STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395695	A. BLDG: 00 B. WING:	04/10/2026

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
GREENERY CENTER FOR REHAB AND NURSING STATE LICENSE NUMBER: **135602**	**2200 HILL CHURCH HOUSTON ROAD** **CANONSBURG, PA 15317**

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F 0000	INITIAL COMMENT Based on a Medicare/Medicaid Recertification, State Licensure, Civil Rights Compliance, and Abbreviated survey in response to three complaints completed on April 10, 2026, it was determined that Greenery Center for Rehabilitation and Nursing 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	F 0000		
F 0550 SS=E		F 0550		

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 0550 SS=E	Continued from page 1 483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.	F 0550	Resident R9 is no longer in the facility. The social worker interviewed R21, R26, R63, R64, and R86. Any voiced concerns will be investigated without fear of retaliation. The social worker will document the follow-up of these investigations in the appropriate location The administrator requested that she attend the resident council meeting regularly. Will review with each current resident their preferred time to get out of bed and return to bed. This will be documented in the nurse aide documentation system and care planned. The social worker and the administrator will interview the current resident population to address any areas of concern or complaints. Resident interviews/satisfaction surveys/follow-up resident council interview will be completed to ascertain if the changes made have improved the life of the residents related to care. We will interview	Completion Date: **05/12/2026** Status: **APPROVED** Date: **05/05/2026**

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F 0550 SS=E	Continued from page 2 §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by:	F 0550	Five residents a week for four weeks and then monthly ongoing The staff have been educated on timely completion of ADL and incontinent care per care plan, The facility staff will be educated on the cell phone/earbud policy: they are not permitted in resident care areas. And that No Vaping is allowed in the facility. Signs indicating No Vaping have been posted at the front and back entrances. Facility Staff will be educated on the Call light policy and their requirement to assist answering call lights to their level of ability. Sensitivity training will be completed with the Nursing staff. Agency staff will also be required to view this training. Audits for the Cellphone/Earbud policy, Vaping, and call light response times will be completed by the DON/Designee four times weekly two audits per shift and monthly times three, with two audits per shift. occurring on varying units and times of the day.	

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F 0550 SS=E	Continued from page 3 Based on review of facility documents, resident council minutes, and resident interviews, it was determined that the facility failed to provide services in an atmosphere of dignity and respect for six of twenty residents (Residents R9, R21, R26, R63, R64, and R86) and seven of fourteen confidential group residents (Residents R100, R200, R400, R600, R700, R900, and R901). Findings Include: Review of the facility-provided document, "Your Rights and Protections as a Nursing Home Resident" indicated: At a minimum, Federal law specifies that nursing homes must protect and promote the following rights of each resident. You have the right to: Be Treated with Respect: You have the right to be treated with dignity and respect, as well as make your own schedule and participate in the activities you choose. You have the right to decide when you go to bed, rise in the morning, and eat your meals.Be Free from Abuse and Neglect: You have the right to be free from verbal, sexual, physical, and mental abuse. Nursing homes can't keep you apart from everyone else against your will. If you feel you have been mistreated (abused) or the nursing home isn't meeting your needs (neglect), report this to the nursing home, your family, your local Long-Term Care Ombudsman, or State Survey Agency. Review of a facility-provided letter dated 3/3/26, signed by nine residents, indicated:	F 0550		

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F 0550 SS=E	Continued from page 4 "As residents we are joining together in anticipation of a serious problem at this facility rectified. Each of us has been either neglected, dismissed, or left unattended by aides or employees who are not doing their jobs. The most frustrating reasons include that they are constantly in possession of their cell phones or wearing earbuds and are either talking, eating, watching silly videos, or listening to music when they should be working. Residents are being left in the dining room until 8:30-9pm because aides are sitting in the breakrooms near the nursing stations playing on their phones. There are residents who are not being fed, left lying in dirty briefs and waiting hours to be transferred from their wheelchairs to their beds, aides/employees in the dining room carrying a hot plate in one hand and their cell phone in the other while residents sit at tables waiting and aides vaping in the halls an din the employee bathroom. This has become an enormous problem that is greatly affecting out quality of care and safety." During a resident group interview on 4/8/26, at 2:00p.m. 13 of 14 residents voiced concerns with staff ignoring their care needs. During the group interview, Residents R200 and R700 became tearful. Concerns voiced during Resident Group meeting on 4/8/26,	F 0550		

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F 0550 SS=E	Continued from page 5 at 2:00 p.m. -They have no intention of taking care of us. 13/14 residents. -Staff turn call lights off, without providing care. 13/14 residents. -Told by administration that "We will look into it." 13/14 residents stated this does not happen. -Staff members are using phones while providing care. -All residents who need assistance getting in and out of bed stated they have concerns with not getting staff assistance. -Residents feel dismissed and dehumanized. 13/14 residents. -13/14 residents fear retaliation if they file a complaint. Resident R100: -From the time I was put in my chair, I have had to wait until 10:45 p.m. before they even thought to put me to bed. I rang for a very long time. Nobody attempted to even try. -You don't know if you are going to get back on bed at all. -Told to stay in bed, that I am too much work. -I don't know if anyone even sees me, or if I am invisible. -They don't want to help you. -I was left from 11a to 11 at night. This is too long. My legs were swollen, I was in a lot of pain. -I try to help by being polite, by waiting my turn. But I feel	F 0550		

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F 0550 SS=E	Continued from page 6 like I'm being completely ignored. -I feel like I'm a table. Just push me in a corner. -I feel like I'm ignored. I say excuse me, hello? I feel like I'm saying stuff, but no one hears. -They say they don't have to time to pull me back up in bed. -It's a 15 to 30 minute wait. Resident R200: -Left on the bed pan through dinner. Staff refused to assist. -On Monday, at 8:30 I pushed my button, and the aide came in, but she was a smart aleck. Said she would change me, but wouldn't put me on the bed pan. The she said she would put me on the bed pan and come back in 30-40 minutes. She put me on the bed pan and she didn't come back. Resident R400: -I'm scared. I don't want to be here. -The nurses don't care. -I kept waiting and waiting, I kept on asking her. They left me sitting in a urine accident. I was all wet. They just walked out the room. For eight hours I sat in poop and piss. I had a rash. They just put the cream on, they don't even wash me properly. Cream on top of cream. -I'm very disappointed.	F 0550		

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F 0550 SS=E	Continued from page 7 -Everyone is forgetting about me. Resident R600: -I've had to wait an hour, hour and a half. I had to call my mom one time to have her get somebody down there to get me out of the room, they shut the door and nobody could see me or hear me. Resident R 700: -They answer your light and say they will be right with you. But they never come. Resident R900: -Every other word when we met with the Administrator was about profit. It was not about patient care, it was not about us. Resident R901: -They are always on their phones. They were these earbuds, and you think they are talking to you. And they're not. When you are feeding someone, you should communicate with them. -They are not paying attention to what they are supposed to be doing. This is our home, they are supposed to be caring for us. They don't care.	F 0550		

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F 0550 SS=E	Continued from page 8 During an interview on 4/9/26, at 2:17 p.m. when asked if she felt the facility maintained sufficient staffing to care for the residents, Resident R86 stated, "Whenever they come in, they don't help put me on the bedpan. I tell them, but they don't do anything." "I call the supervisors and tell them, 'Please, I want someone to come in.'" Resident R86 stated that she is not incontinent, but it becomes painful to hold her bladder for extended times, stated that she is not always provided fresh waters, and that call lights take a very long time to be responded to. Resident R86 stated that to the staff, "It's a big nothing." "I feel very ignored." Resident R86 became tearful during at time. "I see staff walking by, but no one comes in. Makes me feel like I'm dying, I'm not worthy. I try to do everything I can do, because I know there's not enough people." "I don't say anything bad, but sometimes I feel like I want to." During an interview on 4/10/26, at 10:00 a.m. Resident R9 stated, "They don't give a f**k about us." During an interview on 4/10/26, at 10:10 a.m. Resident R64 stated that she is rushed during care, that there weren't washcloths and she had to be cleaned with a pillowcase. Resident R64 stated that she feels like she isn't treated like a human being.	F 0550		

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F 0550 SS=E	Continued from page 9 During an interview on 4/10/26, at 10:23 a.m. Resident R21 stated, "No" and "Sometimes it takes four to five hours to get help." During an interview on 4/10/26, at 10:25 a.m. Resident R63 stated that she has been left in a soiled brief for a long time, causing skin irritation. During a follow-up interview on 4/10/26, at 1:2 p.m. Resident R86 stated, "Last night I had to wait a long time." "I get told to wait because they are going to do somebody else, but they don't come back." Resident R86 again became tearful. During an interview on 4/10/26, at 3:00 p.m. the Nursing Home Administrator confirmed the facility failed to provide services in an atmosphere of dignity and respect for six of twenty residents and seven of fourteen confidential group residents. 28 Pa. Code 201.29(j) Resident Rights 28 Pa. Code 211.10(a)(b)(c)(d) Resident Care Policies 28 Pa. Code 211.12(d)(1)(2)(3)(4) Nursing Services	F 0550		

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F 0565 SS=E	Continued from page 11 483.10(f)(5)(i)-(iv)(6)(7) Resident/Family Group and Response §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups.	F 0565	A Family Council meeting is scheduled for May 8th at 4:30 pm with the Management staff to discuss concerns regarding call light response, resident transfer status and bed mobility this is a new intervention to improve communication with families The follow-up of these conversations/concerns will be documented by the Social Worker in the appropriate location and in a timely manner. A Family Council meeting will be scheduled monthly The DON has created an assignment sheet that will clearly inform staff when, how long, and where their break time can be taken. Staff will be educated by the DON/Designee on the Call light policy and the new assignment sheet, which will show the scheduled break time of staff including how long the break will be. Education will be provided to the staff responsible for resident council and how to address concerns	Completion Date: **05/12/2026** Status: **APPROVED** Date: **05/05/2026**

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F 0565 SS=E	Continued from page 12 §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by:	F 0565	brought up in the meetings Audits will be completed by the DON/Designee on the call light policy, the new assignment sheet and timely response to council concerns weekly times four and monthly times two. Results of these audits will be reviewed by the QAPI committee for further recommendations.	

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F 0565 SS=E	Continued from page 13 Based on review of facility documents, resident council documents, resident council group interview, resident interview, and staff interview it was determined that the facility failed to respond to concerns from resident council and failed to respond to concerns in a timely manner for six out of six months (10/7/25, 11/4/25, 12/2/25, 1/6/26, 2/2/26, 2/4/26, and 3/3/26). Findings include: Review of Resident council minutes dated 10/7/25, 11/4/25, 12/2/25, 1/6/26, 2/2/26, 2/4/26, and 3/3/26 identified resident concerns with inadequate staff response to resident care needs. 11/4/25: Call light response times, lack of licensed nursing response to needs, nurse aides taking breaks together, leaving insufficient staff on the unit to meet needs. 12/2/25: Nurse aides taking breaks together, leaving insufficient staff on the unit to meet needs, late meals, not being assisted out of bed timely. 1/6/26: Call light response times, lack of sufficient staff on the unit to meet needs.	F 0565		

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F 0565 SS=E	Continued from page 14 2/2/26: Lack of licensed nursing response to needs. 2/4/26: Call light response times, nurse aides too busy to complete restorative care, staff not checking on residents, residents not assisted from the dining room after evening meal, not being assisted from or to bed timely. 3/3/26: Lack of call light response, call lights shut off without care being provided, nurse aides too busy to complete restorative care. Review of a facility-provided letter dated 3/3/26, signed by nine residents, indicated: "As residents we are joining together in anticipation of a serious problem at this facility rectified. Each of us has been either neglected, dismissed, or left unattended by aides or employees who are not doing their jobs. The most frustrating reasons include that they are constantly in possession of their cell phones or wearing earbuds and are either talking, eating, watching silly videos, or listening to music when they should be working. Residents are being left in the dining room until 8:30-9pm because aides are	F 0565		

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	395695	A. BLDG: __00_____ B. WING: _____	04/10/2026

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F 0565 SS=E	Continued from page 15 sitting in the breakrooms near the nursing stations playing on their phones. There are residents who are not being fed, left lying in dirty briefs and waiting hours to be transferred from their wheelchairs to their beds, aides/employees in the dining room carrying a hot plate in one hand and their cell phone in the other while residents sit at tables waiting and aides vaping in the halls and in the employee bathroom. This has become an enormous problem that is greatly affecting out quality of care and safety." During a resident group interview on 4/8/26, at 2:00p.m. 13 of 14 residents voiced concerns with the facility administration not resolving their concerns over inadequate staff response to resident care needs. On 4/10/26, the Nursing Home Administrator provided a document completed on 4/10/26, which outlined the facility response to voiced Resident Council Concerns. Nurse aides not getting residents up: "It has been explained to both the staff and residents that each department has specific tasks to complete. Specifically with residents on the therapy caseload, they had been made aware that nursing must follow the transfer status of therapy, to help ensure safety of the resident and this is provided to upon completion an assessment within the	F 0565		

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F 0565 SS=E	Continued from page 16 therapy department." Further review of the document failed to reveal education/instruction to nursing staff to assist residents out of bed timely. Nurse aides sitting in the courtyard for extended times: "Staff have been redirected to taking breaks in the assigned breaking areas." Further review of the document failed to reveal that the extended breaks were addressed, only the location. On 4/10/26, evidence of the education and instructions to staff of these and other concerns addressed on this document. By survey end, this information was not provided by the facility. During an interview on 4/10/26, at approximately 3:00 p.m. the Nursing Home Administrator confirmed that the facility failed to respond to concerns from resident council and failed to respond to concerns in a timely manner for six out of six.	F 0565		

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F 0565 SS=E	Continued from page 17 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.12(d)(3) Nursing Services	F 0565		
F 0575 SS=A	483.10(g)(5)(i)(ii) Required Postings §483.10(g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community.	F 0575	Complete and current contact information for Adult Protective Services has been posted in a form and manner, accessible and understandable to residents and representatives on three of the three nursing units (South, North, West) The Social Worker has been educated by the Administrator on the regulation to maintain these required posting. The Administrator/Designee will complete random audits to ensure the placement of the required posting is maintained. Results of this audit will be presented to the QAPI committee for review and further recommendations.	Completion Date: **05/12/2026** Status: **APPROVED** Date: **05/04/2026**

