

Department of Health & Human Services  
Centers for Medicare & Medicaid Services

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Form Approved OMB  
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395344	(X2) MULTIPLE CONSTRUCTION  A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/15/2024
NAME OF PROVIDER OR SUPPLIER  Edenbrook of Greenwood Hill		STREET ADDRESS, CITY, STATE, ZIP CODE  420 Pulaski Drive Pottsville, PA 17901	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0565  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	<p>Honor the resident's right to organize and participate in resident/family groups in the facility.</p> <p>26142</p> <p>Based on a review of facility policy, the minutes from Resident Council meetings, and grievances lodged with the facility, and resident and staff interviews, it was determined that the facility failed to demonstrate sufficient efforts towards prompt resolution of continued resident complaints voiced during Resident Council meetings including those voiced by seven residents (Residents A4, A5, A6, A7, A8, A9, A10 and A11 ).</p> <p>The findings include:</p> <p>A review of facility policy for grievance program reviewed by the facility April 2023 revealed the process that upon receipt of a grievance, the grievance officer will designate an administrative staff member to investigate the concern. The goal of the facility is to investigate is to investigate the within 7 days. The administrative staff will determine what corrective actions. The resident or person filing the grievance will be informed of the findings of the investigation and the actions that will be taken to correct any identified problems and document on the appropriate concern form.</p> <p>A review of the minutes from the Resident Council meeting dated January 11, 2024, revealed that 22 residents attended the meeting. The residents reported that the council reviewed ongoing concerns and that facility staff reminded the residents that during meal tray pass that staff will answer call bells as soon as the meal trays are passed. The facility asked the residents to be mindful of when the meal is, and try to get their care needs done before meals.</p> <p>A review of resident concern forms filed during the Resident Council meeting dated January 11, 2024, reveled that Residents A4, A5, A6 and A7 voiced concerns that staff are going down the back stairs and smoking, Residents are able to smell staff smoking. The facility noted that the concern was addressed, and completed, dated Janaury 18, 2024, noting zero signs and symptoms of smoking in the stairwell. Will monitor.</p> <p>An additional concern form was filed on January 11, 2024, indicated that Residents A4, A5, A8, A7, A6, A11, A9 and A10 voiced complaints that, staff are more concerned about socializing with each other than doing their jobs after facility administration staff leave for the day. Staff telling you to go to their bed, go to your room, you don't belong here, you are in the wrong hallway. The facility indicated that concern was addressed, and noted the grievance resolution was completed, January 18, 2024, noting the resolution as education completed with staff.</p> <p>(continued on next page)</p>		

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER  
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0565  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	<p>There was no documented evidence at the time of the survey ending February 15, 2024, that any education was provided to the facility staff as a means to resolve the residents' complaints filed January 11, 2024, as the facility noted on the grievance form.</p> <p>A review of a resident concern forms filed during the resident council meeting dated January 11, 2024 reveled that Residents A4 and A9 also stated that, during the middle of the night, approximately between 2 AM and 3 AM staff is extremely loud. Difficult for residents to sleep. The facility indicated that this complaint was addressed and resolution completed, dated Janaury 24, 2024, and noted screaming/loudness is a resident with behaviors.</p> <p>During an interviw February 15, 2024 at approximately 12:30 PM Resident A9 stated that it takes nursing staff up to one hour to respond to her call bell when she rings for assistance. She stated that staff will respond to the call bell, turn the bell off and not return to provide care in a timely manner. She stated that this problem occurs daily. She stated that she had informed licensed nursing staff of the issue and it is still happening.</p> <p>The facility was unable to provide evidence at the time of the survey ending February 15, 2024, that the facility had determined if the residents' felt that their complaints or grievances had been resolved through any efforts taken by the facility in response to the residents concerns with untimely call bell response times, staff behavior and treatment of residents, and the disruptive behaviors of other residents.</p> <p>During an interview with the Nursing Home Administrator (NHA) on February 15, 2024, at 3 PM, the NHA confirmed that the facility was unable to demonstrate that reasonable efforts were taken to ascertain the effectiveness of the facility's efforts in resolving the residents ongoing complaints regarding untimely staff call bell response times, staff behavior and conduct, and the disruptive behaviors of other residents.</p> <p>28 Pa. Code 201.18 (e)(1)(2) Management</p> <p>28 Pa. Code 201.29 (c) Resident rights</p>		

