

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395001	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2026
NAME OF PROVIDER OR SUPPLIER Passavant Retirement and Health		STREET ADDRESS, CITY, STATE, ZIP CODE 105 Burgess Drive Zelienople, PA 16063	

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)
<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy, review of clinical records, review of hospital records and staff interview, it was determined that the facility failed to provide care and services consistent with professional standards of practice by failing to follow physician-ordered bowel protocol for one of six residents (Resident R10) reviewed, which required hospitalization and actual harm resulting in fecal impaction, and failed to make certain that residents were provided appropriate preventative treatments for skin care for one of three residents (Resident R92). Findings include:</p> <p>Review of the facility policy Bowel Management dated 1/26/26, indicated it recognizes its obligation to assure that each resident is assessed and managed for adequate bowel elimination.</p> <p>Clinical record review revealed Resident R10 was admitted to the facility on [DATE], with diagnosis to include malignant neoplasm of prostate (uncontrolled growth of abnormal cells in the prostate gland), retention of urine and diabetes mellitus.</p> <p>Review of physician orders dated 11/8/25, included the following bowel protocol for Resident R10:</p> <p>Polyethylene glycol: dissolve 17 gm in liquid and take once daily as needed, diagnosis constipation.</p> <p>Dulcolax (bisacodyl) 10 mg rectal suppository. Rectal as needed every one day, diagnosis constipation.</p> <p>Fleet Enema 19 gram rectal as needed every one day, diagnosis constipation.</p> <p>Milk of Magnesia 400mg/5 mL oral suspension as needed every two days, diagnosis constipation.</p> <p>Review of Resident R10's bowel and bladder tracking documentation for December 2025 revealed that 5 days, 15 shifts passed between 12/12/25 and 12/16/25, without a bowel movement. A soft bowel movement was documented on 12/17/25.</p> <p>Review of Resident R10's Medication Administration Record (MAR) for December 2025, revealed nursing staff administered the physician -ordered bowel protocol on 12/15/26, 1 dose of polyethylene glycol.</p> <p>Review of progress notes dated 12/19/25 indicated Resident R10 had pallor, visible shaking noted, resident said he feels cold. Resident reported abdominal and back spasm. Physician was called and requested resident sent out for evaluation.</p> <p>Review of hospital diagnostic report dated 12/19/25 revealed a Computed Tomography Arterial (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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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Portography (CTAP) (advanced imaging technique that combines computed tomography with intravenous contrast, it's used to obtain cross-sectional images of abdominal and pelvic organs) was ordered due to increased abdominal pain, sweating and tachycardia.</p> <p>The CTAP scan of the resident's abdomen and pelvis completed on 12/19/25, revealed there is moderate to large stool burden in the rectum which is dilated up to 7cm with wall thickening and surrounding inflammatory change compatible with fecal impaction (stool becomes hard and stuck in the rectum) and stercoral proctitis (inflammation of the rectum caused by prolonged pressure from hard, impacted stool against the rectal wall).</p> <p>Review of hospital records revealed that Resident R10 had an enema in the hospital which resulted in a bowel movement.</p> <p>Interview with Licensed Practical Nurse (LPN) Employee E11 2/27/26 at 10:18 a.m. regarding bowel protocol indicated 3 days with no bowel movement, start with MOM (Milk of Magnesia), usually on 3-11, then next shift suppository, next shift is a fleets enema, if enema doesn't work call physician.</p> <p>Interview with Registered Nurse (RN) Employee E19 2/27/26 at 10:18 a.m. indicated there is a standard bowel protocol. No BM after 3 days, give mom or prune juice, daylight gives MOM, 3-11 gives suppository, then enema on nightshift if ineffective. It's a standard order, the orders are on resident profiles, it's basic protocol of facility.</p> <p>Interview with Registered Nurse (RN) Employee E12 on 2/27/26 at 10:20 a.m. indicated we monitor the documentation. There typically are orders for MOM, suppository, enema. They receive MOM after 3 days of no BM, then if none give suppository, if none, then enema. The night shift runs the bowel report and we proceed with it. There is an order set built into the admission orders.</p> <p>Interview with Licensed Practical Nurse (LPN) Employee E3 2/27/26 at 10:21 a.m. indicated we have a standard bowel protocol. 11p - 7 a staff keeps track of bowel movements, after 3 days of no BM, we start bowel protocol. Usually 11p - 7a looks it up, writes on report so we know, follow an order with MoM or prune juice, give it a shift. Protocol is prune juice, then MoM, then suppository, then enema. Everyone is ordered the bowel protocol; it's a standing prn order. All under PRN, unless the physician takes it out for some certain reason. Some physicians like other medications.</p> <p>Interview with Registered Nurse (RN) Employee E18 2/27/26 at 10:23 a.m. indicated aides record bowel movements (BM) in system, night shift runs a 24 hr. report and anyone with no BM for 3 days gets flagged, bowel protocol, then start- MiraLAX, MOM, if doesn't work, get suppository, then, an enema, then call physician.</p> <p>Interview with Licensed Practical Nurse (LPN) Employee E10 2/27/26 at 10:27 a.m. indicated after 3 days give MOM, then progresses with suppository, then enema, there is an order built with in the admit. The night shift nurse pulls up the report, and we get it and follow up.</p> <p>During an interview with Director of Nursing (DON) on 2/27/26, at 10:30 a.m. confirmed that the facility was unable to provide evidence that the physician ordered bowel protocol was followed for Resident R10 which resulted in hospitalization with fecal impaction.