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F 0575 SS=A	Continued from page 18 This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to post complete and current contact information for Adult Protective Services on three of three nursing units (South, North, and West). Finding include: During an observation on 4/9/26, at approximately 1:00 p.m. observations of the South, North, and West nursing units failed to reveal contact information for Adult Protective Services that included email address, phone number and mailing address. During an interview on 4/10/26, at approximately 3:00 p.m. the Nursing Home Administrator confirmed that the facility failed to post complete and current contact information for Adult Protective Services on three of three nursing units . 28 Pa. Code: 201.18(f)(h) Management. 28 Pa. Code: 201.29(a)(b)(c) Resident Rights.	F 0575		
F 0585 SS=E		F 0585		

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F 0585 SS=E	Continued from page 19 483.10(j)(1)-(4) Grievances §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance	F 0585	The information on the grievance box has been corrected to include the Grievance official's name and contact information, the right to file grievances orally, in writing, or anonymously and the expected time frame for completion of the grievance review. This information has been posted at eyesight level of a person seated in a wheelchair. A Grievance box has been added to the West Unit. The Administrator has educated the Social Worker who is the Grievance officer on the required posting with the required information. A new grievance form/process will be put into place to monitor the time frame for completing the grievance in the expected time frame. The Administrator/Designee will Audit for the placement and required information for the Grievance regulation and 10% of resident grievances for the timely completing weekly times four and monthly times four. Results of these audits will be presented to the QAPI committee for review and recommendations.	Completion Date: **05/12/2026** Status: **APPROVED** Date: **05/04/2026**

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F 0585 SS=E	Continued from page 20 can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the	F 0585		

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F 0585 SS=E	Continued from page 21 date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by:	F 0585		

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F 0585 SS=E	Continued from page 22 Based on observations and staff interviews, it was determined that the facility failed to provide information regarding how to file a grievance and information on the grievance official on three of three nursing units (South, North, and West nursing units). During an observation of the North nursing unit on 4/9/26, at approximately 10:00 a.m. a grievance box was noted, with forms. Information on the grievance official's name and contact information, the right to file grievances orally, in writing, or anonymously, and the expected time frame for completion of the grievance review was not provided. During an observation of the South nursing unit on 4/9/26, at approximately 10:05 a.m. a grievance box was noted, with forms. Information on the grievance official's name and contact information, the right to file grievances orally, in writing, or anonymously, and the expected time frame for completion of the grievance review was not provided . During an observation of the West nursing unit on 4/9/26, at approximately 10:10 a.m. a grievance box was not located. During an observation of the dining area on 4/9/26, at approximately 10:15 a.m. a grievance box was noted, with forms. Information on the grievance official's name and contact information, the right to file grievances orally, in writing, or anonymously, and the expected time frame for	F 0585		

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F 0585 SS=E	Continued from page 23 completion of the grievance review was not provided. During an observation on 4/9/26, at 12:00 p.m. a bulletin board was observed in the hallway leading to the dialysis area, activities room, and the conference room. The information for the grievance official and information on filing grievances was posted but noted to be posted far above the eyesight of a person seated in a wheelchair. During an interview on 4/10/26, at approximately 3:00 p.m. the Nursing Home Administrator confirmed the facility failed to provide information regarding how to file a grievance and information on the grievance official on three of three nursing units. 28 Pa. Code: 201.18(e)(4) Management.	F 0585		
F 0628 SS=B		F 0628		

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F 0628 SS=B	Continued from page 24 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) Discharge Process §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i) (A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must-	F 0628	The facility will ensure that the residents and/or their representatives receive written notice of the facility bed-hold policy at the time of transfer. Resident R 15 has been discharged from the facility. The BOM educated resident R8 and R30 to the facility bed hold policy Before a resident is transferred to a hospital or the resident goes on therapeutic leave, the nursing facility will provide written information to the resident or resident representative that specifies the bed hold policy. Residents on admission will receive a copy of the facility bed hold policy which will be signed by the resident and uploaded into the medical record. When a resident is transferred to a hospital or is on therapeutic leave the BOM will notify the resident/representative by phone the next day to explain the facility's bed hold policy and confirm whether the resident wants to maintain a bed in	Completion Date: **05/12/2026** Status: **APPROVED** Date: **05/04/2026**

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F 0628 SS=B	Continued from page 25 (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days.	F 0628	the facility The DON/Designee will educate the nursing supervisors on the requirement to send a copy of the bed hold policy with the resident on transfer to hospital or on a therapeutic leave Audits will be completed to ensure the bed hold notice was provided and completed promptly for 90% of residents transferring to a hospital or on a therapeutic leave. These Audits will occur weekly times four then monthly times three. Results will be reviewed at the QAPI committee meeting for further recommendations	

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F 0628 SS=B	Continued from page 26 §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy	F 0628		

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F 0628 SS=B	Continued from page 27 for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;	F 0628		

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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
GREENERY CENTER FOR REHAB AND NURSING STATE LICENSE NUMBER: **135602**	**2200 HILL CHURCH HOUSTON ROAD CANONSBURG, PA 15317**

(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 0628 SS=B	Continued from page 28 (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter).	F 0628		

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F 0628 SS=B	Continued from page 29 This REQUIREMENT is not met as evidenced by:	F 0628		

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F 0628 SS=B	Continued from page 30 Based on clinical record review and staff interview, it was determined that the facility failed to ensure that the resident and/or their representative received written notice of the facility bed-hold policy at the time of transfer for three of six residents reviewed for hospitalization (Resident R8, R15, and R30). Findings include: Review of federal regulation §483.15(d) Notice of Bed-Hold Policy, indicated, "facilities must provide written information about these policies to residents prior to and upon transfer for such absences. This information must be provided to all facility residents, regardless of their payment source. These provisions require facilities to issue two notices related to bed-hold policies. The first notice could be given well in advance of any transfer, i.e., information provided in the admission packet. Reissuance of the first notice would be required if the bed-hold policy under the State plan or the facility's policy were to change. The second notice must be provided to the resident, and if applicable the resident's representative, at the time of transfer, or in cases of emergency transfer, within 24 hours. It is expected that facilities will document multiple attempts to reach the resident's representative in cases where the facility was unable to notify the representative. The notice	F 0628		

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F 0628 SS=B	Continued from page 31 must provide information to the resident that explains the duration of bed-hold, if any, and the reserve bed payment policy. It should also address permitting the return of residents to the next available bed. Review of the clinical record indicated Resident R8 was admitted to the facility on 8/24/25. Review of Resident R8's minimum data set (MDS - periodic assessment of resident care needs) dated 3/31/26, included diagnoses of heart failure (a progressive heart disease that affects pumping action of the heart muscles) and history of a stroke. Review of Section C: Cognitive Patterns indicated Resident R8 had moderate cognitive impairment. Review of a progress note dated 9/9/25, at 12:32 p.m. indicated, "wife request to send resident to er for evaluation due to decline. No eating much, barely drinking, and vomiting anytime he tries to eat or drink. Labs are consistently getting worse. 911 called." Further review of Resident R8's clinical record failed to reveal notation that the written notice of bed hold notification was provided to the Resident or Resident Representative upon transfer.	F 0628		

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F 0628 SS=B	Continued from page 32 Review of the clinical record indicated Resident R15 was admitted to the facility on 2/3/26. Review of Resident R15's MDS dated 2/9/26, included diagnoses chronic obstructive pulmonary disease (COPD, a group of progressive lung disorders characterized by increasing breathlessness) and a communication deficit. Review of Section C: Cognitive Patterns indicated Resident R10 had severe cognitive impairment. Review of a progress note dated 2/14/26, at 4:33 p.m. indicated, "Resident left via EMS (emergency medical services) stretcher to [local hospital] for evaluation and treatment of R (right) leg. Wife and brother-in-law at the bed side. Family satisfied with plan of care at this time." Further review of Resident 15's clinical record failed to reveal notation that the written notice of bed hold notification was provided to the Resident or Resident Representative upon transfer. Review of a progress note dated 3/6/26, at 3:51 p.m. indicated, "HGB (hemoglobin) result back and is 5.5.	F 0628		

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F 0628 SS=B	Continued from page 33 resident being sent out to hospital for transfusion per [nurse practitioner]. Family made aware of results and transport to hospital for transfusion." Further review of Resident 15's clinical record failed to reveal notation that the written notice of bed hold notification was provided to the Resident or Resident Representative upon transfer. Review of the clinical record indicated Resident R30 was readmitted to the facility on 8/9/24. Review of Resident R30's MDS dated 2/14/26, included diagnoses of high blood pressure and history of a stroke. Review of Section C: Cognitive Patterns indicated Resident R10 had severe cognitive impairment. Review of a progress note dated 2/5/26, at 10:10 a.m. indicted, "This nurse called to room to find resident on the commode in the bathroom slumped over and not responding per his normal. He was drooling and did not answer any questions or follow any verbal commands. [Nurse practitioner] notified and resident sent to the hospital via squad for evaluation."	F 0628		

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F 0628 SS=B	Continued from page 34 Further review of Resident 30's clinical record failed to reveal notation that the written notice of bed hold notification was provided to the Resident or Resident Representative upon transfer. Review of a progress note dated 4/5/26, at 2:55 a.m. indicated, "This nurse was notified by floor nurse that resident was seizing and had been seizing and given medication without any effective results. 911 was called due to all interventions being ineffective. EMTs took over care and was able to administer medication through IJ line (internal jugular line is a central venous catheter placed into the internal jugular vein in the neck) seizure was stopped and resident was transported to hospital. Son called with no success from floor nurse, Provider notified." Further review of Resident 30's clinical record failed to reveal notation that the written notice of bed hold notification was provided to the Resident or Resident Representative upon transfer. During an interview on 4/10/26, at approximately 3:00 p.m. the Nursing Home Administrator and the Director of Nursing confirmed the facility failed to ensure that the resident and/or their representative received written notice	F 0628		

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F 0628 SS=B	Continued from page 35 of the facility bed-hold policy at the time of transfer for three of six residents reviewed for hospitalization. 28 Pa. Code 211.5(d)(f) Clinical Records	F 0628		
F 0676 SS=E		F 0676		

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F 0676 SS=E	Continued from page 36 483.24(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	Resident R24, R31, R78 and R93 will have a nurse/therapy evaluation to assess the restorative programs needed and POC task documentation will be created to ensure the program is completed by the CNA Resident recently discharged from Therapy will be assessed by both the Therapy department and Nursing for the need for any restorative programming. A POC task for documentation will be created to ensure the program is completed by the CNA. Staff education will be provided by the DON/Designee on the Restorative programs and the needed documentation for the programs. Education will occur on orientation and yearly. Audits will be completed by the DON/Designee on 10% of resident receiving restorative programs to ensure that the POC task documentation and the Nurse summary progress note are	Completion Date: **05/12/2026** Status: **APPROVED** Date: **05/04/2026**

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F 0676 SS=E	Continued from page 37 §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	completed weekly times four on various shifts, then monthly times three months. Results of these audits will be presented to the QAPI committee for review and recommendations.	

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F 0676 SS=E	Continued from page 38 Based on facility policy and clinical record review and staff interview, it was determined that the facility failed to complete a restorative nursing program for four of six residents reviewed for ADLs (activities of daily living) concerns (Residents R24, R31, R78, and R93). Findings include: Review of the facility policy "Restorative Nursing Program" dated 1/5/26, indicated the facility will safely and effectively improve or maintain the patient's current functional status or to prevent deterioration of current functional status as part of the restorative nursing program. During an interview on 4/9/26 at 3:00 p.m., the Physical Therapy Director Employee E20 revealed that restorative activities are documented on the daily "Restorative Nursing Care Flow Record." Clinical record review for Resident R24 revealed a diagnoses list that included stroke and right sided weakness. Review of the current care plan for Resident R24 revealed the resident requires assistance with walking and transferring. An intervention included moderate assistance with all ADLs.	F 0676		

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F 0676 SS=E	Continued from page 39 Review of the physical therapy discharge summary dated 6/26/25, indicated highest practical level achieved. Review of the current "Restorative Nursing Programs" status indicated Resident R24 walked to dine 100 feet with a wheeled walker with staff supervision. Review of the daily "Restorative Nursing Care Flow Record" dated January through March 2026 did not include documentation that the restorative task was completed. Clinical record review for Resident R31 revealed a diagnoses list that included Parkinson's disease (a progressive movement disorder of the nervous system). Review of the current care plan for Resident R31 revealed the resident requires assistance with walking. An intervention included supervision with all ADLs. Review of the physical therapy discharge summary dated 1/26/26, recommended ambulation with staff and wheeled walker. Review of the current "Restorative Nursing Programs" status indicated Resident R31 walked to dine 100 feet with a wheeled walker with staff supervision. Review of the daily "Restorative Nursing Care Flow	F 0676		

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F 0676 SS=E	Continued from page 40 Record" dated January through March 2026 did not include documentation that the restorative task was completed. Clinical record review for Resident R78 revealed a diagnoses list that included quadriplegia and diabetes. Review of the current care plan for Resident R78 revealed the resident is dependent on staff with all ADLs. Review of the physical therapy discharge summary dated 3/4/26, recommended supine/seated exercise program 3X10 reps (three sets of 10 repetitions) to LE (lower extremities). Review of the current "Restorative Nursing Programs" status indicated Resident R78 requires passive stretching of right elbow to extension as tolerated. Review of the daily "Restorative Nursing Care Flow Record" dated January through March 2026 did not include documentation that the restorative tasks were completed. Clinical record review for Resident R93 revealed a diagnoses list that included dementia, diabetes, and history of falls. Review of the current care plan for Resident 93 revealed the resident walks at liberty with distant supervision and a	F 0676		

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F 0676 SS=E	Continued from page 41 wheeled walker. An intervention included supervision assistance with ADLs. Review of the physical therapy discharge summary dated 1/7/26, indicated resident is able to walk in hallways with wheeled walker and encourage increased walking to maintain. Review of the current "Restorative Nursing Programs" status indicated Resident R93 to have AROM (assisted range of motion) to bilateral upper and lower extremities on all planes (side to side, front to back, and rotationally) to tolerance. Review of the daily "Restorative Nursing Care Flow Record" dated January through March 2026 did not include documentation that the restorative tasks were completed. During an interview on 4/9/26 at 2:05 p.m. Nursing Assistant (NA) Employee E21 revealed restorative nursing was not being completed. During an interview on 4/9/26 at 3:00 p.m. the Physical Therapy Director Employee E20 revealed restorative nursing was not being completed. During an interview on 4/9/26 at 1:45 p.m., The Nursing Home Administrator confirmed the above findings and that	F 0676		

