

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: 395243	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Laurel Ridge Center		STREET ADDRESS, CITY, STATE, ZIP CODE 75 Hickle Street Uniontown, PA 15401	
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 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility documents, clinical records, and staff interview, it was determined that the facility failed to implement procedures to ensure availability of prescribed medications. This failure resulted in an Immediate Jeopardy situation for four of 25 residents (Residents R1, R2, R3, and R4). Findings include: Review of the Facility Assessment for 2026, Quarter 1, indicated the facility will provide intravenous medications and treatment for infections. Under the Acuity - Care Requirements section indicated, We also admit residents with IV medications. Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS, periodic assessment of resident care needs) dated 6/21/26, included diagnoses of Diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), Peripheral Vascular Disease (PVD, circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), and Osteomyelitis (inflammation of bone or bone marrow, usually due to infection). Review of Section O: Special Treatments, Procedures, and Programs indicated Resident R1 had been receiving intravenous therapy at the time of admission. Review of hospital discharge paperwork dated 6/18/26, included a note from the infectious disease physician that indicated Resident R1 was ordered ceftaroline (Teflaro, broad-spectrum cephalosporin antibiotic administered intravenously for treating complicated skin and soft tissue infections). I am going to recommend IV antibiotics for several weeks along with clinical follow up. I do want to cover more broadly than just anaerobes. So, in addition to the Flagyl (antibiotic and antiprotozoal medication) I would like to have some aerobic Gram-negative and Gram-positive coverage with ceftaroline. Review of Resident R1's plan of care initiated 6/19/26, revealed Patient has osteomyelitis and is receiving IV antibiotics indicated the facility will, Administer antibiotics as ordered. Review of Resident R1's physician's order dated 6/18/26: Ceftaroline Fosamil Intravenous Solution Reconstituted Use 300 mg intravenously two times a day for sepsis (life-threatening reaction to an infection that causes your immune system to harm healthy tissues and organs). Review of Resident R1's June 2026 medication administration record (MAR) revealed Resident R1 did not receive ceftaroline, from admission [DATE]) through 6/24/26, when he was hospitalized to allow him to receive the missed antibiotic medication. Review of Resident R1's electronic MAR progress notes for the scheduled ceftaroline doses were documented as follows:-Medication not available / on back order from pharmacy, or-Not received from pharmacy pending insurance coverage, or-Pending pharmacy, or-Awaiting pharmacy. Review of Resident R1's progress notes failed to address the medication not being provided until note written by Registered Nurse (RN) Employee E3 dated 6/23/26, at 4:48 p.m. revealed, LM (left message) for [infectious disease physician] about antibiotic changes. Review of Resident R1's progress note dated 6/24/26, at 10:19 a.m. revealed infectious disease physician wanted Resident R1 to remain on the originally (continued on next page)		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 395243 If continuation sheet Page 1 of 10

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	ordered antibiotic. Review of a progress note dated 6/24/26, at 11:23 a.m. revealed Resident R1 was transferred to the hospital to receive medication. Interviews conducted with staff on 7/7/25, revealed all notifications to provider will be through Care Communications (the electronic communication platform) or if by telephone, a progress note will be entered into the electronic medical records system. Review of Resident R1's progress notes dated 6/18/26, through 6/24/26, failed to reveal notification to the nurse practitioner or to the physician related to Resident R1 not receiving his ceftaroline. Review of Care Communications revealed one entry related to Resident R1 not receiving his IV antibiotic, written by RN Employee E2, dated 6/22/26, at 11:47 p.m., Spoke with pharmacy regarding resident's iv ax (IV antibiotics) that was supposed to be started on 6/18 for SEPSIS. They said that they left a message on Friday regarding a co-pay of \$1,324.00 that would need approved. That is a Corporation issue - he was accepted on that antibiotic and needs to be on it!! Has he been getting it???? If he hasn't, there WILL be big problems!!! SOMEONE SHOULD BE FIRED. I