

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395875</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/02/2025</b>
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NAME OF PROVIDER OR SUPPLIER: <b>GREENWOOD CENTER FOR NURSING AND REHAB</b>	STREET ADDRESS, CITY, STATE, ZIP CODE: <b>149 LAFAYETTE AVENUE TAMAQUA, PA 18252</b>
STATE LICENSE NUMBER: <b>017902</b>	

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F 0000	INITIAL COMMENT	F 0000		
F 0553 SS=D	Based on an abbreviated complaint survey and revisit survey completed on January 2, 2025, it was determined that Greenwood Center for Nursing and Rehab corrected the federal deficiencies cited during the survey of October 16, 2024, but remained out of compliance under the requirements of 42 CFR Part 483 Subpart B Requirements for Long Term Care and 28 PA Code Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0553		

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 0553  SS=D	Continued from page 1  483.10(c)(2)(3) Right to Participate in Planning Care  §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care.  §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care.	F 0553	1. Care conference for R3 was scheduled for 1/7/25 and RR is attending with resident. 2. Facility completed 30 day lookback to ensure each applicable MDS has a care conference scheduled with RR or resident invite. 3. Facility implemented new process which includes tracking form to ensure each applicable scheduled MDS has a care plan scheduled with RR and/or resident invite and completion of care plan. NHA educated RNAC and LNAC on this new process. 4. NHA/designee will audit scheduled MDS' weekly for 4 weeks and then monthly for 2 months to ensure the applicable MDS' have a care plan scheduled with RR and resident invite sent and care plan completed. 5. Audits will be submitted to QAPI for review.	Completion Date: <b>01/14/2025</b> Status: <b>APPROVED</b> Date: <b>01/13/2025</b>

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F 0553  SS=D	Continued from page 2  This REQUIREMENT is not met as evidenced by:	F 0553		

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F 0553  SS=D	Continued from page 3  Based on a review of select facility policy, clinical record review, and staff interviews, it was determined the facility failed to afford a resident and their designated representative the right to participate in the development of the resident's plan of care for one resident out of seven residents sampled (Resident 3).  Findings include:  A review of the facility policy titled, "Resident Participation- Assessment/Care Plans," last revised February 2021, revealed the resident and his or her representative are encouraged to participate in the resident's assessment and in the development and implementation of the resident's care plan. Furthermore, the policy indicated facility staff support and encourage resident and resident representative participation in the care planning process by providing sufficient notice in advance of the care plan meeting and planning for enough time for exchange of information and decision-making. The social services director or designee is	F 0553		

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F 0553  SS=D	Continued from page 4  responsible for notifying the resident and representative and for maintaining records of such notices.  A clinical record review revealed Resident 3 was admitted to the facility on August 29, 2024, with diagnoses that included pneumonia (a lung infection) and chronic obstructive pulmonary disease (COPD is a condition caused by damage to the airways or other parts of the lung that blocks airflow and makes it hard to breathe).  A multidisciplinary care conference form dated August 30, 2024, revealed Resident 3's family member is involved in resident care and visits with resident at the facility.  Resident 3's admission record form indicated the resident has identified a family member as his resident representative.  A review of an admission Minimum Data Set assessment (MDS-a federally mandated	F 0553		

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F 0553  SS=D	Continued from page 5  standardized assessment process conducted periodically to plan resident care) dated September 4, 2024, revealed that Resident 3 is severely cognitively impaired with a BIMS score of 06 (Brief Interview for Mental Status- a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 00-07 indicates severe cognitive impairment).  A clinical record review revealed no documented evidence that Resident 3 or Resident 3's representative were invited to participate in or attended his November 2024 quarterly interdisciplinary care plan meeting.  During an interview on January 2, 2025, at approximately 11:00 AM, the Director of Nursing (DON) confirmed there was no documented evidence that Resident 3 or Resident 3's representative participated in or were invited to participate in the resident's care plan development. The DON confirmed it is the facility's responsibility	F 0553		