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F 0676 SS=E	Continued from page 42 the facility failed to complete a restorative nursing program for ADLs concerns for Residents R24, R31, R78, and R93.	F 0676		
F 0684 SS=K		F 0684		

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F 0684 SS=K	Continued from page 43 483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 0684	The physician was notified for Residents R2,R4,R16,R33,R37,R46,R47,R56,R70, R80, R97 and R116 that their Capillary Blood Glucose levels were either greater than 400 or less than 70. The facility NP saw these residents to assess any impact from a Capillary Blood Glucose result not reported to the physician. For residents with current orders for Capillary Blood Sugar testing, results greater than 400 or less than 70 will be recorded, documented, and the MD/designee will be notified to issue further treatment orders as needed. The DON/Designee began educating nursing staff, including contracted staff on the facility's new policy titled "Managing Hypo and Hyperglycemia." The DON/designee will educate new nursing staff to the facility before the start of their first shift. Licensed Nursing Staff will attend Directed In-Service with AAE	Completion Date: **05/12/2026** Status: **APPROVED** Date: **05/04/2026**

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(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 0684 SS=K	Continued from page 44	F 0684	Consulting Services Inc on May 5th, 2026 Titled F684 Quality of Care 483.25. Licensed staff who do not attend the training in person on this date will have to watch the training provided prior to the start of their next shift. The DON/Designee will review all current diabetic residents in the facility with orders for Capillary Blood Sugar testing results during the daily clinical Morning Meeting M-F to verify that residents' Capillary Blood Sugar results were recorded, documented, and the MD/designee was notified. Saturday and Sunday results will be reviewed by the Nursing Supervisor for the same compliance. The DON /Designee will complete audits for the compliance of the new policy Managing Hypo and Hyperglycemia for 10% of facility resident with orders for Blood Sugar testing for 4 weeks then monthly times 4 The facility NHA will query 5 random nurses 3 times a week for 4	

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	395695	A. BLDG: __00_____ B. WING: _____	04/10/2026

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F 0684 SS=K	Continued from page 45	F 0684	weeks then weekly for 4 weeks and then monthly for 3 months to verify their knowledge of the protocols for Hypo/Hyperglycemic Management. Results of the audits will be reviewed during QAPI and frequency adjusted based on the results of the audits.	

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F 0684 SS=K	Continued from page 46 Based on facility review of policy, manufacturer's instructions, clinical records and staff interviews, the facility failed to notify physicians of elevated or decreased Capillary Blood Glucose (CBG) levels, failed to assess residents for hyperglycemia (high blood glucose) and hypoglycemia (low blood sugar) resulting in immediate jeopardy for 12 of 21 residents (R2, R4, R16, R33, R37, R46, R47, R56, R70, R80, R97, and R116). Findings include: Review of the facility policy "Episodic and Narrative Documentation" dated 1/6/26, indicated a narrative entry will be made for physician notification. During an interview with the Nursing Home Administrator on 4/8/26, at approximately 10:00	F 0684		

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F 0684 SS=K	Continued from page 47 a.m. policies for management of diabetes, hypoglycemia, or hyperglycemia were requested. The NHA confirmed the facility was unable to provide policies. Review of the Facility Assessment last reviewed 4/14/25, indicated the facility will provide care for residents diagnosed with diabetes. Review of the United States Food and Drug Administration prescribing information for basaglar insulin (insulin glargine, a long-acting injectable medication to diabetes) dated 12/2015, indicated basaglar insulin begins to work several hours after administration, the maximum effect of basaglar insulin is approximately 12 hours after administration, and works over 24 hours to lower blood sugar levels.	F 0684		

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F 0684 SS=K	Continued from page 48 Review of the glucometer manufacturer's instructions indicated "Low" refers to less than 20 mg/dl, and "High" refers to greater than 600 mg/dl. Review of the clinical record indicated that Resident R2 was admitted to the facility on 12/26/25. Review of the Minimum Data Set (MDS - periodic assessment of resident care needs) dated 3/24/26, included diagnoses of diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time) and chronic kidney disease. Review of a physician order dated 1/5/26, indicated	F 0684		

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F 0684 SS=K	Continued from page 49 that Resident R2 received insulin lispro on a sliding scale. If below 70 (mg/dl) to follow hypoglycemic protocol. If over 400 (mg/dl) to notify the provider. Review of Resident R2's current plan of care for diabetes initiated 11/3/25, indicated "Fasting Serum Blood Sugar/finger stick blood sugar monitoring as ordered by doctor." Review of Resident R2's blood sugar record for January 2026, through April 2026, revealed the following blood sugar values failed to have documentation of notification or follow-up: 1/8/26, 8:55 p.m., BS 520, no notes or documentation	F 0684		

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F 0684 SS=K	Continued from page 50 1/14/26, 4:57 p.m., BS 508, no notes or documentation 1/14/26, 10:30 p.m., BS 453, no notes or documentation 1/29/26, 10:05 p.m., BS 500, had a note, but no recheck. 3/25/26, 3:54 p.m., BS 421, no notes or documentation Review of the clinical record indicated that Resident R4 was admitted to the facility on 10/7/25. Review of the MDS dated 3/15/26, included diagnoses of diabetes and CAD.	F 0684		

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F 0684 SS=K	Continued from page 51 Review of a physician order dated 1/5/26, indicated that Resident R4 received Novolog on a sliding scale and if over 400 (mg/dl) to notify the MD (doctor of medicine). Review of Resident R4's current plan of care for diabetes initiated 3/10/26, indicated "Fasting Serum Blood Sugar/finger stick blood sugar monitoring as ordered by doctor." Review of Resident R4's blood sugar record for January 2026, through April 2026, revealed the following blood sugar value failed to have documentation of notification or follow-up: 3/15/26, 8:30 a.m., BS 483, no notes or	F 0684		

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F 0684 SS=K	Continued from page 52 documentation Review of the clinical record indicated that Resident R16 was admitted to the facility on 1/18/24. Review of the MDS dated 2/17/26, included diagnoses of diabetes and Congestive Heart Failure (CHF). Review of a physician order dated 1/31/26, through 3/30/26, indicated that Resident R16 was to receive blood sugar checks twice daily. This order did not include parameters for provider notification. Review of a physician order dated 1/24/26, through	F 0684		

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F 0684 SS=K	Continued from page 53 2/22/26, indicated that Resident R16 received Tresiba (long-acting insulin) 32 units daily; 2/22/26, through 3/21/26, indicated that Resident R16 received Tresiba 36 units daily. 3/21/26, through 3/21/26, indicated that Resident R16 received Tresiba 40 units daily; 3/30/26, (current order) indicated that Resident R16 received Tresiba 44 units daily. These orders did not include parameters for provider notification. Review of a physician order dated 3/30/26, indicated that Resident R4 received Novolog on a sliding scale and if over 400 (mg/dl) to notify the provider. Review of Resident R16's current plan of care for diabetes initiated 1/19/24, indicated "Fasting Serum Blood Sugar/finger stick blood sugar monitoring as ordered by doctor."	F 0684		

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F 0684 SS=K	Continued from page 54 Review of Resident R16's blood sugar record for January 2026, through April 2026, revealed the following blood sugar values failed to have documentation of notification or follow-up: 2/6/26, 7:24 p.m., BS 426, no notes or documentation 2/26/26, 7:43 a.m., BS 495, no notes or documentation. Resident left for a leave of absence without reevaluation. 2/27/26, 11:00 p.m., BS 471, no notes or documentation. 2/28/26, 7:42 p.m., BS 459, no notes or documentation 3/2/26, 5:34 p.m., BS 470, no notes or documentation	F 0684		

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F 0684 SS=K	Continued from page 55 Review of the clinical record indicated that Resident R33 was admitted to the facility on 1/15/26. Review of the MDS dated 3/10/26, included diagnoses of diabetes and CAD. Review of a physician order dated 1/16/26, through 2/23/26, indicated that Resident R33 received insulin lispro on a sliding scale and if under 70 (mg/dl) or over 400 (mg/dl) to notify the provider . Review of Resident R33's current plan of care for diabetes initiated 1/16/26, indicated "Fasting Serum Blood Sugar/finger stick blood sugar monitoring as	F 0684		

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F 0684 SS=K	Continued from page 56 ordered by doctor." Review of Resident R33's blood sugar record for January 2026, through April 2026, revealed the following blood sugar value failed to have documentation of notification or follow-up: 1/21/26, 1:12 a.m., BS 402, no notes or documentation Review of the clinical record indicated that Resident R37 was admitted to the facility on 6/2/22. Review of the MDS dated 2/12/26, included diagnoses of diabetes and dementia.	F 0684		

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F 0684 SS=K	Continued from page 57 Review of a physician order dated 6/9/25, through 4/6/26, indicated that Resident R37 received insulin lispro on a sliding scale and if under 70 (mg/dl) or over 400 (mg/dl) to notify the MD. Review of Resident R37's current plan of care for diabetes initiated 4/3/24, indicated "Fasting Serum Blood Sugar/finger stick blood sugar monitoring as ordered by doctor." Review of Resident R37's blood sugar record for January 2026, through April 2026, revealed the following blood sugar value failed to have documentation of notification or follow-up:	F 0684		

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F 0684 SS=K	Continued from page 58 3/12/26, 1:39 p.m., BS 487, no notes or documentation Review of the clinical record indicated that Resident R46 was re-admitted to the facility on 3/26/18. Review of the MDS dated 1/28/26, included diagnoses of diabetes and COPD. Review of a physician order dated 9/14/25, and reordered 1/18/26, indicated that Resident R46 received Novolog on a sliding scale and if under 70 (mg/dl) or over 400 (mg/dl) to notify the MD.	F 0684		

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F 0684 SS=K	Continued from page 59 Review of Resident R46's current plan of care for diabetes initiated 3/13/24, indicated "Fasting Serum Blood Sugar/finger stick blood sugar monitoring as ordered by doctor." Review of Resident R46's blood sugar record for January 2026, through April 2026, revealed the following blood sugar value failed to have documentation of notification or follow-up: 1/8/26, 8:49 p.m., BS 401, no notes or documentation 1/30/26, 6:36 p.m., BS 429, no notes or documentation 2/2/26, 2:00 p.m., BS 426, no notes or documentation	F 0684		

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F 0684 SS=K	Continued from page 60 2/11/26, 12:47 p.m., BS 517, no notes or documentation 2/17/26, 10:06 p.m., BS 402, no notes or documentation 2/26/26, 5:15 p.m., BS 418, no notes or documentation 3/11/26, 12:05 p.m., BS 401, no notes or documentation 3/13/26, 9:57 p.m., BS 414, no notes or documentation 3/20/26, 10:49 a.m., BS 414, no notes or documentation 3/30/26, 9:44 p.m., BS 401, no notes or documentation	F 0684		

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F 0684 SS=K	Continued from page 61 Review of the clinical record indicated that Resident R47 was admitted to the facility on 3/13/26. Review of the MDS dated 3/19/26, included diagnoses of diabetes and End Stage Renal Disease. Review of a physician order dated 3/15/26, indicated that Resident R47 received insulin lispro on a sliding scale and " Call MD if greater than 400 for additional orders! " Review of Resident R47's current plan of care for diabetes initiated 3/14/24, indicated "Fasting Serum Blood Sugar/finger stick blood sugar monitoring as ordered by doctor."	F 0684		

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F 0684 SS=K	Continued from page 62 Review of Resident R47's blood sugar record for March 2026, through April 2026, revealed the following blood sugar value failed to have documentation of notification or follow-up: 3/19/26, 9:23 p.m., BS 522, no notes or documentation 3/20/26, 9:12 a.m., BS 538, no notes or documentation. 3/20/26, 1:22 p.m., BS 543, no notes or documentation 3/21/26, 2:16 p.m. Progress Note: " Meter reading HI " (over 600) 3/21/26, 5:44 p.m., BS 439, no notes or documentation	F 0684		

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GREENERY CENTER FOR REHAB AND NURSING STATE LICENSE NUMBER: **135602**	**2200 HILL CHURCH HOUSTON ROAD CANONSBURG, PA 15317**

(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 0684 SS=K	Continued from page 63 3/24/26, 6:31 p.m., BS 591, no notes or documentation 3/25/26, 12:48 p.m., BS 582, no notes or documentation 3/26/26, 10:00 a.m., BS 582, no notes or documentation 3/26/26, 1:17 p.m., BS 538, no notes or documentation 3/29/26, 11:00 a.m., BS 547, no notes or documentation 3/29/26, 2:08 p.m., BS 458, no notes or documentation 3/30/26, 9:36 a.m., BS 546, no notes or documentation 4/2/26, 8:30 a.m., BS 505, no notes or documentation	F 0684		

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 0684 SS=K	Continued from page 64 4/2/26, 5:36 p.m., BS 429, no notes or documentation 4/5/26, 10:13 a.m., BS 440, no notes or documentation 4/7/26, 8:17 a.m., BS 502, no notes or documentation Review of the clinical record indicated that Resident R56 was admitted to the facility on 10/6/17. Review of the MDS dated 4/1/26, included diagnoses of diabetes and CKD. Review of a physician order dated 1/8/26, indicated	F 0684		

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F 0684 SS=K	Continued from page 65 that Resident R56 received Admelog on a sliding scale and if under 70 (mg/dl) or over 400 (mg/dl) to notify the MD. Review of Resident R56's current plan of care for diabetes initiated 12/20/23, indicated "Fasting Serum Blood Sugar/finger stick blood sugar monitoring as ordered by doctor." Review of Resident R56's blood sugar record for January 2026, through April 2026, revealed the following blood sugar value failed to have documentation of notification or follow-up: 1/13/26, 10:46 p.m., BS 66, no notes or documentation	F 0684		

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F 0684 SS=K	Continued from page 66 1/16/26, 6:00 a.m., BS 69, no notes or documentation 1/25/26, 7:12 p.m., BS 495, no notes or documentation 2/17/26, 6:35 p.m., BS 420, no notes or documentation 3/6/26, 5:48 a.m., BS 57, no notes or documentation 4/4/26, 6:11 a.m., BS 55, no notes or documentation Review of the clinical record indicated that Resident R70 was admitted to the facility on 4/15/24. Review of the MDS dated 2/16/26, included	F 0684		