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F 0584  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 26142</p> <p>Based on observations and staff interview, it was determined that the facility failed to provide housekeeping and maintenance services necessary to maintain a clean, safe, orderly and sanitary resident environment and resident care equipment and the second and third floors of the facility.</p> <p>Findings include:</p> <p>Observations of the first floor shower room during an environmental tour of the first floor shower room on February 15, 2024, at 1 PM revealed a strong urine odor emanating from an empty dirty linen cart. There was a black substance observed in between the floor and wall tiles in the shower. The shower chairs observed in the shower room were soiled with a brown material and hair was observed on the seat. An accumulation of lint and hair were observed occluding in the shower floor drains. Multiple white stains were observed on the mesh shower bed.</p> <p>There was a missing ceiling tile in the first floor resident hallway, outside of room [ROOM NUMBER]. There was water observed dripping from the ceiling into a large maintenance rolling cart.</p> <p>Observations of the second floor shower room, on February 15, 2024 at 1:15 PM revealed a black substance was observed in between the tiles on the floor and walls in the showers. An accumulation of debris and hair were observed occluding in the shower floor drains.</p> <p>Observations of the third floor shower room, February 15, 2024 at 1:30 PM revealed revealed a black substance was observed in between the tiles on the floor and walls in the showers. An accumulation of debris and hair were observed occluding in the shower floor drains.</p> <p>In room [ROOM NUMBER] bathroom, a plastic resident wash basin containing a dried brown substance was observed on the floor behind the toilet. There were 2 uncovered bed pans (urine collection devices) placed behind the hand rails on the wall in the bathroom.</p> <p>Interview with the Administrator on February 15, 2024, at approximately 3 PM confirmed that the residents' environment was to be maintained in a clean and sanitary manner.</p> <p>28 Pa. Code 201.18 (e)(2.1) Management</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 26142</p> <p>Based on a review of clinical records, the facility's abuse prohibition policy, and select facility incident reports and staff interview, it was determined that the facility failed to ensure that two residents out of 10 residents sampled were free from physical abuse (Residents A2 and A3 ) perpetrated by another resident (Resident A1).</p> <p>Findings include:</p> <p>Review of a facility policy entitled Abuse Policy - PA dated as reviewed August 14, 2023, defined abuse as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish. Abuse also includes the deprivation by an individual, caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Abuse includes verbal abuse, sexual abuse, physical abuse, and mental abuse. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. The facility's abuse policy indicated that it was the policy of the facility that each resident would be free from abuse. Additionally, residents will be protected from abuse, neglect, and harm while they are residing at the facility and that abuse or harm of any type would not be tolerated, and residents and staff would be monitored for protection. The facility would strive to educate staff and other applicable individuals in techniques to protect all parties. Further review of the abuse policy indicated that the facility's population presented as a factor that could result in maltreatment of residents such as residents with cognitive deficits, sensory deficits, aggressive behaviors, residents who have behaviors such as entering other residents' rooms, wandering behaviors, socially inappropriate behaviors, verbal outbursts, and residents with communication deficits. Additionally, the facility would ensure a comprehensive dementia management program to prevent resident abuse, if applicable.</p> <p>Clinical record review revealed that Resident A1 was admitted to the facility on [DATE] with diagnoses of DEGENERATIVE DISEASE OF NERVOUS SYSTEM, ALCOHOL USE, UNSPECIFIED WITH ALCOHOL-INDUCED PERSISTING DEMENTIA, and ALZHEIMER'S DISEASE WITH EARLY ONSET.</p> <p>An quarterly MDS assessment dated [DATE], revealed that the resident was severely, cognitively impaired, exhibited physical and verbal symptoms towards others, spoke only Spanish and required staff assistance with activities of daily living.</p> <p>A nurses note dated January 5, 2024, at 08:40 AM revealed that a nurse was in the hallway passing meds and heard a female resident (Resident A3) yelling at Resident A1. Resident A3 attempted to physically strike Resident A1 while she was yelling at him. Resident A1 became upset and yelled back at Resident A3 and struck her in the left shoulder/upper arm. The residents were immediately separated, 1:1 was provided to these residents.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of a facility investigation dated January 5, 2024, at 4:45 P.M. revealed that another incident had occurred on this same date, involving Resident A3 and A1. Resident A3 was walking down the hallway when Resident A1 struck her on the left side of her face. Resident A3 stated that she did not see Resident A1 due to her blindness in her right eye and bumped into him. Resident A3 stated that Resident A1 then pushed her into the wall and punched her.</p> <p>A review of a nurses note dated January 5, 2024, at 4:28 P.M revealed that while charting heard residents yelling, when staff entered hallway from desk, Resident A1 was observed to strike a female resident (Resident A3) in the face on her left side for no apparent reason, female resident was ambulating in the hallway with another resident with her coloring papers and pencils to color when she was struck by Resident A1. The residents were immediately removed from each other, staff speaking with resident calmly to help him calm, RN supervisor immediately called and up to unit, PA-C (physician assistant) up to unit, social services up to unit, crisis called, RP called, 911 called, ER called and report given, resident sent to ER, 302, resident left for ER via stretcher with 2 attendants.</p> <p>A review of a nurses note dated January 10, 2024 at 12:55 P.M. Resident A1 readmitted to the facility.</p> <p>A review of a nurses note dated January 10, 2024, at 10:44 P.M. revealed that Resident A1 became aggravated in the dining room when nurse aides attempted to transfer him to scale chair to get his weight. Resident A1 grabbed the arm of Resident A2 a severely cognitively impaired resident. Resident 2 did not receive a visible sign of any injury and was immediately removed from the situation.</p> <p>A review of a facility investigation report dated February 1, 2024, at 2:15 P.M. revealed the Arcadia unit (locked dementia unit) nurse heard a male resident (Resident A1) yelling in Spanish and a female voice (Resident A3) yelling help me, help me, he is hitting me, coming from down the hall. The nurse immediately ran to Resident A3's room. When the nurse attempted to open the door to Resident A3's room, the nurse saw Resident A1 behind the door with Resident A3 in front of him, with her back up against the bathroom door.</p> <p>A review of a witness statement dated February 1, 2024, employee 1 (LPN) stated this nurse was at the nurses station when I heard a resident yelling in Spanish and a women's voice yelling help me, help me coming from down the hall. The yelling came from Resident A3's room. When I went to open the door, it only opened not quite one half way. I squeezed through the door. When I got through the door, I saw Resident A1 behind the door standing in front of Resident A3 who had her back up against the bathroom door. Resident A1 was removed from the room and away from Resident A3.</p> <p>A review of a nurses note dated February 1, 2024 3:05 P.M. revealed that nursing noted This nurse was at the nurses station charting when she heard yelling in Spanish and a woman's voice yelling help me! He's hitting me coming from down the hall. I immediately ran down the hall yelling no! The yelling was coming from inside room [ROOM NUMBER]. When I went to open the door it only opened not quite half way. I squeezed through the door. When I got through the door I saw Resident A1 behind the door standing in front of another resident (Resident A3)who had her back up against the bathroom door. I immediately began redirecting Resident A1 away from the other resident.</p> <p>The intervention implemented following the incident was to place Resident A1 on 1 to 1 supervision.</p> <p>(continued on next page)</p>		