don't know why pharmacy has such a problem getting antibiotics for our residents. Review of an electronic communication written by Resident R1's attending physician dated 6/26/26, at 7:14 p.m. indicated, Is anyone at the pharmacy going to be held accountable for this debacle? Totally unacceptable what happened because of them in my opinion. There was notification to me via the communication board 6 days after the patient was there that they didn't send an IV antibiotic. And the reason they gave, was because of COST!!! Good luck defending that in court when we agreed to accept him and treat him. But beyond that and much more important is that the fact that this gentleman did not receive proper treatment because of them. I do not know anybody who would be willing to accept this as a valid reason if it were one of their family members. I'm really not sure what it is about this pharmacy and delivering medications that are ordered. They delay controlled substances being delivered even though they have valid prescriptions confirmed electronically. Maybe I am mistaken, but I thought the main job of having this pharmacy was to deliver us medications that we order. If there is a problem, contact me immediately. I have NEVER had an issue with someone reaching out to me especially if it has to do with an antibiotic or medication not being covered. I get called for much less relevant issues and I am fine with that. Review of emergency room documentation dated 6/24/26, revealed Resident R1, Presents secondary to his nursing facility being unable to secure the ceftaroline. I spoke with the staff at [facility] and they advised that the patient has not yet received a dose of this antibiotic despite being at the facility since Thursday (6/18/26). They contacted the pharmacy and the pharmacy does not have an ETA for the antibiotic. They then spoke with [Infectious disease] office who spoke who advised that there were no alternatives. Patiently was subsequently sent here for admission for his IV antibiotics. Review of the hospital Discharge summary dated [DATE], revealed Resident R1, presented due to inability to receive IV antibiotics at SNF. Review of the clinical record indicated Resident R2 was admitted to the facility on [DATE]. Review of the MDS 4/29/26, dated included diagnoses of Hepatic Encephalopathy (decline in brain function caused by severe liver disease), Heart Failure (progressive heart disease that affects pumping action of the heart muscles), and End Stage Renal Disease (ESRD, an inability of the kidneys to filter the blood). Review of Section N: Medications indicated Resident R2 received antibiotic medication. Review of Resident R2's plan of care initiated 4/23/26, failed to include a care plan developed for the use of a gastrointestinal antibiotic. Review of Resident R2's physician's order dated 4/23/26, revealed Resident R2 was to receive Rifaximin (antibiotic that stays in gastrointestinal tract) 550 mg two times a day for hepatic encephalopathy. Review of June 2026 MAR and progress notes revealed Resident R2 did not receive rifaximin for 14 of 60 scheduled doses, on:6/1/26, PM dose: documented to see nurse's note on MAR. No nurse's note in EMR (electronic medical record).6/2/26, PM dose: Not available. On order.6/3/26, (continued on next page)		

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	PM dose: Pending pharmacy.6/5/26, AM dose: Unable to find and resident has an appointment.6/9/26, AM dose: Unable to find, not in Pyxis.6/10/26, AM dose: On order.6/24/26, PM dose: Pending pharmacy.6/25/26, PM dose: Med on order.6/26/26, PM dose: Pending pharmacy.6/27/26, PM dose: Pending pharmacy.6/28/26, AM dose: On back order.6/28/26, PM dose: Pending pharmacy.6/29/26, AM dose: On back order.6/29/26, PM dose: Pending pharmacy. Review of Resident R2's progress notes dated 6/1/26, through 6/30/26, failed to reveal notification to the nurse practitioner or to the physician related to Resident R2's not receiving his Rifaximin on the above dates. Review of Care Communications dated 6/1/26, through 6/30/26, failed to reveal notification to the nurse practitioner or to the physician related to Resident R2's not receiving his Rifaximin. During an interview on 7/9/26, at 12:49 p.m. the attending physician confirmed that he had not been made aware by facility staff that Resident R2 had not received his ordered antibiotics. Review of the clinical record indicated Resident R3 was admitted to the facility on [DATE]. Review of the MDS dated [DATE], included diagnoses of cancer, bacteremia (presence of bacteria in the bloodstream), and Klebsiella pneumoniae (a bacterium that can cause pneumonia, urinary tract infections, bloodstream infections, and other serious illnesses, often