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F 0684 SS=K	Continued from page 67 diagnoses of diabetes and dementia. Review of a physician order dated 8/18/25, through 3/1/26, indicated Resident R70 will have her blood sugar checked twice per day, on Mondays, Wednesdays, and Fridays. This order did not include parameters for provider notification. Review of a physician order dated 2/24/26, indicated that Resident R70 received Lantus 6 units. This was increased on 3/2/26, to 12 units, and on 3/25/26, to 16 units. These orders did not include parameters for provider notification. Review of Resident R70's current plan of care for diabetes initiated 7/9/25, indicated "Fasting Serum Blood Sugar/finger stick blood sugar monitoring as	F 0684		

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F 0684 SS=K	Continued from page 68 ordered by doctor." Review of Resident R70's blood sugar record for February 2026, through April 2026, revealed the following blood sugar value failed to have documentation of notification or follow-up: 2/6/26, 7:24 p.m., BS 426, no notes or documentation 2/26/26, 7:43 a.m., BS 495, no notes or documentation. 2/27/26, 11:00 p.m., BS 471, no notes or documentation. 2/28/26, 7:42 p.m., BS 459, no notes or documentation	F 0684		

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F 0684 SS=K	Continued from page 69 3/2/26, 5:34 p.m., BS 470, no notes or documentation Review of the clinical record indicated that Resident R80 was admitted to the facility on 12/3/24. Review of the MDS dated 3/6/26, included diagnoses of diabetes and COPD. Review of a physician order dated 7/14/25, through 2/28/26, indicated Resident R80 will have insulin lispro (8 units plus a sliding scale) before meals and at bedtime every Tuesday, Thursday, Saturday, and Sunday. This order indicated to notify the provider if greater than 400 (mg/dl).	F 0684		

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 0684 SS=K	Continued from page 70 Review of a physician order dated 7/15/25, through 2/28/26, indicated Resident R80 will have insulin lispro (8 units plus a sliding scale) before meals and at bedtime every Monday, Wednesday, and Friday. This order indicated to hold the insulin if blood sugar levels was less than 130 (mg/dl) and notify the provider if greater than 400 (mg/dl). Review of a physician order dated 2/28/26, indicated Resident R80 will have insulin lispro on a sliding scale before meals and at bedtime. This order indicated to notify the provider if greater than 400 (mg/dl). Review of Resident R80's current plan of care for diabetes initiated 12/4/24, indicated "Fasting Serum Blood Sugar/finger stick blood sugar monitoring as ordered by doctor."	F 0684		

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F 0684 SS=K	Continued from page 71 Review of Resident R80's blood sugar record for January 2026, through April 2026, revealed the following blood sugar value failed to have documentation of notification or follow-up: 1/26/26, 11:07 a.m., BS 404, no notes or documentation 1/30/26, 10:25 p.m., BS 454, no notes or documentation 2/28/26, 10:17 p.m., BS 438, no notes or documentation 3/1/26, 9:11 a.m., BS 430, no notes or documentation 3/1/26, 12:02 p.m., BS 430, no notes or	F 0684		

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F 0684 SS=K	Continued from page 72 documentation Review of the clinical record indicated that Resident R97 was admitted to the facility on 8/24/24. Review of the MDS dated 1/20/26, included diagnoses of diabetes and dementia. Review of a physician order dated 11/19/25, indicated Resident R97 will have Novolog on a sliding scale. This order indicated to notify the provider if greater than 400 (mg/dl). No parameters were included for low blood glucose levels. Review of Resident R97's current plan of care for	F 0684		

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F 0684 SS=K	Continued from page 73 diabetes initiated 8/26/24, indicated "Fasting Serum Blood Sugar/finger stick blood sugar monitoring as ordered by doctor." Review of Resident R97's blood sugar record for January 2026, through April 2026, revealed the following blood sugar value failed to have documentation of notification or follow-up: 1/9/26, 5:46 a.m., BS 57, no notes or documentation 1/14/26, 5:42 a.m., BS 65, no notes or documentation 2/20/26, 4:41 p.m., BS 67, no notes or documentation 3/7/26, 5:44 a.m., BS 67, no notes or	F 0684		

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F 0684 SS=K	Continued from page 74 documentation Review of the clinical record indicated that Resident R116 was admitted to the facility on 3/27/26. Review of the MDS dated 4/2/26, included diagnoses of diabetes and heart failure. Review of a physician order dated 3/28/26, indicated Resident R116 will have insulin aspart on a sliding scale. This order indicated to notify the provider if greater than 400 (mg/dl). Review of Resident R116's current plan of care for diabetes initiated 3/31/26, indicated "Fasting Serum	F 0684		

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F 0684 SS=K	Continued from page 75 Blood Sugar/finger stick blood sugar monitoring as ordered by doctor." Review of Resident R116's blood sugar record for January 2026, through April 2026, revealed the following blood sugar value failed to have documentation of notification or follow-up: 3/28/26, 6:33 p.m., BS 405, Supervisor notified, no MD notification documented. 3/2926, 5:35 p.m., BS 450, no notes or documentation 4/2/26, 3:46 p.m., BS 535, Supervisor notified, no MD notification documented.	F 0684		

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 0684 SS=K	Continued from page 76 During an interview on 4/8/26, at 9:30 a.m. Licensed Practical Nurse (LPN) Employee E8 stated that for blood sugar under 70, they would check for signs and symptoms, check the physician orders, give the resident a snack and recheck the blood sugar to verify its correct, and call the doctor and the supervisor. For blood sugar over 400 they would recheck the blood sugar to verify the results. When prompted they stated they would document in the MAR (medication administration record) and progress notes. During an interview on 4/8/26, at 9:40 a.m. LPN Employee E9 stated that for blood sugar under 70, they would notify the doctor, give a snack, monitor the resident, and recheck the blood sugar in one hour. For blood sugar over 400 they would notify the doctor and get new orders if needed, notify the supervisor and recheck the blood sugar in 20 minutes. When prompted they stated they would document in the progress notes.	F 0684		

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F 0684 SS=K	Continued from page 77 During an interview on 4/8/26, at 9:45 a.m. LPN Employee E10 stated for blood sugar under 60 they would check the resident ' s orders, give glucose or a snack and recheck the blood sugar in 20 minutes. For blood sugar over 400 they would call the doctor for new orders, notify the supervisor and recheck the blood sugar in 20 minutes. When prompted they stated they would document in the MAR and progress notes. The Nursing Home Administrator (NHA) and the DON were made aware that an Immediate Jeopardy situation existed for residents on 4/8/26, at 12:03 p.m. and a corrective action plan was requested. The Immediate Jeopardy template was provided to the facility administration at this time.	F 0684		

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F 0684 SS=K	Continued from page 78 This Immediate Jeopardy began on 1/8/26. On 4/8/26, at 5:32 p.m. an acceptable Corrective Action Plan was received which included the following interventions: The facility was notified of the IJ for F-684 on April 8, 2026 @12:03 PM Resident R 97-The Finger Stick Blood Sugar Results (FSBS) from the following dates 1/9/26, 1/14/26, 2/20/26, 3/7/26 were reported to the Nurse Practitioner (NP) on 4/8/2026. Resident was also seen by the NP on 4/8/26.	F 0684		

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F 0684 SS=K	Continued from page 79 Resident R 46- The Finger Stick Blood Sugar Results (FSBS) from the following dates 1/8/26, 1/30/26, 2/2/26, 2/11/26, 2/17/26, 2/17/26, 2/26/26, 3/11/26, 3/13/26, 3/20/26, 3/30/26, were reported to the Nurse Practitioner (NP) on 4/8/2026. Resident was also seen by the NP on 4/8/26. Resident R56- The Finger Stick Blood Sugar Results (FSBS) from the following dates1/13/26, 1/16/26, 1/25/26, 2/17/26, 3/6/26, 4/4/26, were reported to the Nurse Practitioner (NP) on 4/8/2026. Resident was also seen by the NP on 4/8/26. Resident R70- The Finger Stick Blood Sugar Results (FSBS) from the following dates 2/6/26,	F 0684		

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F 0684 SS=K	Continued from page 80 2/26/26, 2/27/26,2/28/26, 3/2/26, were reported to the Nurse Practitioner (NP) on 4/8/2026. Resident was also seen by the NP on 4/8/26. Resident R16- The Finger Stick Blood Sugar Results (FSBS) from the following dates 2/6/26, 2/26/26, 2/27/26, 2/28/26, 3/2/26 were reported to the Nurse Practitioner (NP) on 4/8/2026. Resident was also seen by the NP on 4/8/26. Care plan was also reviewed and updated to include a care plan for diabetes. Resident R47- The Finger Stick Blood Sugar Results (FSBS) from the following dates 3/19/26, 3/20/26(times 2) 3/21/26 (times), 3/24/26, 3/25/26, 3/26/26 (times 2)3/29/26 (times 2), 3/30/26, 4/2/26 (times 2), 4/5/26, 4/7/26, were reported to the Nurse Practitioner (NP) on 4/8/2026. Resident was also seen by the NP on	F 0684		

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GREENERY CENTER FOR REHAB AND NURSING STATE LICENSE NUMBER: **135602**	**2200 HILL CHURCH HOUSTON ROAD CANONSBURG, PA 15317**

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F 0684 SS=K	Continued from page 81 4/8/26. Resident R37- The Finger Stick Blood Sugar Results (FSBS) from the following dates 3/12/26, were reported to the Nurse Practitioner (NP) on 4/8/2026. Resident was also seen by the NP on 4/8/26. Resident R2- The Finger Stick Blood Sugar Results (FSBS) from the following dates 1/8/26, 1/14/26 (times 2) 1/29/26, 3/25/26, were reported to the Nurse Practitioner (NP) on 4/8/2026. Resident was also seen by the NP on 4/8/26. Resident R80- The Finger Stick Blood Sugar Results (FSBS) from the following dates 1/26/26, 1/30/26, 2/28/26, 3/1/26 (times 2) were reported to	F 0684		

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F 0684 SS=K	Continued from page 82 the Nurse Practitioner (NP) on 4/8/2026. Resident was also seen by the NP on 4/8/26. Resident R33- The Finger Stick Blood Sugar Results (FSBS) from the following dates 1/21/26 were reported to the Nurse Practitioner (NP) on 4/8/2026. Resident R116- The Finger Stick Blood Sugar Results (FSBS) from the following dates 3/8/26, 3/28/26, 3/29/26, 4/2/26 26 were reported to the Nurse Practitioner (NP) on 4/8/2026. Resident R4- The Finger Stick Blood Sugar Results (FSBS) from the following dates 3/15/26 were reported to the Nurse Practitioner (NP) on 4/8/2026. Resident R4 is currently out of the facility at the hospital.	F 0684		

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F 0684 SS=K	Continued from page 83 This has the potential to affect current diabetic residents who reside in the facility. 1) On April 8,2026 at approximately 1:00 PM the NP was notified of the above residents past FSBS and has seen all those residents to verify appropriate orders are in place and updated if indicated for the identified resident. 2) On April 8,2026 the NP began seeing current residents in the facility that may be impacted related to a diabetic emergency to verify appropriate orders are in place and updated if indicated. 3) On April 8, 2026, the MDS nurse reviewed current diabetic residents care plans to verify that a care plan was in place and updated if indicated. This was completed at approximately 3PM.	F 0684		

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F 0684 SS=K	Continued from page 84 4) On April 8, 2026, the facility created a new policy titled " Managing Hypo and Hyperglycemia. " 5) The DON/ADON (Director of Nursing / Assistant Director of Nursing) began immediate education for current nurses including agency nurses on this new protocol. Current nurses, including agency nurses' education will be completed by April 9,2026 This training will continue ongoing for all employees who have not yet received it due to PTO, sick leave, etc., and will also be provided to all new hires. This education on the new policy of Managing Hypo and Hyperglycemia will occur prior to the start of their next shift. No nurse will be allowed to work until Education is completed. 6) The LNHA notified the Medical Director of the	F 0684		

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F 0684 SS=K	Continued from page 85 IJ on 4/8/2026 at approximately 1:00PM and that the NP was seeing all current diabetic residents today. 7) The facility will have an Ad HOC QAPI meeting with the Medical Director on April 8,2026 to review and discuss the IJ and the Immediate Plan of Correction. 8) Beginning April 9, 2026, the DON/ADON will review all current diabetic residents in the facility FSBS results during daily clinical Morning Meeting M-F to verify that residents FSBS results were recorded and documented and MD/designee notified. Saturday and Sunday results will be reviewed by the weekend Nursing Supervisor. This will be completed 5x for 4 weeks and then the DON/ADON will review a random 15 residents FSBS 3x week for 4 weeks and then a random 5	F 0684		

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F 0684 SS=K	Continued from page 86 residents weekly for 3 months and then a random 15 residents monthly ongoing. 9) Beginning April 9,2026, the facility NHA will query 5 random nurses, 3 x week for 4 weeks then weekly x 4 weeks and then monthly for 3 months to verify their knowledge of the protocols for Hypo/Hyperglycemic Management. 10) Results of the audits will be reviewed during QAPI and frequency adjusted based on the results of the audits. 11) Root cause has been completed. The ad hoc committee results of that root cause analysis is that a formalized policy was not in place for the management of Hypo /Hyperglycemia was present.	F 0684		

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F 0684 SS=K	Continued from page 87 On 4/8/26, care plans for affected residents were reviewed, and confirmed they were corrected to show goals and interventions related to diabetes and blood glucose monitoring. On 4/8/26, the whole house audit was reviewed by surveyors, revealing its completion and accuracy. During interviews beginning at approximately 9:30 a.m. on 4/8/26, four of four LPNs on duty were able to describe the correct procedure for documenting, monitoring, and needs of notification for blood sugars outside of the ordered parameters.	F 0684		

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F 0684 SS=K	Continued from page 88 On 4/8/26, licensed nursing reeducation was reviewed, revealing its completion. The Immediate Jeopardy was removed on 4/8/26, at 2:08 p.m. when the action plan implementation was verified. During an interview on 4/10/26, at approximately 3:00 p.m. the Nursing Home Administrator and the Director of Nursing confirmed the facility failed to notify physicians of elevated or decreased capillary blood glucose levels, failed to assess residents for hyperglycemia and hypoglycemia, resulting in immediate jeopardy for 12 of 21 residents. 28 Pa. Code: 211.12(d)(1)(3)(5) Nursing services.	F 0684		