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F 0600  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	Interview with the administrator on February 15, 2024 at 3:00 PM confirmed that the facility failed to consistently monitor intrusive wandering and adequately supervise Resident A1 whereabouts and behavior to prevent physical abuse of other residents including Residents A2 and A3.  28 Pa. Code 201.18 (e)(1)(3) Management.  28 Pa. Code 201.29 (a)(c) Resident Rights.  28 Pa. Code 211.12 (d)(3)(5) Nursing Services.		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>21738</p> <p>Based on review of clinical records and staff interview it was determined the facility failed to provide care and services according to accepted standards of clinical practice for initiation of comfort measures (care that is focused on symptom control, pain relief, and quality of life) based on established standards and facility policy to ensure staff awareness of the services and care that will be provided to the resident, with evidence of involvement the resident's designated representative, for one of three residents sampled (Resident B2).</p> <p>Findings include:</p> <p>Review of the clinical record revealed that Resident B2 had diagnoses, which include dementia (group of symptoms affecting intellectual and social abilities severely enough to interfere with daily functioning).</p> <p>A nurses note dated February 8, 2024, at 10:23 AM noted that the resident was unresponsive at that time. Using accessory muscle slightly while breathing. No distress noted. Color pale. No mottling noted at this time. Physician called and updated. New orders for comfort medications. Resident representative made aware of resident's decline. No questions or concerns voiced.</p> <p>A physician order dated February 8, 2024, was noted for Morphine Sulfate oral solution 20 mg/ml give 0.25 ml every two hours as needed for pain/shortness of breath to maintain comfort.</p> <p>A nurses note dated February 8, 2024, at 10:25 AM was noted that the results of a urinalysis were finalized at this time and the physician made aware of same. It was noted, however, due to end-of-life care being provided at this time, no treatment was ordered. The resident's representative was made aware. The entry noted that Per physician will be in before noon to see resident. Awaiting response of discontinuation of all oral medications other than comfort medications.</p> <p>A nurses note dated February 8, 2024, at 10:40 AM noted that call was received from the resident's responsible party requesting an update on the resident. Full physical evaluation completed at this time by nurse. Noted resident not alert, responds to painful stimuli only. Vitals obtained and noted Blood pressure 86/74; temperature 98.6 degrees Fahrenheit; Pulse ox 98% (on oxygen at 2L/min); respirations 18. Call placed back to responsible party who requested that the resident be sent to the emergency room . Physician notified and order to transfer resident to the emergency room for evaluation received.</p> <p>Review of the hospital history and physical notes dated February 8, 2024, indicated the resident was admitted to the hospital for diagnoses, which included acute kidney injury, dehydration, urinary tract infection, and altered mental status.</p> <p>Further review of the clinical record revealed no documented evidence of a physician order for comfort measures. There was no documented evidence of a discussion between the physician and the resident representative to ensure agreement with the physician indication for comfort measures and to withhold treatment (i.e, antibiotics for a urinary tract infection).</p> <p>(continued on next page)</p>		