</p> <p>Review of the clinical record revealed that Resident R92 was admitted to the facility on [DATE]. (continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident R92's MD dated 2/7/26, indicated diagnoses of high blood pressure, dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and malnutrition (lack of sufficient nutrients in the body).</p> <p>Review of Resident R92's clinical record revealed a physician's order dated 7/6/25, for resident to wear Geri Sleeves (a protective sleeve designed for elderly or at-risk individuals to prevent skin tears, bruises, and abrasions) to protect resident's arms on in the morning and off at bedtime.</p> <p>During an observation and interview on 2/25/26, at 11:35 a.m. Resident was up in wheelchair with no Geri Sleeves. LPN Employee E16 confirmed that the facility failed to ensure that Resident R92 was wearing Geri Sleeves as ordered for preventative skin care.</p> <p>28 Pa. Code 211.10(a)(c) Resident policies.28 Pa. Code 211.12(d)(1)(5) Nursing services.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on facility policy, observations and staff interviews it was determined that the facility failed to maintain sanitary conditions in the dish room which created the potential for cross contamination in one of three households. (Mountain Laurel, Brandywine). Findings include: Review of facility policy Infection control for Household Dish room dated 1/26/26 indicated household dish rooms are appropriately disinfected. During an observation of dish room on 2/24/26, at 10:00 a.m. it was revealed two fans area above clean side of dish machine area had a build up of a black substance, dirt and grime on the mountain laurel, brandywine household. During an interview on 2/24/26, at 10:30 a.m. the Household Coordinator Employee E15 confirmed the brown substance on the fans in the dish room and that it has the potential to create cross contamination and food borne illness. 28 Pa Code: 201.14(a) Responsibility of licensee.</p>		

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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider for two of three residents sampled with facility-initiated transfers (Residents R5 and R102), and failed to provide a transfer notice to a representative of the Office of the Long-Term Care Ombudsman Division for three of three residents (Residents R5, R102, and R104). Findings include:</p> <p>Review of facility policy Transfer to Hospital/Emergency and Non-Emergency dated January 2026, indicated when medically indicated and desired by the resident (or by resident representative, if appropriate), resident will be transferred to the hospital with all necessary information to insure continuity of care.</p> <p>Review of the clinical record revealed Resident R5 was admitted to the facility on [DATE].</p> <p>Review of Resident R5's Minimum Data Set (MDS - a periodic assessment of care needs) dated 1/26/26, indicated diagnoses of hyperlipidemia (high levels of fats in the blood), depression, and history of falling.</p> <p>Review of the clinical record indicated Resident R5 was transferred to the hospital on 1/30/26, and returned to the facility on 2/2/26.</p> <p>Review of Resident R5's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals.</p> <p>Review of Resident R5's clinical record, the facility failed to include documented evidence that the facility provided a written transfer notification to the Office of Long-Term Care Ombudsman for the hospitalization on 1/30/26.</p> <p>During an interview on 2/26/26, at 2:09 p.m. Clinical Nurse Manager Employee E9 stated, We don't send a copy of the care plan to the hospital.</p> <p>Review of the clinical record indicated Resident R102 was admitted to the facility on [DATE].</p> <p>Review of Resident R102's MDS dated [DATE], indicated diagnoses of high blood pressure, hip fracture, and difficulty walking.</p> <p>Review of the clinical record indicated Resident R102 was transferred to the hospital on 1/15/26.</p> <p>Review of Resident R102's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility. (continued on next page)</p>		

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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident R102's clinical record, the facility failed to include documented evidence that the facility provided a written transfer notification to the Office of Long-Term Care Ombudsman for the hospitalization on 1/15/26.</p> <p>Review of the clinical record indicated Resident R104 was admitted to the facility on [DATE].</p> <p>Review of Resident R104's MDS dated [DATE], indicated diagnoses of diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), malnutrition (lack of sufficient nutrients to the body), and lack of coordination.</p> <p>Review of the clinical record indicated Resident R104 was transferred to home on [DATE].</p> <p>Review of Resident R104's clinical record, the facility failed to include documented evidence that the facility provided a written transfer notification to the Office of Long-Term Care Ombudsman for the discharge on [DATE].</p> <p>During an interview on 2/26/26, at 2:09 p.m. Clinical Nurse Manager Employee E9 confirmed that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider for two of three residents sampled with facility-initiated transfers (Residents R5 and R102).</p> <p>During an interview on 2/27/26, at 1:35 p.m. the Nursing Home Administrator (NHA) failed to provide additional documentation to indicate that the facility provides a written transfer notice to the Office of the Long-Term Care Ombudsman. During this interview, the NHA confirmed that the facility failed to provide a transfer notice to a representative of the Office of the Long-Term Care Ombudsman Division for three of three residents (Residents R5, R1102, and R104).</p> <p>28 Pa. Code: 201.14(a)Responsibility of licensee.28 Pa. Code: 201.29 (a)(c.3)(2) Resident rights.