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F 0684 SS=K	Continued from page 89	F 0684		
F 0692 SS=E		F 0692		

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F 0692 SS=E	Continued from page 90 483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by:	F 0692	Residents R15 has discharged from the facility, Residents R18, R29 and R33 will have their weights reviewed by the Dietitian for any changes related to weight increase or decline. Any changes will be reported to the Physician/NP for further orders or plan of care changes Resident weights will be completed on admission, weekly times 4 and then monthly until a physician order changes this policy. Weights will be reviewed by the Dietitian and DON/Designee. The Dietitian will review for any changes related to weight increase or decline. Any changes will be reported to the Physician/NP for further orders or plan of care changes Education will be provided by the DON/designee to the nursing staff that resident weight needed to be completed upon admission, then weekly times four and monthly by the 7 th of the month per the weight policy.	Completion Date: **05/12/2026** Status: **APPROVED** Date: **05/04/2026**

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F 0692 SS=E	Continued from page 91	F 0692	DON/Designee will complete audits for weights recorded at 90% of resident admissions, weekly weights, and monthly weights and ensure the Dietitian has reviewed the weights for any changes related to weight increase or decline. Any changes will be reported to the Physician/NP for further orders or plan of care adjustments. Results of these audits will be reviewed at the QAPI committee meeting for further recommendations	

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F 0692 SS=E	Continued from page 92 Based on review of facility policy, clinical record review, and staff interviews, it was determined that the facility failed to properly monitor weight as ordered for four of six residents (Residents R15, R18, R29, and R33). Findings include: Review of the facility policy, "Weight Protocol" dated 1/6/26, indicated "Residents will be weighed within 24 hours upon admission/re-admission by the CNA (nurse aide). Residents will be weighed weekly for 4 weeks and then monthly ongoing by designated staff." Review of the clinical record indicated Resident R15 was admitted to the facility on 2/3/26. Review of Resident R15's Minimum Data Set (MDS - periodic assessment of resident's care needs) dated 2/9/26, included diagnoses chronic obstructive pulmonary disease (COPD, a group of progressive lung disorders characterized by increasing breathlessness) and a communication deficit. Review of Resident R15's current plan of care, initiated 2/6/26, indicated for the facility to, "Monitor wts. (weights)	F 0692		

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F 0692 SS=E	Continued from page 93 per facility policy/approach." Review of a physician's order dated 2/4/26, indicated, "Weekly weights x 4 weeks then monthly." Review of Resident R15's weight record for February 2026, failed to include a weight evaluation on 2/11/26, through discharge on 2/14/26 (discharge to hospital). Review of a physician's order dated 2/25/26, indicated, "Weekly weights x 4 weeks then monthly." Review of Resident R15's weight record for March 2026, and April 2026, failed to reveal a weight recorded after 3/3/26, with no refusals of monitoring documented. Review of the clinical record indicated Resident R18 was admitted to the facility on 3/22/26. Review of Resident R18's MDS dated 3/28/26, included diagnoses of heart failure (a progressive heart disease that affects pumping action of the heart muscles) and diabetes (a metabolic disorder in which the body has high sugar	F 0692		

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F 0692 SS=E	Continued from page 94 levels for prolonged periods of time). Review of Resident R18's current plan of care, initiated 2/6/26, indicated for the facility to, "Monitor wts per facility policy/approach." Review of a physician's order dated 3/22/26, indicated, "Weekly weights x 4 weeks then monthly." Review of Resident R18's weight record for March 2026, failed to include a weight evaluation after 3/22/26. Review of the clinical record indicated Resident R29 was admitted to the facility on 2/5/26. Review of Resident R29's MDS dated 2/11/26, included diagnoses of heart failure and diabetes. Review of Resident R29's current plan of care, initiated 2/6/26, indicated for the facility to, "Monitor wts per facility policy/approach."	F 0692		

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F 0692 SS=E	Continued from page 95 Review of a physician's order dated 2/12/26, indicated, "Weekly weights x 4 weeks then monthly." Review of Resident R29's weight record for February 2026 through April 2026, revealed weight evaluations on 3/3/26 (338 pounds) and 3/5/26 (336 pounds). Per surveyor request, a weight assessment was completed on 4/10/26, which indicated 285 pounds, a change of 51 pounds in 36 days. Review of the clinical record indicated Resident R33 was admitted to the facility on 1/15/26. Review of Resident R33's MDS dated 3/10/26, included diagnoses of heart failure and kidney disease. Review of Resident R33's current plan of care, initiated 1/16/26, indicated for the facility to, "Monitor wts per facility policy/approach." Review of a physician's order dated 3/4/26, indicated, "Weekly weights x 4 weeks then monthly."	F 0692		

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F 0692 SS=E	Continued from page 96 Review of Resident R33's weight record for February 2026 through April 2026, failed to reveal weights captured after 2/1/26. Per surveyor request, a weight assessment was completed on 4/10/26, which indicated 199 pounds, a change of approximately 15 pounds in two months. During an interview on 4/10/26, at approximately 3:00 p.m. the Nursing Home Administrator confirmed that the facility failed to properly monitor weight as ordered for four of six residents. 28 Pa. Code: 211.6(b) Dietary services. 28 Pa. Code: 211.10(c)(d) Resident care policies. 28 Pa. Code: 211.12(d)(1)(3)(5) Nursing services.	F 0692		
F 0698 SS=D		F 0698		

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F 0698 SS=D	Continued from page 97 483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by:	F 0698	Resident R1 receiving Dialysis will be reviewed with the Dialysis Nurse to ensure complete communication has occurred to provide for accurate Plan of Care for the residents. Resident receiving Dialysis will be reviewed with the Dialysis Nurse to determine that complete communication has occurred and that the accurate Plan of Care is in place for the resident. The Medical records staff will be educated to not upload any Dialysis communication that is not complete. Medical Records staff will communicate with the DON/Designee if this occurs. Nursing Staff will be educated on the need for accurate completion of the Dialysis Communication Form by the DON /Designee Audit of 10% of residents receiving Dialysis will have the Dialysis Communication form audited for completion and placement in the Resident Medical Record by the DON/Designee. These will be	Completion Date: **05/12/2026** Status: **APPROVED** Date: **05/04/2026**

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F 0698 SS=D	Continued from page 98	F 0698	completed weekly times four and monthly times three. Results on these audits will be submitted to the QAPI committee for review and further recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395695	A. BLDG: __00_____ B. WING: _____	04/10/2026

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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F 0698 SS=D	Continued from page 99 Based on review of clinical records and staff interviews, it was determined that facility staff failed to maintain ongoing communication with the dialysis (a machine filters waste, salt and fluid from your blood when your kidneys are no longer healthy enough to do this work adequately) center for one of five residents reviewed (Resident R1). Findings include: Review of the facility policy "Dialysis Management" reviewed 1/5/26, indicated the facility has designed and implemented processes which strive to ensure the comfort, safety, and appropriate management of hemodialysis residents regardless of if the procedure is performed at the dialysis center. Review of the clinical record indicated Resident R1 was admitted to the facility on 1/21/26, with diagnoses that included sepsis (overwhelming and life-threatening response to infection that causes organ failure), dependence on renal (kidney) dialysis, and diabetes. Review of the Minimum Data Set (MDS - periodic assessment of care needs) date 1/27/26, indicated the diagnoses remain current. Review of a physician's order dated 1/22/26, indicated Resident R6 was to receive dialysis three days a week on Monday, Wednesday, and Friday.	F 0698		

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F 0698 SS=D	Continued from page 100 Review of a care plan dated 1/22/26, indicated the following interventions: - Monitor pre and post dialysis weights. - Encourage the resident to go for the scheduled dialysis appointments. - Monitor vital signs as needed/ordered. Notify doctor of significant abnormalities. Review of the dialysis communication forms from January 2026 through April 2026, revealed 12 communication forms out of 16 not completed by the nursing facility pre-dialysis on 1/27/26, 2/2/26, 2/4/26, 2/6/26, 2/9/26, 2/11/26, 2/13/26, 2/18/26, 2/20/26, 2/25/26, 3/21/26, and 3/23/26; and 16 possible missing communication sheets on dialysis days 2/16/26, 2/23/26, 2/27/26, 3/2/26, 3/6/26, 3/9/26, 3/11/26, 3/13/26, 3/16/26, 3/18/26, 3/25/26, 3/27/26, 4/1/26, 4/3/26, and 4/6/26. During an interview on 4/10/26, at 9:00 a.m. the Registered Nurse Assessment Coordinator (RNAC) Employee E11 confirmed the facility failed to ensure the dialysis communication form was completed pre and post treatment between the facility and dialysis center and confirmed the missing dialysis sheets were not available at the facility.	F 0698		

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F 0698 SS=D	Continued from page 101 During an interview on 4/10/26, at approximately 3:00 p.m. the Nursing Home Administrator confirmed the facility failed to ensure dialysis communication sheets were completed prior to dialysis treatment. 28 Pa Code: 211.10(c)(d) Resident care policies. 28 Pa Code: 211.12(d)(1)(2)(3)(5) Nursing services.	F 0698		
F 0725 SS=E		F 0725		

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F 0725 SS=E	Continued from page 102 §483.35(a)(1)(2) Sufficient Nursing Staff §483.35 Nursing Services. 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) Sufficient Staff. §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.	F 0725	The facility will provide for sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical mental and psychosocial well-being. Staffing levels will be developed to meet the needs of the resident's care examples are ADL care, Incontinent care Transferring ,meal time, nail care, linen changes based on the facility assessment results. The facility will do this by Working with Veeshift/Eshift Staffing agency and Dropstat a scheduling oversite company to look at staff schedule to optimization the staff required to provide resident Care. The HR Director will develop a hiring plan based on the needs presented by the company Dropstat. Monthly staff meetings will be held by the HR Director to understand the needs of the staff and promote staff retention. Education will be provided To the nursing staff regarding What to do when unable to complete a care task.	Completion Date: **05/12/2026** Status: **APPROVED** Date: **05/07/2026**

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F 0725 SS=E	Continued from page 103 This REQUIREMENT is not met as evidenced by:	F 0725	That they need to follow the change of command and let the nurse know they can not complete the task the nurse will then complete the task or notify their supervisor. Documentation will be completed by the staff or manager that completes the task. The Administrator/Designee will audit daily nursing staff to ensure the required number of staff are present to provide for sufficient nursing staff to meet the residents' needs. the DON/Designee will audit 90% of residents who have care concerns weekly times four and monthly time two Results of these audits will be presented to the QAPI committee for review and recommendations	

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F 0725 SS=E	Continued from page 104 Based on review of facility documents, resident observations and interviews, Resident Council minutes, confidential resident group interview, and grievance review, it was determined that the facility failed to have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of eleven of twenty residents (Resident R21, R26, R56, R63, R64, R86, R117, R118, R119, R120, R121), seven of fourteen confidential group residents (Residents R100, R200, R400, R500, R600, R700, and R900), and for five of six Resident Council monthly meetings (October 2025, November2025, December 2025, and February 2026 and March 2026). Findings Include: Review of the "Facility Assessment" dated 4/14/25, indicated that the facility will follow state required staffing ratios to meet resident to aide/nurse ppd (per patient day) and would provide care for -Activities of Daily Living: (Bathing, showers, oral/denture care, dressing, eating, support with needs related to hearing/vision/sensory impairment; supporting resident independence in doing as much of these activities by himself/herself). -Mobility and fall/fall with injury prevention: Transfers, ambulation, restorative nursing, contracture prevention/care; supporting resident independence in	F 0725		

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F 0725 SS=E	Continued from page 105 doing as much of these activities by himself/herself. -Bowel/bladder: Bowel/bladder toileting programs, incontinence prevention and care, intermittent or indwelling or other urinary catheter, ostomy, responding to requests for assistance to the bathroom/toilet promptly in order to maintain continence and promote resident dignity. During an interview on 4/9/26, at 2:17 p.m. when asked if she felt the facility maintained sufficient staffing to care for the residents, Resident R86 stated, "Whenever they come in, they don't help put me on the bedpan. I tell them, but they don't do anything." "I call the supervisors and tell them, 'Please, I want someone to come in.'" Resident R86 stated that she is not incontinent, but it becomes painful to hold her bladder for extended times, stated that she is not always provided fresh waters, and that call lights take a very long time to be responded to. During an interview on 4/10/26, at 9:30 a.m. Resident R23 stated she often must leave her room to get staff to assist her roommate (Resident R10). During an interview and observation on 4/10/26, at 10:10 a.m. Resident R64 stated there's not enough staff, she feels her care is rushed, and that meals are often late. Resident R64 was noted to have greasy appearing skin and an	F 0725		

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F 0725 SS=E	Continued from page 106 unclean face. During an interview on 4/10/26, at 10:16 a.m. when asked if he felt if the facility maintained sufficient staffing to care for the residents, Resident R56 stated "No, not at all." Resident R56 stated call light response times are long. During an interview on 4/10/26, at 10:23 a.m. when asked if she thought the facility maintained sufficient staffing to care for residents, Resident R21 stated, "No" and "Sometimes it takes four to five hours to get help." During an interview on 4/10/26, at 10:25 a.m. when asked if she thought the facility maintained sufficient staffing to care for residents, Resident R63 stated, "Sometimes the call lights can be long." When asked, Resident R63 confirmed that she has been left in a soiled brief for a long time, causing skin irritation. During a follow-up interview on 4/10/26, at 1:2 p.m. Resident R86 stated, "Lat night I had to wait a long time." "I get told to wait because they are going to do somebody else, but they don't come back."	F 0725		

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F 0725 SS=E	Continued from page 107 Review of Resident Council minutes from 10/7/25: Call light response. 11/4/25: Staff not being present on the floor to provide care, not getting residents out of bed. 12/2/25: Staff not responding to call lights unless it is their section, lack of call light response on evening shift. 2/4/26: Staff not getting residents out of bed, left in the dining room after meals, waiting a long time to be assisted to bed. 3/3/26: Call lights being shut off, care not provided. During a confidential resident group interview on 4/8/26, at 2:00 p.m. the following concerns were voiced: -They have no intention of taking care of us. 13/14 residents. -Staff turn call lights off, without providing care. 13/14 residents. -All residents who need assistance getting in and out of bed stated they have concerns with not getting staff assistance. Resident R100: -From the time I was put in my chair, I have had to wait	F 0725		