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F 0658  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	<p>At the time of the survey, the facility was unable to provide an established policy and corresponding procedures defining the facility's approach to providing comfort care, and those treatments and services.</p> <p>A nurses note dated February 14, 2024, at 4:24 PM noted that Resident B2 was readmitted to the facility.</p> <p>Interview with the director of nursing (DON) on February 15, 2024, at approximately 3:15 PM failed to provide documented evidence of the clinical rationale or specifics of the resident's clinical condition resulting in the physician decision for comfort care prior to the resident's recent hospitalization for treatment as requested by the resident's family. The DON confirmed that the resident was not currently on comfort measures at the time of the survey, following the resident's hospitalization and treatment. The DON failed to provide documented evidence of the criteria/facility policy for placing a resident on comfort measures.</p> <p>28 Pa. Code 211.12 (c)(d)(1)(2)(5) Nursing Services</p> <p>28 Pa. Code 211.10 (a)(c)(d) Resident Care Policies</p>		



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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 26142</p> <p>Based on a review of select facility policy and clinical records, observations, and staff interview it was determined that the facility failed to develop and implement effective person-centered plans to address dementia-related behavioral symptoms displayed one resident out of 10 sampled (Resident A1).</p> <p>Findings included</p> <p>Clinical record review revealed that Resident A1 was admitted to the facility on [DATE] with diagnoses to include, DEGENERATIVE DISEASE OF NERVOUS SYSTEM, ALCOHOL USE, UNSPECIFIED WITH ALCOHOL-INDUCED PERSISTING DEMENTIA, and ALZHEIMER'S DISEASE WITH EARLY ONSET.</p> <p>An quarterly MDS assessment dated [DATE], revealed that the resident was severely, cognitively impaired, exhibited physical and verbal symptoms towards others, spoke only Spanish and required staff assistance for activities of daily living.</p> <p>A review of the resident's care plan addressing the resident's Physical Aggression, Verbal Aggression, refusing</p> <p>cares, throwing communication boards away, yelling at self in window/reflection, yelling at staff/other residents and sexually inappropriate with staff dated July 09, 2023, and last revised on February 8, 2024 revealed interventions for the following: Resident has a language barrier, will be redirected, translation will be provided when</p> <p>needed. If reasonable, discuss The resident's behavior. Explain/reinforce why behavior is</p> <p>inappropriate and/or unacceptable to the resident. Date Initiated: 07/09/2023 Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. Date Initiated: 07/09/2023 Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and</p> <p>potential causes. Date Initiated: 07/09/2023. Resident has a language barrier, will be redirected, translation will be provided when needed Date Initiated: 07/11/2023. Throws communication boards/language communication boards away Date Initiated: 07/09/2023, Administer medications as ordered. Monitor/document for side effects and</p> <p>effectiveness. Date Initiated: 07/09/2023. Anticipate and meet The resident's needs. Date Initiated: 07/09/2023</p> <p>Caregivers to provided opportunity for positive interaction, attention. Stop and talk with him/her as passing by. Date Initiated: 07/09/2023 If reasonable, discuss The resident's behavior. Explain/reinforce why behavior is</p> <p>(continued on next page)</p>		