</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review, observation, and staff interview, it was determined that the facility failed to obtain informed consent before installation of bed rails for three of three residents (Residents R59, R72, and R94). Findings include: Review of facility policy Mobility Bars/Bedrails dated January 2026, indicated residents who attempt to exit a bed through, between, or over or around mobility bars or bed rails are at risk of injury or death. The benefits-to-risk ration of using a potentially restraining device must always be considered, and therefore staff and resident and/or family member must be educated about the risks of the device being considered in a comprehensive person-centered care plan. Review of the clinical record indicated Resident R59 was admitted to the facility on [DATE]. Review of Resident R59's Minimum Data Set (MDS - a periodic assessment of care needs) dated 1/6/26, indicated diagnoses of high blood pressure, hyponatremia (low levels of sodium in the blood), and hemiplegia (paralysis on one side of the body). Review of a physician order dated 1/1/26, indicated enabler bar: both side of bed for bed mobility. During an observation on 2/23/26, at 10:54 a.m. bilateral (both sides) enabler bars were observed on the top of Resident R59's bed. Review of Resident 59's clinical record revealed no documentation of a signed consent or a review of the risks and benefits of the use of the enabler bars with the Resident and/or their Resident Representative. Review of the clinical record revealed Resident R72 was admitted to the facility on [DATE]. Review of Resident R72's MDS dated [DATE], indicated diagnoses of anemia (too little healthy red blood cells in the body), high blood pressure, and arthritis (inflammation of one or more joints, causing pain and stiffness). Review of a physician order dated 2/15/26, indicated enabler bar: both sides of bed for bed mobility. During an observation on 2/23/26, at 12:02 p.m. bilateral enabler bars were observed on top of Resident R72's bed. Review of Resident 72's clinical record revealed no documentation of a signed consent or a review of the risks and benefits of the use of the enabler bars with the Resident and/or their Resident Representative. Review of the clinical record indicated Resident R94 was admitted to the facility on [DATE]. Review of Resident R94's MDS dated [DATE], indicated diagnoses of anemia, high blood pressure, and hyperlipidemia (high levels of fats in the blood). Review of a physician order dated 2/17/26, indicated enabler bar: both sides of bed for bed mobility. During an observation on 2/23/26, at 11:04 a.m. bilateral enabler bars were observed on top of Resident R94's bed. Review of Resident 94's clinical record revealed no documentation of a signed consent or a review of the risks and benefits of the use of the enabler bars with the Resident and/or their Resident Representative. During an interview on 2/26/26, at 12:24 p.m. Clinical Nurse Manager Employee E9 stated, We don't do consents for enabler bars because they aren't restraints. During an interview on 2/26/26, at 12:24 p.m. Clinical Nurse Manager Employee E9 confirmed that the facility failed to obtain informed consent before installation of bed rails for three of three (Residents R59, R72, and R94). 28 Pa. Code: 201.14 (a) Responsibility of licensee. 28 Pa. Code 211.10 (d) Resident care policies. 28 Pa. Code: 211.12 (d)(1)(5) Nursing services.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>Based on review of facility policies, observations, and staff interviews, it was determined that the facility failed to store all drugs and biologicals in a safe, secure, and orderly manner for three of six medication rooms (Larkspur, Allegheny and Tionesta medication rooms). Findings include: Review of the facility policy Storage of Medications last reviewed January 2026, indicated medications and biologicals are stored safely, securely, and properly. Medication storage areas are kept clean, well lit, and free of clutter. During an observation completed on 2/24/26, at 12:19 p.m. the Larkspur Hall medication room contained: A black winter coat A black jacket A brown print bag containing a thermos One tube of ostomy paste that failed to be labeled with a name or date opened as required and an expiration date of 9/1/24. During an interview completed on 2/24/26, at 12:32 p.m. Licensed Practical Nurse (LPN) Employee E11 confirmed the observations and stated, the coat, jacket and bag are mine; I think the ostomy paste is Resident R51's. During an observation completed on 2/24/26, at 12:45 p.m. the Allegheny Hall medication room contained the following: One tube of lubricant jelly that failed to be labeled with a name or date opened as required. One can of saline wound wash that failed to be labeled with a name or date opened as required. During an interview completed on 2/24/26, at 12:47 p.m. LPN Employee E11 confirmed the above items failed to be labeled with a name or date opened as required. During an observation completed on 2/25/26, at 9:24 a.m. the Tionesta medication room contained the following: One bottle of hydrogen peroxide that failed to be labeled with a name or date opened as required. One tube of lubricant jelly that failed to be labeled with a name or date opened as required. During an interview completed on 2/25/26, at 9:29 a.m. Registered Nurse RN Employee E9 confirmed the above observations and that the facility failed to store all drugs and biologicals in a safe, secure, and orderly manner for three of three medication rooms (Larkspur, Allegheny and Tionesta medication rooms). 28 Pa. Code: 211.10(c) Resident care policies. 28 Pa. Code: 211.12(d)(2)(3) Nursing services.</p>		