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F 0725 SS=E	Continued from page 108 until 10:45 p.m. before they even thought to put me to bed. I rang for a very long time. Nobody attempted to even try. -You don't know if you are going to get back on bed at all. -Told to stay in bed, that I am too much work. -They are short-staffed. -They don't want to help you. -I was left from 11a to 11 at night. This is too long. My legs were swollen, I was in a lot of pain. -I try to help by being polite, by waiting my turn. But I feel like I'm being completely ignored. -They say they don't have to time to pull me back up in bed. -It's a 15 to 30 minute wait. Resident R200: -Left on the bed pan through dinner. Staff refused to assist. -On Monday (4/6/25), at 8:30 I pushed my button, and the aide came in, but she was a smart aleck. Said she would change me, but wouldn't put me on the bed pan. The she said she would put me on the bed pan and come back in 30-40 minutes. She put me on the bed pan and she didn't come back. -My roommate doesn't get changed for 4 to 5 hours. Resident R400 -They are way understaffed. -I kept waiting and waiting, I kept on asking her. They left	F 0725		

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F 0725 SS=E	Continued from page 109 me sitting a urine accident. I was all wet. They just walked out the room. For eight hours I sat in poop and piss. I had a rash. They just put the cream on, they don't even wash me properly. Cream on top of cream. Resident R500 -There's not enough staff on the weekends, particularly 11p to 7a. Resident R600 -Biggest concern is not enough people and staff not answering call lights. -I've had to wait an hour, hour and a half. I had to call my mom one time to have her get somebody down there to get me out of the room, they shut the door and nobody could see me or hear me. Resident R700 -One night there was only two on my floor. -They answer your light and say they will be right with you. But they never come. -The nurses say they have so many patients they need to get to. Resident R900 -The staff loaf around. The aide keeps disappearing when it's time to pass out trays.	F 0725		

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F 0725 SS=E	Continued from page 110 -11-7 is the worst times, and the weekends. The call light wait times are so long. Review of a grievance on Resident R118's behalf on 10/1/25, stated, "Family concerned not receiving appropriate oral care, am and pm hygiene bed linens not being changed and not out of bed." Review of a grievance on Resident R117's behalf on 10/7/25, stated, "Family in to visit. Resident was up in chair however her nails were in poor condition, feces under nails. Pad on bed was soiled/urine/feces." Review of a grievance submitted by Resident R86 on 12/20/25, stated, "Stated she is not getting the care she needs." Review of a grievance on Resident R119's behalf on 12/22/25, stated, "Concerned for her mom and roommate (Resident R120) not being set up for meals in bed." Review of a grievance submitted by Resident R86 on 12/23/25, included concerns relating to long call light response times and not being assisted out of bed.	F 0725		

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F 0725 SS=E	Continued from page 111 Review of a grievance on Resident R121's behalf on 1/5/26, stated, "Resident's wife reported aide told resident to use brief and not urinal." Review of a grievance submitted by Resident R78 on 2/12/26, included concerns relating to not receiving showers and not being assisted to bed until midnight. During an interview on 4/10/26, at approximately 3:00 p.m. the Nursing Home Administrator confirmed that the facility failed to have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of eight of eleven residents, seven of 14 confidential group residents, and for five of six Resident Council monthly meetings. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(e)(6) Management. 28 Pa. Code: 201.20(a) Staff development. 28 Pa. Code: 211.12(a)(c)(d)(1)(2)(3)(4) Nursing services.	F 0725		

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F 0730 SS=E	§483.35(d)(7) Nurse Aide Perform Review – 12Hr/Year In-ser §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by:	F 0730	Employees E2, E3, E4, E5, and E6 from facility documents given to the survey team will have their annual performance evaluation completed by their Department Manager/DON. The DON/Designee will complete annual evaluations for Nurse Aide on an annual basis. The Administrator will provide education to the facility DON/Designee on the importance of completing Annual Evaluations on the employee in the facility. These evaluations will include Core Values and Objectives, of Quality of Work, Attendance and Punctuality, Communication Skills, Judgement and Decision-making skills Cooperation and Teamwork and Knowledge of position. Audits will be completed by the HR Director/Designee on 10% of Nurse Aide employees each month that the Employee Annual Evaluation has been completed. The results of these audits will be reviewed by the QAPI committee for further recommendations	Completion Date: **05/12/2026** Status: **APPROVED** Date: **05/04/2026**

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F 0730 SS=E	Continued from page 113 Based on review of facility documents and staff interview, it was determined that the facility failed to complete annual performance evaluations for five of five nurse aides (Employees E2, E3, E4, E5, and E6). Finding include: During an interview on 4/10/26, at approximately 10:00 a.m. Human Resources Director Employee E1 confirmed that the facility did not complete performance reviews for Employees E2, E3, E4, E5, and E6. During an interview on 4/10/26, at approximately 3:00 p.m. the Nursing Home Administrator confirmed that the facility failed to provide the required 12 hours annual in-service education within 12 months of their hire date anniversary for five of five nurse aides. 28 Pa. Code: 201.14(a) Responsibility of Licensee. 28 Pa. Code: 201.20(a)(b)(c)(d) Staff Development. 28 Pa. Code: 211.12(c)(d)(1)(2)(5) Nursing Services.	F 0730		
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:
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F 0761 SS=D	Continued from page 114 483.45(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 DON/designee completed an OTC medication room audit on 3 units (North, South, West) for expired medications; all expired medications found were destroyed. The DON /designee will educate nursing staff on storing over-the-counter (OTC) medication according to manufactures guidelines for labeling and expiration dates, and ensure that treatment carts and the treatment room are locked. This education will also be part of the Nursing New Hire process during orientation. Audits will be completed by the DON/designee on the storage of OTC medication according to manufacturer guidelines for labeling and expiration dates, and ensuring treatment carts and treatment rooms are locked. These audits will be done four times weekly and three times monthly. The QAPI committee will review the results of these audits for further	Completion Date: **05/12/2026** Status: **APPROVED** Date: **05/04/2026**

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F 0761 SS=D	Continued from page 115	F 0761	recommendations.	

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F 0761 SS=D	Continued from page 116 Based on review of facility policies, observations and staff interview, it was determined that the facility failed to make certain that out of date medications were discarded in one of three medication rooms (North Unit medication room) and failed to properly secure a treatment cart on one of two nursing units (South Unit). Findings include: Review of the facility policy Medication Storage in the Facility, dated 1/5/26, indicated medications and biologicals are stored safely, securely, and properly. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medication. Also, "Outdated, contaminated, or deteriorated medication and those in containers that are cracked, soiled, or without secure closures are immediately removed from inventory." During an observation of the North Unit medication room on 4/7/26, at 1:40 p.m. revealed: (7) Blood collection tubes with an expiration date of 3/31/26. (15) Blood collection tubes with an expiration date of 1/4/26. (7) Blood collection tubes with an expiration date of 10/1/25.	F 0761		

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F 0761 SS=D	Continued from page 117 (1) Anaerobic blood culture bottle with an expiration date of 12/01/25. (1) Aerobic blood culture bottle with an expiration date of 1/23/26. (4) glycerin swab sticks with an expiration date of 1/2026. (62) hydrocortisone packets with an expiration date of 10/2025. (2) hydrocolloid dressings with an expiration date of 07/2024. (3) foam dressings with an expiration date of 2/20/24. (3) Huber needle sets with an expiration date of 11/3/25. (1) Silicone contact layer with an expiration date of 3/28/26. During an interview on 4/7/26, at approximately 1:55 p.m. Licensed Practical Nurse Employee E7 confirmed the above items were expired. During an observation on 4/8/26, at 9:45 a.m. a treatment cart was unsecured inside the supply room with the door propped open. The treatment cart contained two bottles of peroxide, one bottle of rubbing alcohol, seven bottles of resident specific ammonium lactate 12 % (lotion used to treat dry, scaly skin conditions), and seven tubes of triamcinolone acetonide (cream used to reduce inflammation, itching, and redness, or joint pain), and various bandages and gauze.	F 0761		

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F 0761 SS=D	Continued from page 118 During an interview on the same date and time, Registered Nurse Assessment Coordinator (RNAC) Employee E11 confirmed the treatment cart should be secured when unattended, and the door to the supply room should not be propped open. During an interview on 4/10/26, at approximately 3:00 p.m. the Nursing Home Administrator confirmed that the facility failed to make certain that out-of-date medications were discarded in one of three medication rooms and failed to properly secure a treatment cart inside a propped door. 28 Pa. Code: §211.9(a)(1)(k) Pharmacy services. 28 Pa. Code: §211.12(d)(1)(5) Nursing services.	F 0761		
F 0801 SS=F		F 0801		

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F 0801 SS=F	Continued from page 119 483.60(a)(1)(2) Qualified Dietary Staff §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered	F 0801	The facility will employ a full-time qualified Dietary Manager. The interim Dietary Manager will be taking CDM renewal on 05/08/2026 The Administrator educated the governing body for the requirement for the Dietary Manager have a CDM certification The Administrator will audit compliance of the requirement that the Dietary Manager maintains a CDM certification.	Completion Date: **05/12/2026** Status: **APPROVED** Date: **05/04/2026**

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F 0801 SS=F	Continued from page 120 dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services. (i) The director of food and nutrition services must at a minimum meet one of the following qualifications- (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or (E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and (ii) In States that have established standards for food service managers or dietary managers, meets State	F 0801		

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F 0801 SS=F	Continued from page 121 requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by:	F 0801		

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F 0801 SS=F	Continued from page 122 Based on review of employee files, and staff interviews, it was determined that the facility failed to employ a full-time qualified dietary services manager in the absence of a full-time qualified dietitian for 25 of 25 days. (March 16, 2026, through April 10,2026) Findings include: Review of the job description "Dietary Manager" indicated they oversee all food service operations to ensure residents receive nutritious, safe, and appealing meals that must meet clinical and dietary requirements. The key responsibilities included the following: - Manage daily operations of the dietary department. - Work closely with a Registered Dietitian to implement meal plans - Maintain food safety standards. - Hire, train, schedule and supervise dietary staff (cooks, aides, dishwashers) - Ensure food quality, taste, temperature, and presentation meets expectations. - Order food and supplies and maintain inventory	F 0801		

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F 0801 SS=F	Continued from page 123 During an interview on 4/7/26, at 10:05 a.m. interim Dietary Manager Employee E12 stated she currently does not have her CDM license. She previously held a CDM license but allowed it to lapse after October 2024 after the nursing home she was employed at closed and she decided to pursue a different career path. She also stated the RD only works at the facility on Mondays. Review of employee files indicated the following: - Employee E12 was hired on 1/29/26, as a Graduate Nurse (GN) while she awaited her Registered Nurse State Board test to be completed (scheduled for 4/22/26). - On 3/19/26, Employee E12 signed the "Dietary Manager" job description. During an interview on 4/10/26, at approximately 11:00 a.m. the Nursing Home Administrator (NHA) confirmed the facility was unable to provide a job description for the Registered Dietitian (RD) position and stated the RD is a consultant for the facility so she did not have a job description. The NHA confirmed there was not a full-time dietitian employed at the facility and that the facility did not employ a qualified dietary manager in the absence of a full-time dietitian. 28 Pa. Code 201.18(b)(3) Management.	F 0801		

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F 0801 SS=F	Continued from page 124	F 0801		
F 0802 SS=F		F 0802		

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F 0802 SS=F	Continued from page 125 483.60(a)(3)(b) Sufficient Dietary Support Personnel §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. §483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). This REQUIREMENT is not met as evidenced by:	F 0802	The facility will provide sufficient dietary staff to perform essential kitchen duties. On the assessment of the kitchen function, it was found that the facility was using an older menu which did not match the food ordering guide. Creating the need for frequent menu changes. The menu and order guide have now been reconciled, which will decrease the need for menu changes. The Tray Line will be moved from the dining room into the kitchen to improve time management, meal preparation and accuracy of meal including condiments needed. Education will be provided by the Administrator/Designee on the need for accuracy and time management for meal production. The Administrator will audit the kitchen meal production and accuracy weekly for four weeks and monthly for two results will be presented to the QAPI committee for review and recommendations	Completion Date: **05/12/2026** Status: **APPROVED** Date: **05/04/2026**

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F 0802 SS=F	Continued from page 126 Based on observations, resident interviews, review of facility documents, and staff interviews, it was determined that the facility failed to provide sufficient dietary staff to perform essential kitchen duties. Findings include: Review of the facility document "Meal Service Times", indicated the following meal schedules: Main Dining room: Breakfast 730 830 a.m. Lunch 11:30 12:30 p.m. Dinner 5:15 pm 6:15 pm. Cart Service: Breakfast 7:45 a.m. 8:30 a.m. Lunch 11:45 a.m. 12:30 p.m. Dinner 5:30 p.m. 6:15 p.m. Review of Food Committee meeting notes from 1/5/26, indicated concerns related to condiments not being on carts, lack of notice about menu changes, and meal	F 0802		

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F 0802 SS=F	Continued from page 127 delivery being late due to carts of trays not being distributed when brought to the floor. Review of Food Committee meeting notes from 3/2/26, indicated concerns related to posted menu not being followed, missing items from meal trays, meals being late, food being cold, and running out of food before meal service is complete. During an interview on 4/7/26, at 10:05 a.m. interim Dietary Manager Employee E12 stated the facility did not have enough staff for the kitchen to run efficiently. She stated the Certified Dietary Manager (CDM) walked out of the facility without notice on 3/16/26, and she stepped into the position temporarily on 3/19/26. She held the position of CDM at a different nursing facility that closed in 2024 but let her certification lapse as she pursued another career path. She stated the facility only had a Registered Dietician one day a week, on Mondays. During an interview on 4/7/26, at 11:00 a.m. Resident R59 stated the food is consistently cold, and staff refuse to microwave it for them. During an interview on 4/7/26, at 11:06 a.m. Resident 115 stated if residents want warm food they eat in the dining room, because the meals delivered to his room are always cold and staff refuse to heat it for him.	F 0802		