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F 0553  SS=D	Continued from page 6  to afford residents and their designated representatives the right to participate in the development of the resident's plan of care.  28 Pa. Code 201.29(a) Resident rights.  28 Pa. Code 211.12(d)(3) Nursing services.	F 0553			

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P 5510	<p>Nursing services.</p> <p>(2) Effective July 1, 2023, a minimum of 1 nurse aide per 12 residents during the day, 1 nurse aide per 12 residents during the evening, and 1 nurse aide per 20 residents overnight.</p> <p>This REGULATION is not met as evidenced by:</p>	P 5510	<ol style="list-style-type: none"> <li>1. Facility cannot retroactively correct past nursing ratios.</li> <li>2. Facility continues to recruit for open nursing positions through online systems and fliers and utilize agency staff.</li> <li>3. Facility implemented system of daily staffing meetings to ensure efforts were met to meet the necessary ratios. Nursing scheduler was educated on this new process.</li> <li>4. NHA will audit ratios weekly for 4 weeks and then monthly for 2 months to ensure CNA ratios are met.</li> <li>5. Audits will be submitted to QAPI for review.</li> </ol>	<p>Completion Date: <b>01/27/2025</b></p> <p>Status: <b>APPROVED</b></p> <p>Date: <b>01/27/2025</b></p>

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P 5510	Continued from page 1  Based on a review of nurse staffing and staff interview, it was determined the facility failed to ensure the minimum nurse aide staff to resident ratio was provided on each shift for seven shifts out of the 21 reviewed.  Findings include:  A review of the facility's weekly staffing records revealed that on the following date the facility failed to provide minimum nurse aide staff of 1:12 on the day shift, based on the facility's census:  December 21, 2024- 7.28 NAs on the day shift, versus the required 8.5 for a census of 102. December 24, 2024- 7.78 NAs on the day shift, versus the required 8.5 for a census of 102. December 25, 2024- 8.09 NAs on the day shift, versus the required 8.5 for a census of 102. December 26, 2024- 7.75 NAs on the day shift, versus the required 8.5 for a census of 102.  A review of the facility's weekly staffing records	P 5510		

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P 5510	<p>Continued from page 2</p> <p>revealed that on the following date the facility failed to provide minimum nurse aide staff of 1:12 on the evening shift, based on the facility's census:</p> <p>December 24, 2024- 5.09 NAs on the night shift, versus the required 8.42 for a census of 101.</p> <p>A review of the facility's weekly staffing records revealed that on the following date the facility failed to provide minimum nurse aide staff of 1:20 on the night shift, based on the facility's census:</p> <p>December 24, 2024- 4.5 NAs on the night shift, versus the required 5.1 for a census of 102. December 25, 2024- 4.06 NAs on the night shift, versus the required 5.0 for a census of 100.</p> <p>On the above dates mentioned no additional excess higher-level staff were available to compensate this deficiency.</p> <p>An interview with the Director of Nursing, on</p>	P 5510		

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P 5510	Continued from page 3	P 5510		
P 5520	<p>January 2, 2025, at approximately 12:30 PM, confirmed the facility had not met the required nurse aide to resident ratios on the above dates.</p> <p>Nursing services.</p> <p>(3) Effective July 1, 2024, a minimum of 1 nurse aide per 10 residents during the day, 1 nurse aide per 11 residents during the evening, and 1 nurse aide per 15 residents overnight.</p> <p>This REGULATION is not met as evidenced by:</p>	P 5520	<ol style="list-style-type: none"> <li>1. Facility cannot retroactively correct past nursing ratios.</li> <li>2. Facility continues to recruit for open nursing positions through online systems and fliers and utilize agency staff.</li> <li>3. Facility implemented system of daily staffing meetings to ensure efforts were met to meet the necessary ratios. Nursing scheduler was educated on this new process.</li> <li>4. NHA will audit ratios weekly for 4 weeks and then monthly for 2 months to ensure CNA ratios are met.</li> <li>5. Audits will be submitted to QAPI for review.</li> </ol>	<p>Completion Date: <b>01/27/2025</b></p> <p>Status: <b>APPROVED</b></p> <p>Date: <b>01/27/2025</b></p>