exhibiting antibiotic resistance). Review of hospital discharge paperwork dated 6/3/26, indicated Resident R3 was to receive intravenous ceftriaxone (Rocephin, antibiotic medication) and intravenous Linezolid (Zyvox, an antibiotic used to treat various bacterial infections, including pneumonia and skin infections). Review of the Clinical admission Assessment completed on 6/4/26, under the Care Planning section indicated Administer antibiotic therapy as prescribed was documented as not active. Review of the plan of care initiated 6/5/26, for Patient is receiving PO (by mouth) antibiotics related to abdominal wound infection indicated to Administer antibiotic as ordered. Further review of the plan of care failed to reveal goals and interventions developed for the use of intravenous antibiotic medications. Review of physician's orders dated 6/5/26, 6/6/26, 6/13/26, and 6/23/26, indicated Resident R3 was to receive ceftriaxone, two grams intravenously one time a day. Review of June 2026 MAR and progress notes indicated that Resident R3 did not receive Ceftriaxone on:6/05/26: Unable to complete/ on back order from pharmacy.6/11/26: Documented as held. Resident at CT scan, returned at approx. 1:30 p.m., no request to provider to see if it should be provided. 6/14/26: Medication not available/ on back order from pharmacy.6/15/26: Unavailable.6/24/26: Documented to see nurse's note on MAR. No nurse's note in EMR. Review of physician's orders dated 6/4/26, 6/5/26, 6/6/26, and 6/10/26, indicated Resident R3 was to receive linezolid, 600 mg intravenously two times a day. Review of physician's orders dated 6/22/26 and 6/23/26, indicated Resident R3 was to receive linezolid, 300 mg intravenously two times a day. Review of June 2026 MAR and progress notes indicated that Resident R3 did not receive linezolid IV infusions on:6/5/26, PM dose: Documented to see nurse's note on MAR. No nurse's note in emr.6/6/26, AM dose: awaiting from pharmacy.6/07/26, AM dose: not available.6/07/26, PM dose: Documented to see nurse's note on MAR. No nurse's note in emr.6/08/26, AM dose: Documented to see nurse's note on MAR. No nurse's note in emr.6/08/26, PM dose: med not available.6/09/26, AM dose: called pharmacy about IV ATB Linezolid Resident has not received this ATB since admission 6/6 reported to MD.6/09/26, PM dose: On order.6/10/26, PM dose: No documentation.6/11/26, AM dose: Documented as held. Resident at CT scan, returned at approx. 1:30 p.m., no request to provider to see if it should be provided. 6/16/26, PM dose: Documented as held. No note stating reason.Review of Resident R3's progress notes did not include a reason for the omissions. Review of Resident R3's progress notes dated 6/1/26, through 6/30/26, failed to reveal notification to the nurse practitioner or to the physician related to Resident R3's not receiving her ceftriaxone or linezolid on the above dates. Review of Care Communications dated 6/1/26, through 6/30/26, failed to reveal notification to the (continued on next page)		

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	nurse practitioner or to the physician related to Resident R3's not receiving her ceftriaxone or linezolid. During an interview on 7/9/26, at 12:49 p.m. the attending physician confirmed that he had not been made aware by facility staff that Resident R3 had not received her ordered antibiotics. Review of the clinical record indicated Resident R4 was admitted to the facility on [DATE]. Review of the MDS dated [DATE], included diagnoses of atrial fibrillation (disease of the heart characterized by irregular and often faster heartbeat), osteoarthritis (degeneration of the joint causing pain and stiffness), and history of cancer. Review of the plan of care initiated 5/23/25, for Patient has a suspected/actual infection, UTI (urinary tract infection) and is at risk for sepsis failed to include any updates after 10/14/25, Review of a physician's order dated 6/6/26, at 7:40 a.m. indicated Resident R4 was to receive meropenem (broad-spectrum intravenous antibiotic used to treat serious bacterial infections) one gram intravenously three times per day. The medication was scheduled to be received at 6:00 a.m., 2:00 p.m., and 10:00 p.m., with the first dose to be given on 6/6/26, at 2:00 p.m. Review of Resident R4's MAR and progress notes indicated that Resident R4 did not receive meropenem IV infusions on: 6/6/26, 2:00 p.m. dose: med not available 6/6/26, 10:00 p.m. dose: No documentation. 6/7/26, 6:00 a.m. dose: unable to get IV access, med not delivered. 6/7/26, 2:00 p.m. dose: awaiting on medication from pharmacy; Supervisor aware. 6/7/26, 10:00 p.m. dose: pending pharmacy. 