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<p>F 0944</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program.</p> <p>Based on review of facility policy, facility in-service documentation, personnel files, and staff interviews, it was determined that the facility failed to provide training on the Quality Assurance and Performance Improvement (QAPI) program for five of seven staff members (Licensed Practical Nurse (LPN) Employee E3, Food Service Assistant (FSA) Employee E4, Nurse Aide (NA) Employee E5, Agency NA Employee E6, and NA Employee E7). Findings include: Review of facility policy Inservice - Mandatory Hours for Registered Nurses (RN) and Licensed Practical Nurses dated January 2026, indicated RNs and LPNs will be provided with opportunities to acquire annual continued education from in-services, self-studies, or seminars. Each nurse is responsible to attend in-services each anniversary year. The nurse will notify the Nursing Educator ahead of time if in-services are needed to meet their annual anniversary deadline. Review of facility policy Inservice - Mandatory Hours for Nurse Aides dated January 2026, indicated Nurse Aides will be provided with opportunities to acquire at least 12 hours annually of continued education from in-services or seminars, as required by OBRA (Omnibus Budget Reconciliation Act) regulations. The facility has high standards for the team members and has an obligation to provide continued training and education to help team members perform their jobs effectively. The nurse aide is required to complete the 12 hours of annual continued education prior to their annual review. Review of LPN Employee E3's personnel file indicated a date of hire on 3/31/21. Review of LPN Employee E3's personnel file did not include annual in-service training on the QAPI program from 3/31/24 through 3/31/25. Review of FSA Employee E4's personnel file indicated a date of hire on 10/20/08. Review of FSA Employee E4's personnel file did not include annual in-service training on the QAPI program from 10/20/24 to 10/20/25. Review of NA Employee E5's personnel file indicated a date of hire on 11/4/20. Review of NA Employee E5's personnel file did not include annual in-service training on the QAPI program from 11/4/24 through 11/4/25. Review of Agency NA Employee E6's personnel file indicated a date of hire on 9/30/20. Review of Agency NA Employee E6's personnel file did not include annual in-service training on the QAPI program from 9/30/24 through 9/30/25. Review of NA Employee E7's personnel file indicated a hire date on 8/21/18. Review of NA Employee E7's personnel file did not include annual in-service training on the QAPI program from 8/21/24 through 8/21/25. During an interview on 2/25/26, at 1:24 p.m. Clinical Nurse Educator Employee E8 confirmed that the facility failed to provide training on the QAPI program for five of seven staff members (LPN Employee E3, FSA Employee E4, NA Employee E5, Agency NA Employee E6, and NA Employee E7). 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.20(a)(d) Staff development.</p>		

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<p>F 0946</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide training in compliance and ethics.</p> <p>Based on review of facility policy, facility in-service documentation, personnel files, and staff interviews, it was determined that the facility failed to provide training on Compliance and Ethics for four of seven staff members (Licensed Practical Nurse (LPN) Employee E3, Food Service Assistant (FSA) Employee E4, Nurse Aide (NA) Employee E5 and Agency NA Employee E6). Findings include: Review of facility policy Inservice - Mandatory Hours for Registered Nurses (RN) and Licensed Practical Nurses dated January 2026, indicated RNs and LPNs will be provided with opportunities to acquire annual continued education from in-services, self-studies, or seminars. Each nurse is responsible to attend in-services each anniversary year. The nurse will notify the Nursing Educator ahead of time if in-services are needed to meet their annual anniversary deadline. Review of facility policy Inservice - Mandatory Hours for Nurse Aides dated January 2026, indicated Nurse Aides will be provided with opportunities to acquire at least 12 hours annually of continued education from in-services or seminars, as required by OBRA (Omnibus Budget Reconciliation Act) regulations. The facility has high standards for the team members and has an obligation to provide continued training and education to help team members perform their jobs effectively. The nurse aide is required to complete the 12 hours of annual continued education prior to their annual review. Review of LPN Employee E3's personnel file indicated a date of hire on 3/31/21. Review of LPN Employee E3's personnel file did not include annual in-service training on Ethics and Compliance from 3/31/24 through 3/31/25. Review of FSA Employee E4's personnel file indicated a date of hire on 10/20/08. Review of FSA Employee E4's personnel file did not include annual in-service training on Ethics and Compliance from 10/20/24 to 10/20/25. Review of NA Employee E5's personnel file indicated a date of hire on 11/4/20. Review of NA Employee E5's personnel file did not include annual in-service training on Ethics and Compliance from 11/4/24 through 11/4/25. Review of Agency NA Employee E6's personnel file indicated a date of hire on 9/30/20. Review of Agency NA Employee E6's personnel file did not include annual in-service training on Ethics and Compliance from 9/30/24 through 9/30/25. During an interview on 2/25/26, at 1:24 p.m. Clinical Nurse Educator Employee E8 confirmed that the facility failed to provide training on Compliance and Ethics for four of seven staff members (LPN Employee E3, FSA Employee E4, NA Employee E5, and Agency NA Employee E6). 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.20(a)(d) Staff development.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395001	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2026
NAME OF PROVIDER OR SUPPLIER Passavant Retirement and Health		STREET ADDRESS, CITY, STATE, ZIP CODE 105 Burgess Drive Zelienople, PA 16063	