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P 5520	<p>Continued from page 4</p> <p>Based on a review of nurse staffing and staff interview, it was determined the facility failed to ensure the minimum nurse aide staff to resident ratio was provided on each shift for 17 shifts out of 21 reviewed.</p> <p>Findings include:</p> <p>A review of the facility's weekly staffing records revealed that on the following date the facility failed to provide minimum nurse aide staff of 1:10 on the day shift, based on the facility's census:</p> <p>December 20, 2024- 8.63 NAs on the day shift, versus the required 10.20 for a census of 102.                  December 21, 2024- 7.28 NAs on the day shift, versus the required 10.20 for a census of 102.                  December 22, 2024- 9.66 NAs on the day shift, versus the required 10.20 for a census of 102.                  December 24, 2024- 7.78 NAs on the day shift, versus the required 10.20 for a census of 102.                  December 25, 2024- 8.09 NAs on the day shift, versus the required 10.20 for a census of 102.</p>	P 5520		

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P 5520	Continued from page 5  December 26, 2024- 7.75 NAs on the day shift, versus the required 10.20 for a census of 102.  A review of the facility's weekly staffing records revealed that on the following date the facility failed to provide minimum nurse aide staff of 1:11 on the evening shift, based on the facility's census:  December 21, 2024- 9.19 NAs on the evening shift, versus the required 9.27 for a census of 102. December 23, 2024- 9.31 NAs on the evening shift, versus the required 9.36 for a census of 103. December 24, 2024- 5.09 NAs on the evening shift, versus the required 9.18 for a census of 101. December 25, 2024- 8.53 NAs on the evening shift, versus the required 9.27 for a census of 102.  A review of the facility's weekly staffing records revealed that on the following date the facility failed to provide minimum nurse aide staff of 1:15 on the night shift, based on the facility's census:  December 20, 2024- 6.59 NAs on the night shift,	P 5520		

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P 5520	Continued from page 6  versus the required 6.8 for a census of 102. December 21, 2024- 6.66 NAs on the night shift, versus the required 6.8 for a census of 102. December 22, 2024- 6.69 NAs on the night shift, versus the required 6.8 for a census of 102. December 23, 2024- 5.25 NAs on the night shift, versus the required 6.87 for a census of 103. December 24, 2024- 4.5 NAs on the night shift, versus the required 6.73 for a census of 101. December 25, 2024- 4.06 NAs on the night shift, versus the required 6.8 for a census of 102. December 26, 2024- 6.59 NAs on the night shift, versus the required 6.67 for a census of 100.  On the above dates mentioned no additional excess higher-level staff were available to compensate this deficiency.  An interview with the Director of Nursing, on January 2, 2025 at approximately 12:30 PM, confirmed the facility had not met the required nurse aide to resident ratios on the above dates.	P 5520		