6/8/26, 6:00 a.m. dose: no IV site to administer medication. Review of Resident R4's progress notes dated 6/5/26, through 6/10/26, failed to reveal notification to the nurse practitioner or to the physician related to Resident R4's not receiving her meropenem on the above dates. Review of Care Communications dated 6/5/26, through 6/10/26, failed to reveal notification to the nurse practitioner or to the physician related to Resident R4's not receiving her meropenem. On 7/8/26, at 9:20 a.m. the Nursing Home Administrator (NHA) and the Interim Director of Nursing (DON) were made aware that an Immediate Jeopardy situation existed and a corrective action plan was requested. The Immediate Jeopardy template was provided to the facility administration at this time. On 7/8/26, at 3:20 p.m. an acceptable Corrective Action Plan was reviewed which included the following interventions: R1 has been discharged from the facility. Upon identification that the resident did not receive the prescribed antibiotic for six days due to unavailability, the resident was immediately assessed by licensed nursing staff and founder of no adverse reaction. The provider was notified of the delaying antibiotic therapy period out of concern for further delay and potential for worsening infection, the patient was transferred to the hospital for evaluation with received prescribed antibiotic. R2 for the month of June, the patient was found to have missed 14 out of 60 doses of Rifaximin. Upon identification, the patient was immediately assessed with no adverse reaction to the patient. The patient is now receiving the medication as prescribed by the provider. R3 has been discharged from the facility The resident was found to have missed several doses of their prescribed antibiotic. Upon identification, the patient was immediately assessed with no adverse reaction. The patient's antibiotic stop date was extended to ensure that the patient received the required doses prescribed by the provider. An initial audit of the current residents will be conducted by the Director of Nursing or designee for the past seven days to verify medications were available from the pharmacy and administered as per MD (Doctor of Medicine) orders. Any residents identified with unavailable meds will have the provider notified and mediation will be adjusted if indicated as per provider. Will be completed by 7/8/26. The DON/designee conducted mandatory re-inservicing for facility licensed nurses and licensed agency nurses prior to the start of their next shift on the Medication Shortage, with the focus on notification to the provider and pharmacy for missing medications, medication administration, ordering of medications, and medication error policies. Education will include the process for obtaining medications from RxNow (medication dispensing machine) cabinet and notifying (continued on next page)		

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	physician, or medication change if indicated. The DON/designee will review new admissions on the following day to verify medications were delivered and administered as per the MD orders. Pharmacy and provider will be notified of any identified unavailable medications. Ad hoc QAPI (Quality Assurance and Performance Improvement) meeting - Completed 7/7/26. NHA/DON/designee sched a meeting on 7/8/26, with the pharmacy consultant to review concerns with medication availability and will schedule weekly x4 meetings, then monthly x2, to review any identified trends. The Admissions Director will review scheduled admissions prior to arrival to verify medication availability from the pharmacy. If medication is not available, the Admissions Director will notify the hospital for a medication adjustment prior to discharge from the hospital. DON or designee to conduct weekly x4, then monthly x2 audits of five residents on each medication cart to verify medications were available from the pharmacy and administered as per MD orders. Results of the audits to be presented at the QAPI meetings for review and recommendations. Review of resident clinical records and facility provided audit on 7/9/26, confirmed that all residents were reviewed for missed medications and the attending physician was notified. Review of facility-provided sign-in sheets, dated 7/8/26, and 7/9/26, confirmed reeducation was provided to all licensed nurses provider notification, actions to take if medications are not available, ordering medications, and documentation. During interviews conducted on 7/9/26, confirmed two of two registered nurses and two of two licensed practical nurses received reeducation on provider notification, actions to take if medications are not available, ordering medications, and documentation. Review of facility documents confirmed a meeting was completed with the