12/26/2024**

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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F 0887 SS=E	Continued from page 79 (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by:	F 0887	of nearby COVID-19 vaccination providers. 4. Audit of all new hire documentation will be conducted weekly x4 then monthly x2 for screening, education and providing a list of nearby providers for the COVID-19 vaccination with results reported to QAPI. 5. Compliance date: January 28, 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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F 0887 SS=E	Continued from page 80 Based on review of newly hired staff and staff interview, it was determined that the facility failed to screen, educate, and offer the COVID-19 vaccine to four of four newly hired employees (Employees 1, 2, 3, and 4). Findings include: Review of the CMS (Center for Medicare and Medicaid Services) memo (QSO-21-19-NH) published May 11, 2021, indicates that the facility is to offer current COVID-19 vaccinations to staff. Employees are to be medically screened for eligibility and educated on the risks and benefits of the vaccine. Additionally, the facility must maintain appropriate documentation to reflect that the facility provided the required COVID-19 vaccine education to staff, and whether the staff member received the vaccine. Review of the facility's new hire list revealed that Employees 1 and Employee 2, both nurse aide trainees, were hired on August 5, 2024. There was	F 0887		

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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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
GREEN HOME INC STATE LICENSE NUMBER: **072202**	**37 CENTRAL AVENUE WELLSBORO, PA 16901**

(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
F 0887 SS=E	Continued from page 81 no documented evidence to indicate that the facility completed screening, offered the COVID-19 vaccine, or completed education regarding the risks and benefits if applicable. Review of the facility's new hire list revealed that Employee 3, licensed practical nurse, was hired on October 14, 2024. There was no documented evidence to indicate that the facility completed screening, offered the COVID-19 vaccine, or completed education regarding the risks and benefits if applicable. Review of the facility's new hire list revealed that Employees 4, nurse aide, was hired on December 9, 2024. There was no documented evidence to indicate that the facility completed screening, offered the COVID-19 vaccine, or completed education regarding the risks and benefits if applicable. Interview with Employee 5, employee health, on December 13, 2024, at 11:18 AM confirmed the above findings for Employees 1, 2, 3, and 4.	F 0887		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395318	A. BLDG: __00_____ B. WING: _____	12/13/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
GREEN HOME INC STATE LICENSE NUMBER: 072202	37 CENTRAL AVENUE WELLSBORO, PA 16901

(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
F 0887 SS=E	Continued from page 82 28 Pa. Code 211.5(f) Medical records 28 Pa. Code 211.12(d)(1)(5) Nursing services	F 0887		

Certified End Page

GREEN HOME INC

STATE LICENSE NUMBER: 072202

SURVEY EXIT DATE: 12/13/2024

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