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F 0802 SS=F	Continued from page 128 During an interview on 4/7/26, at approximately 11:19 a.m. Resident R98 stated the food tastes bad and is often cold. During an interview on 4/7/26, at 11:23 a.m. Resident R76 stated he eats in the dining room because the food is cold if he eats in his room. During an interview on 4/8/26, at approximately 3:30 p.m. Resident R9 stated that, "meals are late and ice cold." During a confidential group interview on 4/8/26, at 2:00 p.m. 14 of 14 residents collectively confirmed that meals are consistently late and cold. During observations on 4/9/26, at 12:07 p.m. tray line was still being assembled in the dining room. At 12:15 p.m. the residents in the dining room began to get their meals. Carts delivery to resident rooms began at 1:15 p.m. During an interview on 4/9/26, at 12:10 p.m. acting Dietary Manager stated lunch was running about 30 minutes behind due to not having enough staff to prepare the meal timely. The menu for the day was roasted turkey, mashed potatoes, carrots, and tapioca pudding. The morning kitchen staff included one Cook Employee E15, Cook (in training) Employee E17, and Dietary Aide Employee E18. During an interview on 4/10/26. at 3:00 p.m. the Nursing Home Administrator confirmed the facility failed to provide	F 0802		

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	395695	A. BLDG: __00_____ B. WING: _____	04/10/2026

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F 0802 SS=F	Continued from page 129 sufficient dietary staff to perform essential kitchen duties. 28 Pa. Code 211.6(b)(c)(d) Dietary Services	F 0802		
F 0804 SS=F		F 0804		

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 0804 SS=F	Continued from page 130 483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by:	F 0804	The facility will provide the residents with food and drink that is at safe and appetizing temperatures The tray line will be moved to the kitchen from the dining room to improve efficiency of meal production and improve meal temperatures. Equipment consisting of Thermal Pellet base/heating element and Thermal Dome will be purchased to add additional heated time to the food from the time the meal is planned until delivered to the resident. Ancillary staff as Activities Aide, Medical Records Clerk, Business office assistant will be utilized to assist with tray pass. The Nursing and Dietary staff will be educated by the Administrator/Designee on new process of tray line and meal delivery to the residents and that during meal delivery the cart door must remain closed when not in use. Audits will be completed by the Administrator/Designee on providing the residents with food and drink that is safe and appetizing	Completion Date: **05/12/2026** Status: **APPROVED** Date: **05/04/2026**

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F 0804 SS=F	Continued from page 131	F 0804	temperatures. The last tray served will have food temperatures taken to provide safe and appetizing temperatures three times a week at different meal times and then weekly at different meal times then monthly ongoing Results of these audits will be presented to the QAPI committee for review and recommendations	

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F 0804 SS=F	Continued from page 132 Based on a review of facility policy, facility documents, resident interviews, staff interviews and observations, it was determined the facility failed to provide the residents with food and drink that is at a safe and appetizing temperatures for five of 21 residents interviewed (R59, R115, R98, R76 and R9), 14 of 14 residents in a confidential group meeting, two of three resident council minutes reviewed (1/5/26 and 3/2/26), and observations of a test tray (4/9/26). Findings include: Review of facility policy "Dietary/ Food Handling" reviewed 1/5/26, indicated guidelines for the safe preparation, handling, and storage of perishable food. Temperatures must be maintained at the following (Fahrenheit) settings for the items indicated below: Cold food - 45 degrees or below Frozen food - 0 (zero) degrees or below Hot food - 140 degrees or above Review of the USDA Food Safety Minimal Internal Temperature chart indicated all poultry should reach 165 F to ensure thorough cooking and should be kept at 140 F or higher for holding temperature. During an interview on 4/7/26, at 11:00 a.m. Resident R59 stated the food is consistently cold, and staff refuse to microwave it to heat it up.	F 0804		

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F 0804 SS=F	Continued from page 133 During an interview on 4/7/26, at 11:06 a.m. Resident 115 stated if residents want warm food they eat in the dining room, because the meals delivered to his room are always cold and staff refuse to heat it for him. During an interview on 4/7/26, at approximately 11:19 a.m. Resident R98 stated the food tastes bad and is often cold. During an interview on 4/7/26, at 11:23 a.m. Resident R76 stated he eats in the dining room because the food is cold if he eats in his room. During an observation on 4/8/26, at 9:28 a.m. breakfast was still being served to the residents on the North Unit. The metal kitchen cart was observed left open between staff removing the trays with five resident trays left in the cart. The back hallway on North Unit was observed to have four resident trays on a cooling rack being used to deliver meals. During an interview on 4/8/26, at 9:30 a.m. Nurse Aid (NA) Employee E5 confirmed the cart doors are left open between trays. During an observation on 4/8/26, at 9:36 a.m. the metal kitchen cart was left open with nine resident trays still inside.	F 0804		

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F 0804 SS=F	Continued from page 134 During an interview on 4/8/26, at 9:36 a.m. NA Employee E22 stated they were unaware the kitchen carts needed to be closed between removing resident meal trays. During an interview on 4/8/26, at approximately 3:30 p.m. Resident R9 stated that, "meals are late and ice cold." During a confidential group interview on 4/8/26, at 2:00 p.m. 14 of 14 residents collectively confirmed that meals are consistently late and cold. During observations on 4/9/26, at 12:07 p.m. tray line was still being assembled in the dining room. At 12:15 p.m. the residents in the dining room began to get their meals. During an observation on 4/9/26, at 1:00 p.m. food temperatures were as follows: -Roasted turkey (sliced and placed in metal tray, no liquid): 99 F -Mashed potatoes: 207 F -Gravy: 162 F -Diced carrots were 159 F	F 0804		

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F 0804 SS=F	Continued from page 135 During an observation on 4/9/26, at 1:15 p.m. revealed lunch trays for cart delivery to the nursing unit began. During an observation on 4/9/26, at 2:35 p.m. a test tray was obtained as the last tray was delivered to the remaining resident. Food temperatures were as follows: -Sliced turkey was 48 F -Mashed potatoes with gravy on top was 55.8 F -Diced carrots: 51 F The food was palatable and smelled savory but was not at an appealing or appetizing temperature. The presentation was in a circular pattern with carrots brightening the plate. During an interview on 4/9/26, at 2:40 p.m. the acting Dietary Manager Employee E12 confirmed the temperatures of the test tray and stated the facility only had one small, insulated food cart, and two metal uninsulated carts for meal tray delivery. During an interview on 4/10/26, at approximately 3:30 p.m. the Nursing Home Administrator confirmed the facility failed to provide the residents with food that is at a safe and appetizing temperature.	F 0804		

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F 0804 SS=F	Continued from page 136 28 PA Code: 211.6(b)(c)(d) Dietary services.	F 0804		
F 0835 SS=E		F 0835		

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F 0835 SS=E	Continued from page 137 483.70 Administration §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by:	F 0835	Nursing Home Administrator (NHA) and the Director of Nursing (DON) will effectively manage the facility to ensure provider notification of resident changes in condition by ongoing auditing and staff education on the requirement to notify the physician of abnormal blood sugar results to prevent a negative outcome to occurs Weekly reports by both the Administrator and the DON will be presented to the Greenery Center for Rehab and Nursing governing body to ensure the delivery of high-quality short-term rehabilitation and long-term care services while maintaining compliance with all federal, state (Pennsylvania), and local regulations. The Nursing Supervisor will be educated by the DON/Designee on the importance of notifying a physician of abnormal blood sugar results This education will be ongoing for licensed nursing staff. The DON/Designee will complete weekly ongoing audit of 90%	Completion Date: **05/12/2026** Status: **APPROVED** Date: **05/07/2026**

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F 0835 SS=E	Continued from page 138	F 0835	abnormal blood sugar results and physician notification to prevent any negative outcome from occurring.	

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F 0835 SS=E	Continued from page 139 Based on review of job descriptions, clinical records, and staff interviews, it was determined that the Nursing Home Administrator (NHA) and the Director of Nursing (DON) failed to effectively manage the facility to ensure provider notification of resident changes in condition. This failure resulted in immediate jeopardy for 12 of 21 residents (R2, R4, R16, R33, R37, R46, R47, R56, R70, R80, R97, and R116). Findings include: Review of the facility-provided Nursing Home Administrator (NHA) job description indicated, "The Nursing Home Administrator (NHA) is responsible for the overall leadership, management, and operation of The Greenery Center for Rehab and Nursing. This role ensures the delivery of high-quality short-term rehabilitation and long-term care services while maintaining compliance with all federal, state (Pennsylvania), and local regulations. The NHA promotes a resident centered environment focused on clinical excellence, safety, and compass." Review of the facility-provided Director of Nursing (DON) job description indicated, "The Director of Nursing (DON) is responsible for the overall clinical leadership and management of nursing services at The Greenery Center for Rehab and Nursing. This role ensures the delivery of high-quality, resident-centered care in both short-term	F 0835		

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F 0835 SS=E	Continued from page 140 rehabilitation and long-term care settings, while maintaining full compliance with Pennsylvania Department of Health and CMS regulations." Based on findings identified in this report, the facility failed to ensure that physicians or other advanced practice providers were notified of capillary blood glucose levels beyond the parameters set in the physicians' orders. The NHA and the DON failed to fulfill their essential job duties to ensure the federal and state guidelines and regulations were followed. During an interview on 4/10/26, at approximately 3:00 p.m. the NHA and current DON confirmed that facility administration failed effectively manage the facility to ensure provider notification of changes in condition. This failure created an Immediate Jeopardy situation for 12 of 21 residents. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(3)(e)(1) Management. 28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services.	F 0835		

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F 0838 SS=C	483.71(a)(1)(3)(b)(1)(c)(1)-(5) Facility Assessment §483.71 Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations (including nights and weekends) and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. §483.71(a) The facility assessment must address or include the following: §483.71(a)(1) The facility's resident population, including, but not limited to: (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population, using evidence-based, data-driven "methods" that considering the types of diseases, conditions, physical and behavioral health needs, cognitive disabilities, overall acuity, and other pertinent facts that are present within that population, consistent with and informed by individual resident assessments as required under § 483.20; (iii) The staff competencies and skill sets that are necessary to provide the level and types of care needed for the resident population; (iv)The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and	F 0838	The facility will accurately complete the Facility Assessment to include Review of the Disease and Conditions, Activities of Daily Living that residents require. Physical Environment and Building/Plant. Staffing Plan and in-service education for facility staff. This assessment will be reviewed quarterly and as necessary. Results of this assessment will be presented to the Governing Board of the Greenery Center for Rehab and Nursing quarterly and when changes are made. The Administrator will be educated by the Regional Nurse Consult on completing the required sections of the facility assessment. The Governing Board of the Greenery Center for Rehab and Nursing will monitor this assessment for further compliance with this regulation. Results will be presented at the QAPI committee meeting for review and further recommendations.	Completion Date: 05/12/2026 Status: APPROVED Date: 05/04/2026

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F 0838 SS=C	Continued from page 142 (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.71(a)(2) The facility's resources, including but not limited to the following: (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, behavioral health, and specific rehabilitation therapies; (iv) All personnel, including managers, nursing and other direct care staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.71(a)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach as required in §483.73(a)(1). § 483.71(b) In conducting the facility assessment, the	F 0838		

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F 0838 SS=C	Continued from page 143 facility must ensure: § 483.71(b)(1) Active involvement of the following participants in the process: (i) Nursing home leadership and management, including but not limited to, a member of the governing body, the medical director, an administrator, and the director of nursing; and (ii) Direct care staff, including but not limited to, RNs, LPNs/LVNs, NAs, and representatives of the direct care staff, if applicable. (iii) The facility must also solicit and consider input received from residents, resident representatives, and family members. §483.71(c) The facility must use this facility assessment to: §483.71(c)(1) Inform staffing decisions to ensure that there are a sufficient number of staff with the appropriate competencies and skill sets necessary to care for its residents' needs as identified through resident assessments and plans of care as required in § 483.35(a)(3). §483.71(c)(2) Consider specific staffing needs for each resident unit in the facility and adjust as necessary based on changes to its resident population. §483.71(c)(3) Consider specific staffing needs for each shift, such as day, evening, night, and adjust as necessary based on any changes to its resident population. §483.71(c)(4) Develop and maintain a plan to maximize recruitment and retention of direct care staff.	F 0838		

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	395695	A. BLDG: __00_____ B. WING: _____	04/10/2026

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
GREENERY CENTER FOR REHAB AND NURSING STATE LICENSE NUMBER: **135602**	**2200 HILL CHURCH HOUSTON ROAD CANONSBURG, PA 15317**

(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 0838 SS=C	Continued from page 144 §483.71(c)(5) Inform contingency planning for events that do not require activation of the facility's emergency plan, but do have the potential to affect resident care, such as, but not limited to, the availability of direct care nurse staffing or other resources needed for resident care. This REQUIREMENT is not met as evidenced by:	F 0838		

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F 0838 SS=C	Continued from page 145 Based on review of facility documents and staff interview, it was determined that the facility failed to accurately complete the Facility Assessment. Findings include: Review of the "Facility Assessment Tool," dated 4/15/25, revealed the facility did not complete the template to indicate accurate information on: The section titled "Disease and Conditions" included tables to document information on the categories of care and average number of residents who received special treatments. This table was left blank. Additionally, a table was included to document the levels of assistance with Activities of Daily Living that residents required. This table was left blank. The section titled "Disease and Conditions" indicated the facility denies resident admissions if they require ventilator care. Review of the section titled "Physical Environment and Building/Plant Needs" included ventilators as a type of physical equipment available for resident care.	F 0838		

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F 0838 SS=C	Continued from page 146 Review of the section titled "Physical Environment and Building/Plant Needs" included a gift shop, and a café/snack bar/bistro available for resident use. Review of the section titled "Staffing Plan" indicated that the facility follows all state and federal guidelines for staffing education. Review of facility provided in-service education information revealed no nurse aide met the 12-hour annual requirement. During an interview on 4/1026, at approximately 3:00 p.m. the Nursing Home Administrator confirmed that the facility failed to accurately complete the Facility Assessment. 28 Pa. Code 201.18(b)(3)(e)(2) Management.	F 0838		
F 0867 SS=F		F 0867		