NHA, DON, and the pharmacy consultant on 7/8/26, in which the process for reordering medications, pharmacy communication, procedure for missed medications, incomplete and/or inaccurate prescriptions, and the use of the RxNow dispensing unit were reviewed. The Immediate Jeopardy was lifted on 7/9/26, at 11:30 a.m. when the action plan implementation was verified. During an interview on 7/9/26, at approximately 12:15 p.m. the Nursing Home Administrator and the Interim Director of Nursing confirmed that the facility failed to implement procedures to ensure availability of prescribed medications. This failure resulted in an Immediate Jeopardy situation for four of 25 residents 28 Pa. Code 201.14(a) Responsibility of Licensee 28 Pa. Code 211.9(a)(1) Pharmacy Services 28 Pa. Code 211.10(c) Resident Care Policies 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility documents, clinical records, and staff interview, it was determined that the facility failed to notify the medical provider of the inability to provide ordered antibiotic medications for four of 25 residents (Residents R1, R2, R3, and R4). Findings include: Review of the facility policy, Physician / Advanced Practice Provider (APP) Notification dated 5/15/26, indicated an effective process for next day notification must be in place and communicated to all physicians/APPs and licensed nurses. During staff interviews completed on 7/7/25, indicated all notifications to provider will be through Care Communications (the electronic communication platform) or if by telephone, a progress note will be entered into the electronic medical records system. Review of a physician's order for Resident R1 dated 6/18/26: Ceftriaxone Fosamil Intravenous Solution Reconstituted Use 300 mg intravenously two times a day for sepsis (life-threatening reaction to an infection that causes your immune system to harm healthy tissues and organs). Review of Resident R1's June 2026 medication administration record (MAR) indicated that Resident R1 did not receive ceftriaxone, from admission [DATE] through 6/24/26, when he was hospitalized to allow him to receive the missed antibiotic medication. Review of Resident R1's progress notes dated 6/18/26, through 6/24/26, failed to reveal notification to the nurse practitioner or to the physician related to Resident R1 not receiving his ceftriaxone. Review of Care Communications revealed one entry related to Resident R1 not receiving his IV antibiotic, written by RN Employee E2, dated 6/22/26, at 11:47 p.m., Spoke with pharmacy regarding resident's iv ax (IV antibiotics) that was supposed to be started on 6/18 for SEPSIS. They said that they left a message on Friday regarding a co-pay of \$1,324.00 that would need approved. That is a Corporation issue - he was accepted on that antibiotic and needs to be on it!! Has he been getting it???? If he hasn't, there WILL be big problems!!! SOMEONE SHOULD BE FIRED. I don't know why pharmacy has such a problem getting antibiotics for our residents. Review of an electronic communication written by Resident R1's attending physician dated 6/26/26, at 7:14 p.m. indicated, There was notification to me via the communication board 6 days after the patient was there that they didn't send an IV antibiotic. If there is a problem, contact me immediately. I have NEVER had an issue with someone reaching out to me especially if it has to do with an antibiotic or medication not being covered. I get called for much less relevant issues and I am fine with that. Review of Resident R2's physician's order dated 4/23/26, indicated Resident R2 was to receive Rifaximin (antibiotic that stays in gastrointestinal tract) 550 mg two times a day for hepatic encephalopathy. Review of June 2026 MAR and progress notes indicated that Resident R2 did not receive rifaximin for 14 of 60 scheduled doses, on 6/1/26, 6/2/26, 6/3/26, 6/5/26, 6/9/26, 6/10/26, 6/24/26, 6/25/26, 6/26/26, 6/27/26, 6/28/26 x 2 doses, and 6/29/26 x 2 doses. Review of Resident R2's progress notes and the Care Communications log dated 6/1/26, through 6/30/26, failed to reveal notification to the nurse practitioner or to the physician related to Resident R2's not receiving his Rifaximin on the above dates. During an interview on 7/9/26, at 12:49 p.m. the attending physician confirmed that he had not been made aware by facility staff that Resident R2 had not received his ordered antibiotics. Review of Resident R3's physician's orders dated 6/5/26, 6/6/26, 6/13/26, and 6/23/26, indicated Resident R3 was to receive ceftriaxone, two grams intravenously one time a day. Review of June 2026 MAR and progress notes indicated that Resident R3 did not receive Ceftriaxone on 6/5/26, 6/11/26, 6/14/26, 6/15/26, and 6/24/26. Review of physician's orders dated 6/4/26, 6/5/26, 6/6/26, and 6/10/26, indicated Resident R3 was to receive linezolid, 600 mg intravenously two times a day. Review of (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	physician's orders dated 6/22/26 and 6/23/26, indicated Resident R3 was to receive linezolid, 300 mg intravenously two times a day. Review of June 2026 MAR and progress notes indicated that Resident R3 did not receive linezolid IV infusions on 6/5/26. 