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P 5520	Continued from page 7	P 5520		
P 5530	Nursing services.  (4) Effective July 1, 2023, a minimum of 1 LPN per 25 residents during the day, 1 LPN per 30 residents during the evening, and 1 LPN per 40 residents overnight.  This REGULATION is not met as evidenced by:	P 5530	1. Facility cannot retroactively correct past LPN ratios. 2. Facility continues to recruit for open nursing positions through online systems and fliers and utilize agency staff. 3. Facility implemented system of daily staffing meetings to ensure efforts were met to meet the necessary ratios. Nursing scheduler was educated on this new process. 4. NHA will audit LPN ratios weekly for 4 weeks and then monthly for 2 months to ensure LPN ratios are met. 5. Audits will be submitted to QAPI for review.	Completion Date: <b>01/27/2025</b> Status: <b>APPROVED</b> Date: <b>01/27/2025</b>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395875</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/02/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>GREENWOOD CENTER FOR NURSING AND REHAB</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>149 LAFAYETTE AVENUE TAMAQUA, PA 18252</b>		
STATE LICENSE NUMBER: <b>017902</b>				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
P 5530	<p>Continued from page 8</p> <p>Based on a review of nurse staffing and staff interview, it was determined the facility failed to ensure the minimum licensed practical nurse staff to resident ratio was provided on each shift for 14 shifts out of 21 shifts reviewed.</p> <p>Findings include:</p> <p>A review of the facility's weekly staffing records revealed that on the following dates the facility failed to provide minimum licensed practical nurse (LPN) staff of 1:25 on the day shift based on the facility's census.</p> <p>December 20, 2024 - 3.03 LPNs on the day shift, versus the required 4.08 for a census of 102.                  December 21, 2024 - 2.91 LPNs on the day shift, versus the required 4.08 for a census of 102.                  December 22, 2024 - 3.09 LPNs on the day shift, versus the required 4.08 for a census of 102.                  December 23, 2024 - 4.06 LPNs on the day shift, versus the required 4.08 for a census of 102.                  December 25, 2024 - 3.44 LPNs on the day shift,</p>	P 5530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395875</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/02/2025</b>
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P 5530	Continued from page 9  versus the required 4.08 for a census of 102. December 26, 2024 - 3.94 LPNs on the day shift, versus the required 4.08 for a census of 102.  A review of the facility's weekly staffing records revealed that on the following date the facility failed to provide minimum licensed practical nurse (LPN) staff of 1:30 on the evening shift based on the facility's census.  December 20, 2024 - 3.13 LPNs on the evening shift, versus the required 3.40 for a census of 102. December 21, 2024 - 2.06 LPNs on the evening shift, versus the required 3.40 for a census of 102. December 24, 2024 - 3.22 LPNs on the evening shift, versus the required 3.37 for a census of 101. December 25, 2024 - 3.13 LPNs on the evening shift, versus the required 3.40 for a census of 102.  A review of the facility's weekly staffing records revealed that on the following date the facility failed to provide minimum licensed practical nurse (LPN) staff of 1:40 on the night shift based on the facility's	P 5530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395875</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/02/2025</b>
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P 5530	Continued from page 10  census.  December 21, 2024 - 1.47 LPNs on the night shift, versus the required 2.55 for a census of 102. December 23, 2024 - 2.13 LPNs on the night shift, versus the required 2.58 for a census of 103. December 25, 2024 - 2.19 LPNs on the night shift, versus the required 2.55 for a census of 102. December 26, 2024 - 1.38 LPNs on the night shift, versus the required 2.5 for a census of 100.  On the above date mentioned no additional excess higher-level staff were available to compensate this deficiency.  An interview with the Director of Nursing on January 2, 2025, approximately 12:30 PM, confirmed the facility had not met the required LPN to resident ratio on the above dates.	P 5530		
P 5630		P 5630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395875</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/02/2025</b>
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P 5630	Continued from page 11  Nursing services.  (1) Effective July 1, 2023, the total number of hours of general nursing care provided in each 24-hour period shall, when totaled for the entire facility, be a minimum of 2.87 hours of direct resident care for each resident.  This REGULATION is not met as evidenced by:	P 5630	1. Facility cannot retroactively correct past nursing hours. 2. Facility continues to recruit for open nursing positions through online systems and fliers and utilizing agency staff. 3. Facility implemented system of daily staffing meetings to ensure efforts were met to meet the necessary nursing hours. Nursing scheduler was educated on this new process. 4. NHA will audit nursing hours weekly for 4 weeks and then monthly for 2 months to ensure CNA Nursing hours are met. 5. Audits will be submitted to QAPI for review	Completion Date: <b>01/27/2025</b> Status: <b>APPROVED</b> Date: <b>01/27/2025</b>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395875</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/02/2025</b>	
NAME OF PROVIDER OR SUPPLIER: <b>GREENWOOD CENTER FOR NURSING AND REHAB</b>  STATE LICENSE NUMBER: <b>017902</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>149 LAFAYETTE AVENUE TAMAQUA, PA 18252</b>		
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P 5630	<p>Continued from page 12</p> <p>Based on a review of nurse staffing and resident census and staff interview, it was determined the facility failed to consistently provide minimum general nursing care hours to each resident daily on three out of the seven days reviewed.</p> <p>Findings include:</p> <p>A review of the facility's staffing levels revealed that on the following dates the facility failed to provide minimum nurse staffing of 2.87 hours of general nursing care to each resident:</p> <p>December 21, 2024- 2.56 direct care nursing hours per resident. December 24, 2024- 2.56 direct care nursing hours per resident. December 25, 2024- 2.55 direct care nursing hours per resident.</p> <p>The facility's general nursing hours were below minimum required levels on the dates noted above.</p>	P 5630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395875</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/02/2025</b>
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P 5630	Continued from page 13  An interview with the Director of Nursing on January 2, 2025, at approximately 12:30 PM confirmed that the facility failed to consistently provide minimum general nursing care hours to each resident daily.	P 5630		
P 5640	Nursing services.  (2) Effective July 1, 2024, the total number of hours of general nursing care provided in each 24-hour period shall, when totaled for the entire facility, be a minimum of 3.2 hours of direct resident care for each resident.  This REGULATION is not met as evidenced by:	P 5640	<ol style="list-style-type: none"> <li>1. Facility cannot retroactively correct past nursing hours.</li> <li>2. Facility continues to recruit for open nursing positions through online systems and fliers and utilizing agency staff.</li> <li>3. Facility implemented system of daily staffing meetings to ensure efforts were met to meet the necessary nursing hours. Nursing scheduler was educated on this new process.</li> <li>4. NHA will audit nursing hours weekly for 4 weeks and then monthly for 2 months to ensure CNA Nursing hours are met.</li> <li>5. Audits will be submitted to QAPI for review</li> </ol>	Completion Date: <b>01/27/2025</b> Status: <b>APPROVED</b> Date: <b>01/27/2025</b>