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F 0867 SS=F	Continued from page 147 483.75(c)(1)-(4)d)(1)(2)(e)(1)-(3)(g)(2)(ii)(iii) QAPI/QAA Improvement Activities §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.71 and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including	F 0867	A Quality Assurance and Performance Improvement (QAPI) will be held by the Administrator/Designee on May 11, 2026 Resident recently discharged from Therapy will be assessed by both the Therapy department and Nursing for the need for any restorative programming. A POC task for documentation will be created to ensure the program is completed by the CNA. When Staff in is insufficient to provide these services the Therapy Department staff will assist. The DON/Designee will Monitored the when the need for the therapy staff to assist occurs A Quality Assurance and Performance Improvement (QAPI) will be held by the administrator/Designee at least quarterly or more often if needed. Minutes of the QAPI committee will be presented to the Governing Body of the Greenery Center for Rehab and Nursing.	Completion Date: **05/12/2026** Status: **APPROVED** Date: **05/06/2026**

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F 0867 SS=F	Continued from page 148 the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the	F 0867	The Management Team will be educated on the timing and requirement of the QAPI committee by the Administrator. The Governing Body of the Greenery Center for Rehab and Nursing will monitor for compliance of this regulation. The DON/Designee will audit the Restorative care documentation on the CNA task weekly times four and monthly times two. The DON/ Designee will monitor the need for therapy to assist ongoing	

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F 0867 SS=F	Continued from page 149 incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.71. Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:	F 0867		

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F 0867 SS=F	Continued from page 150 (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by:	F 0867		

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F 0867 SS=F	Continued from page 151 Based on review of the facility documents and resident and staff interviews, it was determined that the facility's Quality Assurance Performance Improvement (QAPI) committee failed to ensure that the delivery of care and services was effectively provided to residents. Findings include: Review of the facility's "Performance Improvement Program Plan" indicated, "It is the policy of Greenery Center to continually improve the delivery of health care services by designing, measuring, assessing, improving, and redesigning processes of resident care; thereby improving performance." "When processes are will designed, they establish expectations and draw on a variety of information sources. New and/or modified processes should meet the following criteria: a. Be consistent with the organization's mission, vision, values and standards of care. b. Met the needs of the staff and individuals served. c. Must be clinically sound and current d. Must be consistent with sound business practices e. Incorporate available information from other sources about the occurrence of sentinel events.	F 0867		

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F 0867 SS=F	Continued from page 152 f. Incorporate results of performance improvement activities." During a confidential resident group interview on 4/8/26, at 2:00 p.m. residents expressed concerns that the resident restorative program had been discontinued, and the restorative duties were placed on the nurse aides. The residents in the group confirmed that they are not receiving restorative care. Review of Resident Council minutes dated 2/2/26, revealed concerns expressed by residents that the restorative program had been discontinued. During an interview on 4/10/26, at approximately 11:00 a.m. the Nursing Home Administrator (NHA) confirmed that the facility is currently in the state enforcement process for a lack of nurse aide care, dating back to February 2026. It was confirmed with the NHA that residents, the Resident Council, the local Ombudsman, resident interviews, and facility staffing data all indicated that nurse aide staffing was insufficient to meet the basic resident care needs. When asked if the facility had used its QAPI process and plan to ensure effective delivery of the restorative program to residents, the NHA confirmed that the plan was not	F 0867		

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F 0867 SS=F	Continued from page 153 utilized. It was then confirmed with the NHA that had the QAPI plan had been utilized it would have revealed that placing additional job duties on nurse aides, when currently the facility is experiencing nurse aide staffing shortages, was not a feasible replacement for the restorative program. During an interview on 4/10/26, at approximately 3:00 p.m. the NHA confirmed that the facility's Quality Assurance Performance Improvement committee failed to ensure that the delivery of care and services was effectively provided to residents. 28 Pa. Code 201.14(a) Responsibility of licensee.	F 0867		
F 0868 SS=D		F 0868		

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F 0868 SS=D	Continued from page 154 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) QAA Committee §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary. §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member	F 0868	A Quality Assurance and Performance Improvement (QAPI) will be held by the Administrator/Designee on May 11, 2026 A Quality Assurance and Performance Improvement (QAPI) will be held by the administrator/Designee at least quarterly or more often if needed. Minutes of the QAPI committee will be presented to the Governing Body of the Greenery Center for Rehab and Nursing. The Management Team will be educated on the timing and requirement of the QAPI committee by the Administrator. The Governing Body of the Greenery Center for Rehab and Nursing will monitor for compliance of this regulation.	Completion Date: **05/12/2026** Status: **APPROVED** Date: **05/04/2026**

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 0868 SS=D	Continued from page 155 of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by:	F 0868		

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F 0868 SS=D	Continued from page 156 Based on facility policy review, review of Quality Assurance attendance records, and staff interview, it was determined that the facility failed to conduct Quality Assessment and Assurance (QAA) meetings at least quarterly with all the required committee members for one of three quarterly meetings (Quarter four of 2025). Findings Include: The facility "Quality Assurance and Performance Improvement (QAPI)" policy dated 1/5/26, indicated the QAPI program is an ongoing comprehensive program that addresses all the systems of care and shall evaluate, monitor, and investigate quality of care in the facility. Meeting, at a minimum, at least quarterly; monthly or more often if needed. Review of Quality assurance and Performance Improvement sign in sheets and attendance records for Quarter Four of 2025, failed to reveal a meeting was held as required. During an interview on 4/10/26, at 10:40 a.m. the Nursing Home Administrator confirmed that the facility failed to conduct Quality Assessment and Assurance (QAA) meetings at least quarterly with all the required committee members for one of four quarterly meeting (Quarter Four of 2025), as required.	F 0868		

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F 0868 SS=D	Continued from page 157	F 0868		
F 0880 SS=F		F 0880		

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F 0880 SS=F	Continued from page 158 483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 0880	The Facility has developed a Water Management Team which includes the Administrator, DON and Maintenance Director. Which has implemented control measures for Legionella testing within the facility following the "Legionella Policy and Water Management Plan" Both water temperature and water flushing logs were completed for the month of March and documented by the Maintenance Director. Water testing temperature logs and Water Flushing logs will be completed by the Maintenance Director as per the Legionella policy and Water Management Plan monthly. The Administrator has educated the Maintenance Director on the Legionella Policy and Water Management Plan. The Water Management Team have completed the Training from the CDC PreventLD. The Administrator will complete audits for completion of Legionella testing to include both the water temperature logs, and the water	Completion Date: **05/12/2026** Status: **APPROVED** Date: **05/04/2026**

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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(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 0880 SS=F	Continued from page 159 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 0880	flushing logs monthly times four then quarterly times two .Results of this audit will be presented to the QAPI committee for review and further recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395695	A. BLDG: __00_____ B. WING: _____	04/10/2026

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F 0880 SS=F	Continued from page 160	F 0880		

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F 0880 SS=F	Continued from page 161 Based on review of facility policy, documentation, and staff interviews it was determined that the facility failed to implement control measures for Legionella within the facility for three of twelve months (February, March, and April 2026). Findings include: Review of the facility policy "Legionella Policy and Water Management Plan" dated 1/5/26, indicated water testing will be via monthly water temperatures and flushes to ensure water is being maintained and specific actions should be taken for prevention of Legionella and for investigation should a case occur. A review of the water temperature monitoring logs dated February, March, and April 2026 did not include evidence of monthly testing per facility policy. During an interview on 4/10/26 at approximately 1:45 p.m., the interim Maintenance Director, Employee E14 confirmed the facility had no documentation of water testing as per the Legionella Policy for February, March, and April 2026. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18(b)(1)(e)(1) Management.	F 0880		

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F 0880 SS=F	Continued from page 162	F 0880		
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 163 483.80(d)(3)(i)-(vii) COVID-19 Immunization §483.80 Infection control §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 or resident representative, has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; and (vi) The resident's medical record includes documentation that indicates, at a minimum, the following:	F 0887	The facility will document that each resident was offered a Covid 19 immunization and the resident or resident's representative was provided education regarding the benefits and potential side effects of immunizations. Resident R 20 is no longer in the facility. Resident R24, R31, R98 will be offered the Covid 19 immunization, and the resident or resident's representative will be provided education regarding the benefits and potential side effects of immunizations. On Admission and annually residents will be offered a Covid 19 immunization, and the resident or resident's representative was provided with education regarding the benefits and potential side effects of immunizations. Education will be provided to the licensed Nursing Staff that resident on admission and annually need to be offered the COVID-19 Immunization provided education regarding the benefits and potential	Completion Date: **05/12/2026** Status: **APPROVED** Date: **05/04/2026**

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 164 (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. (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	side effects of immunizations. Audits will be completed by the DON/Designee on 10% of facility admission for being offered and educated on side effects of the COVID-19 weekly times four and monthly times two Results of these audits will be reviewed at the QAPI committee meeting for further recommendations.	

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F 0887 SS=E	Continued from page 165 Based on a review of select facility policies and procedures, current Centers for Disease Control (CDC) guidelines, clinical record review, and staff interview, it was determined that the facility failed to document each resident was offered a Covid 19 immunization and the resident or resident's representative was provided education regarding the benefits and potential side effects of immunizations, for four of five residents reviewed for immunizations (Residents R20, R24, R31, and R98). Findings include: A review of facility policies, "Covid Protocols Post PHE," dated 1/5/26, indicated vaccines are administered in accordance with Centers for Disease Control and Prevention (CDC) recommendations. All residents are encouraged to remain up to date with all recommended Covid 19 vaccine doses. Staff and residents will be educated on the risks/benefits of the Covid vaccination and will be offered the vaccination. A review of the clinical record indicated Resident R20 was admitted to the facility on 6/6/22, with diagnoses that included COPD (chronic obstructive lung disorder). A review of the "Resident Influenza/Pneumococcal/Covid-19 Consent Declination" dated 10/8/25 did not include evidence that the resident was offered the Covid-19 vaccine.	F 0887		

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F 0887 SS=E	Continued from page 166 A review of the clinical record "Immunizations" documentation on 4/10/26 at 11:00 a.m., did not include information that the Covid-19 vaccines were offered or declined. A review of the clinical record indicated Resident R24 was admitted to the facility on 9/17/11, with diagnoses that included stroke. A review of the "Resident Influenza/Pneumococcal/Covid-19 Consent Declination" dated 10/2/25 did not include evidence that the resident was offered the Covid-19 vaccine. A review of the clinical record "Immunizations" documentation on 4/10/26 at 11:00 a.m., did not include information that the Covid-19 vaccines were offered or declined. A review of the clinical record indicated Resident R31 was admitted to the facility on 5/31/22, with diagnoses that included Parkinson's (a progressive movement disorder of the nervous system) and bipolar disorder. A review of the "Resident Influenza/Pneumococcal/Covid-19 Consent Declination" dated 10/14/25 did not include evidence that the resident was offered the Covid-19 vaccine. A review of the clinical record "Immunizations" documentation on 4/10/26 at 11:00 a.m., did not include information that the Covid-19 vaccines were offered or declined.	F 0887		

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F 0887 SS=E	Continued from page 167 A review of the clinical record indicated Resident R98 was admitted to the facility on 3/24/20, with diagnoses that included congestive heart failure, and diabetes. A review of the "Resident Influenza/Pneumococcal/Covid-19 Consent Declination" dated 10/8/25 did not include evidence that the resident was offered the Covid-19 vaccine. A review of the clinical record "Immunizations" documentation on 4/10/26 at 11:00 a.m., did not include information that the Covid-19 vaccines were offered or declined. During an interview on 4/10/26 at 11:00 a.m., the Infection Control Preventionist (ICP) Employee E13 confirmed the above findings, and that the facility failed to document each resident was offered a Covid-19 vaccine and the resident or resident's representative was provided education regarding the benefits and potential side effects of immunizations, for Residents R20, R24, R31, and R98.	F 0887		

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F 0947 SS=E	483.95(g)(1)-(4) Required In-Service Training for Nurse Aides §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.71 and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by:	F 0947	Twelve hours of servicing will be provided for the Nurse Aide who's files were reviewed by the survey team. Beginning next month, the DON or their designee will conduct monthly in-service training for Nurse Aides, totaling 12 required class hours. The HR Director will be educated by the Administrator on the need to provide 12 hours of Inservice education to Nurse Aides yearly. The HR director will audit 10% of nurse aides to ensure they complete the monthly class required to acquire 12 hours of in-servicing. Results of these audits will be presented to the QAPI committee for review and recommendations.	Completion Date: **05/12/2026** Status: **APPROVED** Date: **05/04/2026**

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F 0947 SS=E	Continued from page 169 Based on review of facility documents, staff education records, and staff interviews, it was determined that the facility failed to conduct at least 12 hours of in-service education, within 12 months of their hire date anniversary, for nurse aides as required for five of five nurse aides (Employees E2, E3, E4, E5, and E6). Finding include: Review of the "Facility Assessment" last reviewed 4/15/25, indicated the facility follows all state and federal guidelines for staffing education. Review of the facility provided, "Nursing Assistant In-Service Hours" document indicated that Nurse Aide (NA) Employees E2, E3, 14, and E5, E6 had the following education: Nurse Aide (NA) Employee E2 had a hire date of 3/7/86, with 2.00 hours in-service education between 3/7/25, and 3/7/26. NA Employee E3 had a hire date of 3/6/20, with 2.00 hours in-service education between 3/6/25, and 3/6/26. NA Employee E4 had a hire date of 9/30/91, with 4.00 hours in-service education between 9/30/24, and 9/30/25. NA Employee E5 had a hire date of 12/21/00, with 4.00 hours in-service education between 12/21/24, and 12/21/25. NA Employee E5 had a hire date of 1/22/24, with 4.00 hours in-service education between 1/22/25, and 1/22/26.	F 0947		

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F 0947 SS=E	Continued from page 170 No additional documentation of hours were provided to the survey team, as requested, by the end of the survey. During an interview on 4/10/26, at approximately 3:00 p.m. the Nursing Home Administrator confirmed that the facility failed to provide the required 12 hours annual in-service education within 12 months of their hire date anniversary for five of five nurse aides. 28 Pa. Code: 201.14(a) Responsibility of Licensee. 28 Pa. Code: 201.20(c) Staff Development. 28 Pa. Code: 211.12(c)(d)(1)(2)(5) Nursing Services.	F 0947		

Certified End Page

GREENERY CENTER FOR REHAB AND NURSING

STATE LICENSE NUMBER: 135602

SURVEY EXIT DATE: 04/10/2026

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