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 0947</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.</p> <p>Based on review of facility policy, facility in-service documentation, personnel files, and staff interviews, it was determined that the facility failed to provide training on Dementia Management for four of seven staff members (Registered Nurse (RN) Employee E1, Nurse Aide (NA) Employee E2, Food Service Assistant (FSA) Employee E4, and NA Employee E5), and failed to ensure that two of four sampled Nurse Aides received a minimum of 12 hours of in-service education per year (NA Employee E5 and Agency NA Employee E6). Findings include: Review of facility policy Inservice - Mandatory Hours for Registered Nurses (RN) and Licensed Practical Nurses dated January 2026, indicated RNs and LPNs will be provided with opportunities to acquire annual continued education from in-services, self-studies, or seminars. Each nurse is responsible to attend in-services each anniversary year. The nurse will notify the Nursing Educator ahead of time if in-services are needed to meet their annual anniversary deadline. Review of facility policy Inservice - Mandatory Hours for Nurse Aides dated January 2026, indicated Nurse Aides will be provided with opportunities to acquire at least 12 hours annually of continued education from in-services or seminars, as required by OBRA (Omnibus Budget Reconciliation Act) regulations. The facility has high standards for the team members and has an obligation to provide continued training and education to help team members perform their jobs effectively. The nurse aide is required to complete the 12 hours of annual continued education prior to their annual review. Review of RN Employee E1's personnel file indicated a date of hire on 2/23/98. Review of RN Employee E1's personnel file did not include annual in-service training on Dementia Management from 2/23/25 through 2/23/26. Review of NA Employee E2's personnel file indicated a date of hire on 1/19/21. Review of NA Employee E2's personnel file did not include annual in-service training on Dementia Management from 1/19/25 through 1/19/26. Review of FSA Employee E4's personnel file indicated a date of hire on 10/20/08. Review of FSA Employee E4's personnel file did not include annual in-service training on Dementia Management from 10/20/24 to 10/20/25. Review of NA Employee E5's personnel file indicated a date of hire on 11/4/20. Review of NA Employee E5's personnel file did not include annual in-service training on Dementia Management from 11/4/24 through 11/4/25. Review of facility nurse aide training records revealed that NA Employee E5 did not receive 12 hours of in-service training from 11/4/24 through 11/5/25. The facility was unable to provide documented evidence that NA Employee E5 had received a minimum of 12 hours of in-service training yearly. Review of Agency NA Employee E6's personnel file indicated a date of hire on 9/30/20. Review of facility nurse aide training records revealed that Agency NA Employee E6 did not receive 12 hours of in-service training from 9/30/24 through 9/30/25. The facility was unable to provide documented evidence that Agency NA Employee E6 had received a minimum of 12 hours of in-service training yearly. During an interview on 2/25/26, at 1:24 p.m. Clinical Nurse Educator Employee E8 stated, Dementia and Behavioral training are done during the annual skills fair. I can go find documentation that employees attended. I'm not responsible for FSA Employee E4, I don't know what department he falls under. The facility failed to provide additional documentation that RN Employee E1, NA Employee E2, FSA Employee E4, and NA Employee E5 had annual in-service training on Dementia Management. During an interview on 2/25/26, at 1:24 p.m. Clinical Nurse Educator Employee E8 confirmed that the facility failed to provide training on Dementia Management for four of seven staff members (RN Employee E1, NA Employee E2, FSA Employee E4, and NA Employee E5) and failed to ensure that two of four sampled Nurse Aides received a minimum of 12 hours of in-service education per year (NA Employee E5 and Agency NA Employee E6). 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.20(a)(d) Staff development.</p>		

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<p>F 0949</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide behavior health training consistent with the requirements and as determined by a facility assessment.</p> <p>Based on review of facility policy, facility in-service documentation, personnel files, and staff interviews, it was determined that the facility failed to provide training on Behavioral Health for six of seven staff members (Registered Nurse (RN) Employee E1, Nurse Aide (NA) Employee E2, Food Service Assistant (FSA) Employee E4, NA Employee E5, Agency NA Employee E6, and NA Employee E7). Findings include: Review of facility policy Inservice - Mandatory Hours for Registered Nurses (RN) and Licensed Practical Nurses dated January 2026, indicated RNs and LPNs will be provided with opportunities to acquire annual continued education from in-services, self-studies, or seminars. Each nurse is responsible to attend in-services each anniversary year. The nurse will notify the Nursing Educator ahead of time if in-services are needed to meet their annual anniversary deadline. Review of facility policy Inservice - Mandatory Hours for Nurse Aides dated January 2026, indicated Nurse Aides will be provided with opportunities to acquire at least 12 hours annually of continued education from in-services or seminars, as required by OBRA (Omnibus Budget Reconciliation Act) regulations. The facility has high standards for the team members and has an obligation to provide continued training and education to help team members perform their jobs effectively. The nurse aide is required to complete the 12 hours of annual continued education prior to their annual review. Review of RN Employee E1's personnel file indicated a date of hire on 2/23/98. Review of RN Employee E1's personnel file did not include annual in-service training on Behavioral Health from 2/23/25 through 2/23/26. Review of NA Employee E2's personnel file indicated a date of hire on 1/19/21. Review of NA Employee E2's personnel file did not include annual in-service training on Behavioral Health from 1/19/25 through 1/19/26. Review of FSA Employee E4's personnel file indicated a date of hire on 10/20/08. Review of FSA Employee E4's personnel file did not include annual in-service training on Behavioral Health from 10/20/24 to 10/20/25. Review of NA Employee E5's personnel file indicated a date of hire on 11/4/20. Review of NA Employee E5's personnel file did not include annual in-service training on Behavioral Health from 11/4/24 through 11/4/25. Review of Agency NA Employee E6's personnel file indicated a date of hire on 9/30/20. Review of Agency NA Employee E6's personnel file did not include annual in-service training on Behavioral Health from 9/30/24 through 9/30/25. Review of NA Employee E7's personnel file