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P 5640	Continued from page 14  Based on a review of nurse staffing and resident census and staff interview, it was determined the facility failed to consistently provide minimum general nursing care hours to each resident daily on six out of the seven days reviewed.  Findings include:  A review of the facility's staffing levels revealed that on the following dates the facility failed to provide minimum nurse staffing of 3.2 hours of general nursing care to each resident:  December 20, 2024- 2.93 direct care nursing hours per resident. December 21, 2024- 2.56 direct care nursing hours per resident. December 23, 2024- 2.96 direct care nursing hours per resident. December 24, 2024- 2.56 direct care nursing hours per resident. December 25, 2024- 2.55 direct care nursing hours per resident.	P 5640		

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P 5640	Continued from page 15  December 26, 2024- 3.01 direct care nursing hours per resident.  The facility's general nursing hours were below minimum required levels on the dates noted above.  An interview with the Director of Nursing on January 2, 2025, at approximately 12:30 PM confirmed that the facility failed to consistently provide minimum general nursing care hours to each resident daily.	P 5640			



# Certified End Page

**GREENWOOD CENTER FOR NURSING AND REHAB**

**STATE LICENSE NUMBER: 017902**

**SURVEY EXIT DATE: 01/02/2025**

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

  
Jeanne Parisi  
Deputy Secretary for Quality Assurance

  
Debra L. Bogen, MD, FAAP  
Secretary of Health



**Pennsylvania  
Department of Health**

THIS IS A CERTIFICATION PAGE

**PLEASE DO NOT DETACH**

THIS PAGE IS NOW PART OF THIS SURVEY