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>inappropriate and/or unacceptable to the resident. Date Initiated: 07/09/2023, Q 15 Min Safety Checks. Date Initiated: 12/18/2023, Revision on: 01/11/2024. Difficulty using interpreter devices/services due to dementia and impaired communication, Date Initiated: 02/08/2024. Placed on 1:1 observation after altercation with another resident. Date Initiated: 02/01/2024 Portable radio provided 02/08/2024</p> <p>Clinical record review revealed that Resident A1 displayed multiple instances of aggressive behavior towards staff and other residents from the date of his admission through the date of the survey ending February 15, 2024.</p> <p>Nursing documentation revealed the following:</p> <p>January 3, 2024, at 03:39 AM During dinner time Resident A1 became agitated &amp; combative. Yelling and trying to punch the nurse aides trying to redirect him back to his room so he can eat his dinner.</p> <p>January 5, 2024, at 08:40 AM the licensed nurse was in the hallway passing meds and heard a female resident yelling at Resident A1 , the female resident (Resident A3) attempted to physically strike Resident A1 while she was yelling at him, Resident A1 became upset and yelled back at her and struck her in the left shoulder/ upper arm.</p> <p>January 5, 2024, at 4:28 PM the licensed nurse heard residents yelling, when staff entered hallway from the nurse's desk Resident A1 was observed to strike a female resident in the face on her left side, crisis was called, RP called, 911 called, ER called and report given, resident sent to emergency room for emergency (302) psychiatric commitment.</p> <p>January 10, 2024, 12:55 PM Resident A1 returned from Hospital Stay related to his behaviors.</p> <p>January 10, 2024, at 10:44 PM resident A1 became aggravated in the dining room when nurse aides attempted to transfer him to scale chair to get his weight, he grabbed the arm of Resident A2 who did not receive a visible sign of any injury.</p> <p>January 17, 2024, at 2:52 PM Resident A1 was speaking to a female (non Spanish speaking resident) in Spanish and attempting to hold her arm. Staff intervened and separated residents immediately. Resident in and out of other residents' room most of the shift pulling things out their closets. Also pulling things off of the med cart. Not easily re-directed.</p> <p>January 20, 2024, at 3:02 PM Resident A1 in and out of rooms all shift moving/taking others belongings. Not easily redirected. When redirecting resident became agitated. At nurses' cart attempting to take computer mouse x 4 times.</p> <p>January 28, 2024, at 8:54 PM Resident A1 had several outbursts of anger this shift. Attempted to punch a CNA in her face as she was trying to keep him from touching another resident. Also had outbursts when entering other residents rooms &amp; being told no. Very difficult to redirect.</p> <p>January 28, 2024, 11:37 PM Resident A1 was being aggressive toward staff, yelling and cursing at the staff. Resident A1 put up his fist as if to hit one of the CNA's.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Edenbrook of Greenwood Hill		STREET ADDRESS, CITY, STATE, ZIP CODE  420 Pulaski Drive Pottsville, PA 17901	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>January 29, 2024, 15:18 PM Resident A1 rummaging throughout unit. Taking stuff from other rooms, off the medication cart, etc. Took a cup off of the counter in the dining room. When staff tried taking it resident flipped out almost hitting one of the aides. Resident kept attempting to take my computer and mouse off the medication cart. When trying to redirect he began yelling again.</p> <p>January 30, 2024, at 10:01 AM Resident A1 attempting to kiss and grab at aide during AM care.</p> <p>January 31, 2024, at 20:43 Resident A1 Going into other resident's rooms and taking their belongings. When approached by staff to retrieve items, became verbally abusive with staff and threatening with closed fist. Banged fists off of med cart, took mouse and computer from med cart.</p> <p>February 1, 2024, 3:05 PM Staff heard yelling in Spanish and a woman's voice yelling help me! He's hitting me coming from down the hall. I immediately ran down the hall yelling no! The yelling was coming from inside Resident A3's room. When I went to open the door it only opened not quite half way. I squeezed through the door. When I got through the door I saw Resident A1 behind the door standing in front of resident A3, who had her back up against the bathroom door. I immediately began redirecting Resident A1 away from the other resident.</p> <p>February 2, 2024, at 12:40 PM Resident A1 with increased agitation and sexually aggressive towards the CNA that was sitting in room this shift.</p> <p>February 8, 2024, at 6:32 PM Resident A1 was pacing in hallway and room. Took everything out of his closet and threw it on the floor. Entered dining room and attempted to take purse off of a female resident. When stopped by staff member, he went after staff member with closed fist, she jumped back out of his reach, he then attempted to kick her.</p> <p>February 9, 2024 at 08:54 AM when attempting care for Resident A1, he began yelling in Spanish and punched the licensed nurse in the ear.</p> <p>February 12, 2024 at 2:22 PM Resident A1 was taking all of his clothing out of his closet. Aide tried stopping him and he hit her in the arm.</p> <p>There was no indication that the facility had developed and implemented an individualized plan, including identifying and attempting purposeful and meaningful activities based on the resident's interests, past history or customary routines, and preferences, to address the resident's known dementia related behavior to promote the resident's quality of life of the resident Resident A1's highest practical level of psychosocial well-being and safety.</p> <p>Interview with the Nursing Home Administrator (NHA) on February 15, 2024, at approximately 2 PM confirmed the facility had not updated the resident's care plan for behaviors from July 2023, until February 2, 2024, when the facility placed the resident on 1:1 supervision after an altercation with another resident, and provided a portable radio on February 8, 2024, to address the resident's known dementia related behaviors to include yelling out, screaming out, cursing and verbally and physically assaulting residents and staff. The NHA stated that Resident A1 was not understood by the staff due to his Spanish dialect. He stated that he had advanced dementia and he was also not understood most of the time by the Spanish speaking staff.</p> <p>(continued on next page)</p>		