indicated a hire date on 8/21/18. Review of NA Employee E7's personnel file did not include annual in-service training on Behavioral Health from 8/21/24 through 8/21/25. During an interview on 2/25/26, at 1:24 p.m. Clinical Nurse Educator Employee E8 stated, Dementia and Behavioral training are done during the annual skills fair. I can go find documentation that employees attended. I'm not responsible for FSA Employee E4, I don't know what department he falls under. The facility failed to provide additional documentation that RN Employee E1, NA Employee E2, FSA Employee E4, NA Employee E5, Agency NA Employee E6, and NA Employee E7 had annual in-service training on Behavioral Health. During an interview on 2/25/26, at 1:24 p.m. Clinical Nurse Educator Employee E8 confirmed that the facility failed to provide training on Behavioral Health for six of seven staff members (RN Employee E1, NA Employee E2, FSA Employee E4, NA Employee E5, Agency NA Employee E6, and NA Employee E7). 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.20(a)(d) Staff development.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, observation, and interviews with staff, it was determined that the facility failed to make certain residents were provided necessary treatment and services, consistent with professional standards of practice, for a pressure ulcer (PU/PUs- injuries to skin and underlying tissue resulting from prolonged pressure on the skin) for two of three residents (Resident R1, and R92). Findings include: Review of the facility policy Treatment of Wounds last reviewed January 2025 indicated that the facility will provide the treatment ordered by the physician. Review of the clinical record revealed that Resident R1 was admitted to the facility on [DATE]. Review of Resident R1's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 2/4/26, indicated diagnoses of high blood pressure, diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and chronic pain. Section M0300 indicated that a stage four pressure ulcer (pressure injury with full thickness skin loss with extensive destruction; tissue necrosis: or damage to muscle, bone or supporting structure) is present. Review of Pressure Ulcer list provided by the facility, dated 2/20/25, indicated that Resident R1 had stage four pressure ulcer on the left heel. Review of Resident R1's clinical record revealed a physician's order dated 2/3/26, for resident to wear Prevalon Boots (a medical device that is applied to the foot to relieve pressure and help reduce the risk of pressure injuries) at all times. Remove for hygiene and skin checks. During an observation and interview on 2/25/26, at 11:37 a.m. Resident was up in wheelchair with no Prevalon boots on. Licensed Practical Nurse (LPN) Employee E16 confirmed that the facility failed to ensure that Resident R1 was wearing Prevalon Boots as ordered. Review of the clinical record revealed that Resident R92 was admitted to the facility on [DATE]. Review of Resident R92's MD dated 2/7/26, indicated diagnoses of high blood pressure, dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and malnutrition (lack of sufficient nutrients in the body). Review of Resident R92's clinical record revealed a physician's order dated 3/4/25, for resident to wear Prevalon Boot on right foot at all times, and on left foot when in bed. During an observation and interview on 2/25/26, at 11:35 a.m. Resident was up in wheelchair with no Prevalon boots on. LPN Employee E16 stated that although Resident R92 currently does not have a pressure injury on her heel, resident tends to have the area re-open and that the boot was ordered for prevention of reoccurrence or pressure injury. LPN Employee E16 confirmed that the facility failed to ensure that Resident R92 was wearing a Prevalon Boot as ordered for prevention of pressure injuries. 28 Pa. Code: 201.29(a) Resident Rights.28 Pa. Code 211.10(c)(d) Resident Care Policies.28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review facility policies, observations, clinical records, and staff interviews it was determined that the facility failed to make certain that appropriate treatments and services were provided for the use of a suprapubic catheter (a thin flexible tube inserted through a small incision in the lower abdomen directly into the bladder to drain urine) as required for one of three residents (Resident R51). Findings include: Review of the facility Catheters Care; Urinary last reviewed 1/2026. Indicated the purpose of this procedure is to prevent infection of the resident's urinary tract. If the catheter material is contributing to obstruction, notify the physician and change the catheter if instructed to do so. Catheter irrigation may be ordered to prevent obstruction in residents at risk for obstruction. Review of the clinical record revealed that Resident R51 was admitted to the facility on [DATE]. Review of Resident 51's Minimum Data Set (MDS- a periodic assessment of needs) dated 1/21/26, indicated diagnoses of depression, dementia and Guillain-Barre syndrome (a condition that causes muscle weakness and numbness that can lead to paralysis). Section H0100 - Appliances indicated Resident R51 has an indwelling catheter. (including suprapubic catheter and nephrostomy tube). Review of physician orders dated 4/20/23, indicated Resident R51 has a suprapubic catheter. Review of Resident R51's physician orders dated 8/7/25, indicated flush catheter with 60 cubic centimeters (cc) for blockage. The order failed to indicate what to use to flush the catheter. During an interview completed on 2/26/26, at 2:16 p.m. Registered Nurse (RN) Employee E12 confirmed the order did not indicate what to use to flush the catheter and stated, it should and confirmed that the facility failed to make certain that appropriate treatments and services were provided for the use of a suprapubic catheter required for one of three residents (Resident R51). 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 211.10(c)(d) Resident care policies. 28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.</p>		