6/6/26, 6/7/26 x2 doses, 6/8/26 x2 doses, 6/9/26 x 2 doses, 6/10/26, 6/11/26, and 6/16/26. Review of Resident R3's progress notes and the Care Communications log dated 6/1/26, through 6/30/26, failed to reveal notification to the nurse practitioner or to the physician related to Resident R3's not receiving her ceftriaxone or linezolid on the above dates. During an interview on 7/9/26, at 12:49 p.m. the attending physician confirmed that he had not been made aware by facility staff that Resident R3 had not received her ordered antibiotics. Review of a physician's order dated 6/6/26, at 7:40 a.m. indicated Resident R4 was to receive meropenem (broad-spectrum intravenous antibiotic used to treat serious bacterial infections) one gram intravenously three times per day. The medication was scheduled to be received at 6:00 a.m., 2:00 p.m., and 10:00 p.m., with the first dose to be given on 6/6/26, at 2:00 p.m. Review of Resident R4's MAR and progress notes indicated that Resident R4 did not receive meropenem IV infusions on 6/6/26, 2:00 p.m. 6/6/26, 10:00 p.m., 6/7/26, 6:00 a.m., 6/7/26, 2:00 p.m., 6/7/26, 10:00 p.m., and 6/8/26, 6:00 a.m. Review of Resident R4's progress notes and the Care Communications log dated 6/6/26, through 6/9/26, failed to reveal notification to the nurse practitioner or to the physician related to Resident R4's not receiving her meropenem on the above dates. During an interview on 7/9/26, at approximately 12:15 p.m. the Nursing Home Administrator and the Interim Director of Nursing confirmed that the failed to notify the medical provider of the inability to provide ordered antibiotic medications for four of 25 residents. 28 Pa. Code 201.14(a) Responsibility of Licensee28 Pa. Code 211.9(a)(1) Pharmacy Services28 Pa. Code 211.10(c) Resident Care Policies28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on review of facility documentation and staff interviews, it was determined that the facility failed to ensure that nurses exhibited skills and competency for ten of 18 licensed practical nurses (Employees E4, E5, E6, E7, E8, E9, E10, E11, E12, and E13) by having failed to provide order medications that were available in the medication dispensing machine for 16 of 50 residents (R2, R5, R6, R7, R8, R9, R10, R11, R12, R13, R14, R15, R16, R17, R18, and R19). Findings include: Review of the facility policy, Medication Administration dated 5/15/26, indicated, medications are administered as prescribed in accordance with good nursing principles and practices. Review of the facility-provided document from the facility-contracted pharmacy entitled, Proper Medication Administration indicated, Circle initials if the medication was not available and provide a detailed explanation Follow electronic processes for documenting omissions and refusals if using e-MARs (electronic medication administration records). Review of the Licensed Practical Nurse (LPN) job description indicated the LPN will administer medications and perform treatments per physician orders. Resident R2's ordered midodrine:-6/22/26: Documented to see nurse's note on MAR. No nurse's note in EMR, by LPN Employee E11 Review of the facility provided RxNow (medication dispensing machine) inventory list included midodrine as a stocked item. Resident R5's ordered heparin:6/19/26: awaiting from pharmacy documented by Agency LPN Employee E56/23/26: unable to find medication / on back order from pharmacy documented by LPN Employee E46/29/26: pending pharmacy documented by Agency LPN Employee E67/03/26: not available documented by LPN Employee E7 Review of the facility provided RxNow inventory list included heparin as a stocked item. Resident R6's ordered Risperdal:6/9/26: Medication not available/ on back order from pharmacy documented by LPN Employee E4Resident R6's ordered mirtazapine:6/9/26: Medication not available documented by LPN Employee E46/13/26: Medication not available/ on back order from pharmacy documented by LPN Employee E46/19/26: Unable to find medication documented by LPN Employee E4Resident R6's ordered trazodone:6/12/26: waiting on pharmacy documented by Agency LPN Employee E5Resident R6's ordered benzotropine mesylate:6/19/26: Medication not available documented by LPN Employee E4 Review of the facility provided