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F 0744  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	The NHA confirmed the facility failed to develop and implement effective individualized person-center interventions to minimize, modify or manage Resident A1's dementia-related behavior.  28 Pa Code 211.12 (d)(1)(3)(5) Nursing services		

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F 0745  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	<p>Provide medically-related social services to help each resident achieve the highest possible quality of life.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 21738</p> <p>Based on observation, review of clinical records, and resident and staff interview, it was revealed that the facility failed to provide therapeutic social services to promote the mental and psychosocial well-being of one resident out of 10 sampled (Resident B1).</p> <p>Findings include:</p> <p>A review of the clinical record revealed that Resident B1 was admitted to the facility on [DATE], with diagnoses to include cerebral infarction.</p> <p>A quarterly Minimum Data Set assessment (MDS-standardized assessment completed at specific intervals to identify specific resident care needs) dated November 28, 2023, revealed that the resident was cognitively intact, with a BIMS score of 15 ( Brief Interview for Mental Status (BIMS) section of the MDS which assesses cognition, a tool to assess the resident's attention, orientation, and ability to register and recall new information, a score of 13-15 equates to being Cognitively Intact).</p> <p>The resident's care plan initially dated July 25, 2023, indicated that the resident hoards objects in her room with potential conflict with other residents and staff. The goal was for the resident to have less episodes of hoarding. Interventions include to assist the resident with more appropriate methods of coping and interacting, were to encourage the resident to express feelings appropriately, if reasonable discuss the resident's behavior, explain/reinforce why the behavior is inappropriate and/or unacceptable to the resident, intervene as necessary to protect the rights and safety of others, inform resident that the behavior is not acceptable and suggest appropriate ways to express self.</p> <p>Observation of Resident B1's room (a four-bedded room he shared with other residents) on February 15, 2024, at 1:30 PM revealed multiple boxes filled with the resident's belongings and other accumulated items directly on the floor surrounding the resident's bed. During interview with Resident B1 the resident stated that she was fine and did not want to discuss the excessive amount of items accumulated in her room.</p> <p>At the time of the survey ending February 15, 2024, there was no documented evidence that the facility was providing therapeutic social services to addressing the resident's hoarding behavior and had implemented behavior modification plans.</p> <p>There was no documented evidence of the provision of therapeutic social services developed and planned to assist the resident with factors that may be contributing to the resident's hoarding. There was no documented discussion of possibly placing some items in the facility's resident storage area which would still allow Resident B1 to have access to her belongings in the facility.</p> <p>(continued on next page)</p>		

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F 0745  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	During an interview on February 15, 2024, at approximately 3:00 PM, the administrator confirmed that Resident B1's hoarding behavior is a concern. The administrator failed to provide documented evidence that the facility consistently provided the necessary therapeutic social services to assist and support Resident B1 with resolving her hoarding behavior to promote the resident's mental and psychosocial well-being while helping to ensure the resident's room is maintained in an orderly and sanitary manner.  28 Pa. Code 201.29 (a) Resident rights.		