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<p>F 0691</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review, and staff interviews it was determined that the facility failed to obtain a physician order for care of an urostomy (surgical procedure that creates an opening in the abdomen wall to allow urine to exit the body when the bladder is not functioning properly) for one of three residents reviewed (Resident R7). Findings include: Review of facility policy Colostomy/Ileostomy/Urostomy Care last reviewed January 2026, indicated the purpose is to provide guidelines that will aid in preventing exposure of the resident's skin to fecal matter or urine. Review of the clinical record revealed that Resident R7 was admitted to the facility on [DATE]. Review of Resident R7s Minimum Data Set (MDS-periodic assessment of resident care needs) dated 2/11/26, indicated diagnoses of hypertension (high blood pressure), hemiplegia (one-sided paralysis) and depression. Section H0100 appliances indicated ostomy (including urostomy, ileostomy, and colostomy) present. Review of Resident R7's physician order dated 3/1/22, indicated urostomy care change appliance/bag every week and as needed. The order failed to include size and type of urostomy appliance to be used. Review of Resident R7's active current care plan failed to include size and type of urostomy appliance being used. During an interview completed on 2/26/26, at 10:30 a.m. Registered Nurse (RN) Employee E17 confirmed the order failed to include the size and type of urostomy appliance to be used and stated it should be and the current care plan did not include the size and type of urostomy appliance to be used and stated we cut to size and confirmed that the facility failed to obtain a physician order for care of an urostomy for one of three residents reviewed (Resident R7). 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12(d)(1)(2)(5) Nursing services</p>		

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<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to provide accurate and timely documentation related to offering the COVID-19 vaccination for one of five residents (Resident R88). Findings include: Review of facility policy Immunization Program dated January 2026, indicated when COVID-19 vaccine is available to the facility each resident will be offered the vaccine unless the immunization is medically contraindicated or the resident has already been vaccinated. Upon admission, if the above criteria is not met, reach Resident/Resident Representative will be provided educational material regarding the benefits and the risks of the COVID-19 vaccine. After reviewing educational information and the Immunization consent form, upon admission, the Resident/Resident Representative will sign the Immunization Consent form indicating their choice to accept or decline the COVID-19 vaccine. All documentation of acceptance or refusal must be transcribed on to the Immunization Consent form. Review of the clinical record revealed Resident R88 was admitted to the facility on [DATE]. Review of Resident R88's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/4/26, indicated diagnoses of anemia (too little health red blood cells in the body), high blood pressure, and dementia (a group of symptoms that affects memory, thinking and interferes with daily life). Question O0350 was coded no for Resident's COVID-19 vaccination is up to date. Review of Resident R88's clinical record failed to include documentation that the COVID-19 vaccination was offered and administered or declined. During an interview on 2/27/26, at 12:42 p.m. Infection Preventionist Employee E13 confirmed that the facility failed to provide accurate and timely documentation related to offering the COVID-19 vaccination for one of five residents (Resident R88). 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code 211.5(f) Medical records.</p>		

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<p>F 0941</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members.</p> <p>Based on review of facility policy, facility in-service documentation, personnel files, and staff interviews, it was determined that the facility failed to provide training on Effective Communication for one of seven staff members (Licensed Practical Nurse (LPN) Employee E3). Findings include: Review of facility policy Inservice - Mandatory Hours for Registered Nurses (RN) and Licensed Practical Nurses dated January 2026, indicated RNs and LPNs will be provided with opportunities to acquire annual continued education from in-services, self-studies, or seminars. Each nurse is responsible to attend in-services each anniversary year. The nurse will notify the Nursing Educator ahead of time if in-services are needed to meet their annual anniversary deadline. Review of LPN Employee E3's personnel file indicated a date of hire on 3/31/21. Review of LPN Employee E3's personnel file did not include annual in-service training on Effective Communication from 3/31/24 through 3/31/25. During an interview on 2/25/26, at 1:24 p.m. Clinical Nurse Educator Employee E8 confirmed that the facility failed to provide training on Effective Communication for one of seven staff members (LPN Employee E3). 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.20(a)(d) Staff development.</p>		

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<p>F 0942</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that staff members are educated on resident rights and facility responsibilities to properly care for its residents.