RxNow inventory list included Risperdal, mirtazapine, trazodone, and benzotropine mesylate as stocked items. Resident R7's ordered enoxaparin:6/21/26: Documented to see nurse's note on MAR. No nurse's note in EMR, by Agency LPN Employee E86/22/26: Medication not available/ on back order from pharmacy documented by LPN Employee E4 Review of the facility provided RxNow inventory list included enoxaparin as a stocked item. Resident R8's ordered omeprazole:6/3/26: Medication not available/ on back order from pharmacy documented by LPN Employee E4 Review of the facility provided RxNow inventory list included omeprazole as a stocked item. Resident R9's ordered Lexapro:6/5/26: Medication not available/ on back order from pharmacy documented by LPN Employee E4Resident R9's ordered Namenda:7/3/26: not able to administer on order documented by LPN Employee E7Resident R9's ordered Plavix:7/6/26: not available to give documented by LPN Employee E7Resident R9's ordered pantoprazole:7/7/26: Medication not available/ on back order from pharmacy documented by LPN Employee E4 Review of the facility provided RxNow inventory list included Lexapro, Namenda, Plavix, and pantoprazole as stocked items. Resident R10's ordered Synthroid:6/30/26: not available to administer documented by LPN Employee E9 Review of the facility provided RxNow inventory list included Synthroid as a stocked item. Resident R11's ordered pregabalin:6/11/26: unavailable documented by Agency LPN Employee E106/11/26 (second dose): unavailable documented by Agency LPN Employee E10Resident (continued on next page)		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395243	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Laurel Ridge Center		STREET ADDRESS, CITY, STATE, ZIP CODE 75 Hickle Street Uniontown, PA 15401	
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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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R11's ordered penicillin:6/26/26: pending pharmacy documented by Agency LPN Employee E66/27/26: Unable to find medication documented by LPN Employee E46/27/26: pending pharmacy documented by Agency LPN Employee E6 Review of the facility provided RxNow inventory list included pregabalin and penicillin as stocked items. Resident R12's ordered omeprazole:6/24/26: Medication not available/ on back order from pharmacy documented by LPN Employee E4 Review of the facility provided RxNow inventory list included omeprazole as a stocked item. Resident R13's ordered famotidine:6/9/26: Medication not available documented by LPN Employee E46/16/26: Unable to find medication documented by LPN Employee E46/9/26: Medication not available/ on back order from pharmacy documented by LPN Employee E4 Review of the facility provided RxNow inventory list included famotidine as a stocked item. Resident R14's ordered morphine ER:6/22/26: (10:00 p.m. dose) Documented to see nurse's note on MAR. No nurse's note in EMR, by LPN Employee E116/23/26: (10:00 a.m. dose) Medication not available/ on back order from pharmacy documented by LPN Employee E46/23/26: (10:00 p.m. dose) pending script/pharmacy documented by Agency LPN Employee E6 Review of the facility provided RxNow inventory list included morphine ER as a stocked item. Resident R15's ordered clopidogrel (Plavix): 6/16/26: unable to find medication documented by LPN Employee E4 Review of the facility provided RxNow inventory list included Plavix as a stocked item. Resident R16's ordered clopidogrel (Plavix): 6/16/26: unable to find medication / on back order from pharmacy documented by LPN Employee E4 Review of the facility provided RxNow inventory list included Plavix as a stocked item. Resident R17's ordered linagliptin (Tradjenta): 7/6/26: on order not available to administer documented by LPN Employee E7 Review of the facility provided RxNow inventory list included Tradjenta as a stocked item. Resident R18's ordered atorvastatin:7/4/26: Not received from pharmacy at this time documented by Agency LPN Employee E11Resident R18's ordered Losartan:7/5/26: Documented as held by LPN Employee E13. No documentation in the progress notes associated with this order. A progress note dated 7/5/26, at 3:24 p.m. indicated, Not received from pharmacy but did not include what medication this note was associated with. Review of the facility provided RxNow inventory list included atorvastatin and Losartan as stocked items. Resident R19's ordered Losartan: 7/5/26: Medication on order documented by LPN Employee E13. Review of the facility provided RxNow inventory list included Losartan as a stocked item. During an interview on 7/9/26, at approximately 11:00 a.m. the Nursing Home Administrator and the Interim Director of Nursing confirmed that Agency nurses do not have access to the RxNow dispensing machine, but all nurse supervisors do, and there is always a nurse on shift with access to the RxNow. During an interview on 7/9/26, at approximately 11:30 a.m. the Nursing Home Administrator and the Interim Director of Nursing confirmed that the facility failed to ensure that nurses exhibited skills and competency for ten of 18 licensed practical nurses by having failed to provide order medications that were available in the medication dispensing machine for 16 of 50 residents 28 Pa. Code 201.18(b)(1)(3) Management.28 Pa. Code 211.9(a)(1)(f)(4) Pharmacy Services.28 Pa. Code 211.12(d)(5) Nursing Services		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395243	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Laurel Ridge Center		STREET ADDRESS, CITY, STATE, ZIP CODE 75 Hickle Street Uniontown, PA 15401	
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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on review of job descriptions, clinical records, and staff interviews, it was determined that the Nursing Home Administrator (NHA) and the former Director of Nursing (DON) failed to implement procedures to ensure availability of prescribed medications. This failure resulted in a resident who was ordered intravenous antibiotic medication to be rehospitalized to receive the ordered medication (Resident R1). This failure created an Immediate Jeopardy situation for four of 25 residents who failed to receive medications (Resident R1, R2, R3, and R4). Findings include: Review of the facility-provided Nursing Home Administrator (NHA) job description indicated, Create an environment where staff members are highly engaged and are focused on providing the highest level of clinical care and compassion to patients, residents and families. Responsible for assuring that the center operates in full compliance with Federal and State regulations while Doing the Right Things, which will result in high levels of performance in each of the [Corporation] Strategic Focus Areas. The Administrator is responsible for planning and is accountable for all activities and departments of the Center subject to rules and regulations promulgated by government agencies to ensure proper health care services to residents. The Administrator administers, directs, and coordinates all activities of the Center to assure that the highest degree of quality of care is consistently provided to residents. Review of the facility-provided Director of Nursing (DON) job description indicated, The Director of Nursing leads the Center clinical team to fulfill the organization's mission, vision and values. This position has overall accountability for providing leadership, direction, and administration of day-to-day operations associated with direct patient care activities, nursing practice, and clinical education and development, including continuous improvement of nursing services and staff to meet patients/residents and their families' needs and expectations. The DON communicates a shared vision for clinical excellence and ensures the realization of high quality and cost-effective health care services that are consistent with [Corporation] evidence-based practices and policies, regulatory and other legal requirements, and philosophies. This position is responsible for driving, supporting and modeling a service-oriented culture focused on top of license practice, interprofessional collaboration, employee engagement, quality, patient safety, service excellence, fiscal responsibility, and the overall patient/resident experience. The DON collaborates with the Administrator and Center Leadership Team to drive business excellence, including strategic planning, budget preparation, and effective oversight of resource utilization. Based on findings identified in this report, the facility failed to prevent the failed to implement procedures to ensure availability of prescribed medications. The NHA and the previously employed DON failed to fulfill their essential job duties to ensure the federal and state guidelines and regulations were followed. During an interview on 7/9/26, at approximately 12:15 p.m. the NHA and current DON confirmed that facility administration failed to implement procedures to ensure availability of prescribed medications. This failure resulted in a resident who was ordered intravenous antibiotic medication to be rehospitalized to receive the ordered medication (Resident R1). This failure created an Immediate Jeopardy situation for four of 25 residents who failed to receive medications. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(3)(e)(1) Management. 28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services.		