</p> <p>Based on review of facility policy, facility in-service documentation, personnel files, and staff interviews, it was determined that the facility failed to provide training on Resident Rights for two of seven staff members (Licensed Practical Nurse (LPN) Employee E3 and Nurse Aide (NA) Employee E5). Findings include: Review of facility policy Inservice - Mandatory Hours for Registered Nurses (RN) and Licensed Practical Nurses dated January 2026, indicated RNs and LPNs will be provided with opportunities to acquire annual continued education from in-services, self-studies, or seminars. Each nurse is responsible to attend in-services each anniversary year. The nurse will notify the Nursing Educator ahead of time if in-services are needed to meet their annual anniversary deadline. Review of facility policy Inservice - Mandatory Hours for Nurse Aides dated January 2026, indicated Nurse Aides will be provided with opportunities to acquire at least 12 hours annually of continued education from in-services or seminars, as required by OBRA (Omnibus Budget Reconciliation Act) regulations. The facility has high standards for the team members and has an obligation to provide continued training and education to help team members perform their jobs effectively. The nurse aide is required to complete the 12 hours of annual continued education prior to their annual review. Review of LPN Employee E3's personnel file indicated a date of hire on 3/31/21. Review of LPN Employee E3's personnel file did not include annual in-service training on Resident Rights from 3/31/24 through 3/31/25. Review of NA Employee E5's personnel file indicated a date of hire on 11/4/20. Review of NA Employee E5's personnel file did not include annual in-service training on Resident Rights from 11/4/24 through 11/4/25. During an interview on 2/25/26, at 1:24 p.m. Clinical Nurse Educator Employee E8 confirmed that the facility failed to provide training on Resident Rights for two of seven staff members (LPN Employee E3 and NA Employee E5). 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.20(a)(d) Staff development.</p>		

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<p>F 0943</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation.</p> <p>Based on review of facility policy, facility in-service documentation, personnel files, and staff interviews, it was determined that the facility failed to provide training on Abuse, Neglect, and Exploitation for one of seven staff members (Nurse Aide (NA) Employee E5). Findings include: Review of facility policy Inservice - Mandatory Hours for Nurse Aides dated January 2026, indicated Nurse Aides will be provided with opportunities to acquire at least 12 hours annually of continued education from in-services or seminars, as required by OBRA (Omnibus Budget Reconciliation Act) regulations. The facility has high standards for the team members and has an obligation to provide continued training and education to help team members perform their jobs effectively. The nurse aide is required to complete the 12 hours of annual continued education prior to their annual review. Review of NA Employee E5's personnel file indicated a date of hire on 11/4/20. Review of NA Employee E5's personnel file did not include annual in-service training on Abuse, Neglect, and Exploitation from 11/4/24 through 11/4/25. During an interview on 2/25/26, at 1:24 p.m. Clinical Nurse Educator Employee E8 confirmed that the facility failed to provide training on Abuse, Neglect, and Exploitation for one of seven staff members (NA Employee E5). 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.20(a)(d) Staff development.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395001	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2026
NAME OF PROVIDER OR SUPPLIER Passavant Retirement and Health		STREET ADDRESS, CITY, STATE, ZIP CODE 105 Burgess Drive Zelienople, PA 16063	
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)		
<p>F 0945</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program.</p> <p>Based on review of facility policy, facility in-service documentation, personnel files, and staff interviews, it was determined that the facility failed to provide training on Infection Control for one of seven staff members (Nurse Aide (NA) Employee E5). Findings include: Review of facility policy Inservice - Mandatory Hours for Nurse Aides dated January 2026, indicated Nurse Aides will be provided with opportunities to acquire at least 12 hours annually of continued education from in-services or seminars, as required by OBRA (Omnibus Budget Reconciliation Act) regulations. The facility has high standards for the team members and has an obligation to provide continued training and education to help team members perform their jobs effectively. The nurse aide is required to complete the 12 hours of annual continued education prior to their annual review. Review of NA Employee E5's personnel file indicated a date of hire on 11/4/20. Review of NA Employee E5's personnel file did not include annual in-service training on Infection Control from 11/4/24 through 11/4/25. During an interview on 2/25/26, at 1:24 p.m. Clinical Nurse Educator Employee E8 confirmed that the facility failed to provide training on Infection Control for one of seven staff members (NA Employee E5). 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.20(a)(d) Staff development.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395001	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2026
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0575</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency.</p> <p>Based on observations and staff interview it was determined that the facility failed to have required postings for the facility in areas that are accessible to all residents with complete contact information for State Agency, Adult Protective Services, Medicaid Fraud Control Unit, and State Long-Term Care Ombudsman program posted in six of six neighborhoods (Brandywine, Mountain Laurel, Trillium, Tionesta, Allegheny, and Larkspur). Findings include: During an observation on 2/26/26, from 9:30 a.m. through 9:45 a.m. in all six neighborhoods there was a variety of information posted for residents. This information failed to include address, and email address for State Agency, and for Adult Protective Services, and failed to include an email address for Medicaid Fraud Control Unit, and also failed to include a name, address, and email for the Ombudsman as required. During an interview on 2/27/26, at 11:30 a.m. the Nursing Home Administrator confirmed that the facility failed to have required postings in areas that are accessible to all residents with complete contact information for State Agency, Adult Protective Services, Medicaid Fraud Control unit, and State Long-Term Care Ombudsman program as required. 28 Pa. Code: 201.14(a)Responsibility of licensee.28 Pa. Code: 201.18(b)(3) Management.</p>		