STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395243	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurel Ridge Center	75 Hickle Street Uniontown, PA 15401

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on review of facility policy, observation, resident, and staff interviews, it was determined that the facility failed to provide a safe, clean, comfortable, and homelike environment for six of seventeen residents as required (Residents R3, R505, R500, R501, R502, and R504) on one of three nursing units and the main dining room. Findings included: Review of the facility policy Accommodation of Needs dated 3/12/25, indicated the resident has the right to a safe, clean comfortable, and homelike environment including, but not limited to, receiving treatment and support for daily living safely. Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. The maintenance of comfortable sound levels. During an observation on 6/24/25, at 11:32 a.m. Resident R2's room was observed. A large box fan was present, actively blowing toward Resident R2's bed. Large amounts of dust were visible on the fan grill. During a resident group interview (Residents R505, R500, R501, R502, and R504) on 6/24/25, at 1:30 p.m., all five residents in attendance stated the kitchen staff slam the kitchen door when they enter or exit the kitchen. The residents stated, they slam the door on purpose. This is a daily occurrence during all three meals and during some activities. Residents reported they are uncomfortable and startled each time the door slams. Resident R505 stated, he discussed this with the Nursing Home Administrator (NHA) a couple of weeks ago and it continues to occur. During an observation on 6/25/25, between 9:35 a.m. through 9:37 a.m., of the kitchen entry/exit hallway door, slammed three times. Nearby staff was observed flinching. During an interview with Employee E2 at 9:37 a.m., when asked why she flinched, she stated it was the loud noise of the slamming door. Employee E2 was observed working down the hall from the door that had been slammed closed. During an observation with the NHA on 6/25/25, approximately 9:40 a.m., of the kitchen entry/exit hallway door, staff entered, and the door slammed shut. A demonstration of the door revealed it automatically slams closed on each entry/exit. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with Maintenance Employee E1 on 6/26/25 at 8:15 a.m., revealed the kitchen staff had been told multiple times to keep the dining room door to the kitchen closed, as the vacuum will cause the hallway door to the kitchen to slam shut upon each entry/exit. During an interview on 6/25/25, at approximately 9:40 a.m., the Nursing Home Administrator confirmed the facility failed to provide a safe, clean, comfortable, and homelike environment for six of seventeen residents as required (Residents R2, R22, R500, R501, R502, and R504) on one of three nursing units and the main dining room. 28 Pa. Code: 207.2(a) Administrator's responsibility. 28 Pa. Code: 201.29(k) Resident rights.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, clinical record review, and staff interview, it was determined that the facility failed to ensure that the resident and/or their representative received written notice of the facility bed-hold policy at the time of transfer for five of nine residents reviewed for hospitalization (Resident R1, R15, R23, R25, and R27). Findings include: Review of facility policy Bed-Holds dated 3/4/25, indicated the purpose of the policy it To provide written notification of the bed hold policy to the resident/resident representative at the time of transfer out of the service location - this applies to all payers. Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE]. Review of Resident R1's minimum data set (MDS, periodic assessment of resident care needs) dated 5/19/25, included diagnoses of cerebral palsy (group of disorders that affect a person's ability to move and maintain balance and posture), paraplegia (paralysis of the legs and lower body, typically caused by spinal injury or disease), and a seizure disorder. Review of a progress note dated 2/4/25, at 7:09 p.m. indicated evaluation of a high fever. Further review of Resident R1's clinical record failed to reveal notation that the written notice of bed hold notification was provided to the resident or resident representative upon transfer. Review of the clinical record indicated Resident R15 was originally admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident R15's MDS dated [DATE], included diagnoses coronary artery disease (damage or disease in the heart's major blood vessels) history of a stroke. Review of a progress note dated 3/2/25, at 8:15 p.m. indicated Resident R15 was transferred to the hospital due to a potential hypertensive crisis and erratic behavior. Further review of Resident 15's clinical record failed to reveal notation that the written notice of bed hold notification was provided to the resident or resident representative upon transfer. Review of the clinical record indicated Resident R23 was originally admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident R23's MDS dated [DATE], included diagnoses of a seizure disorder and a psychotic disorder (mental disorder characterized by a disconnection from reality). Review of a progress note dated 3/15/25, at 8:43 p.m. indicated Resident R23 was sent to the hospital for low oxygen levels in his blood and increased confusion. (continued on next page)

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	Review of a progress note dated 6/17/25, at 9:19 a.m. indicated Resident R23 was sent to the hospital for evaluation of hallucinations. Further review of Resident 23's clinical record failed to reveal notation that the written notice of bed hold notification was provided to the resident or resident representative upon either transfer. Review of the clinical record indicated Resident R25 was admitted to the facility on [DATE]. Review of Resident R25's MDS dated [DATE], included diagnoses of chronic kidney disease (gradual loss of kidney function) and diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time). Review of a progress note dated 2/2/25, at 3:40 p.m. indicated Resident R25 was transferred to the hospital due to fever and low oxygen level. Further review of Resident 25's clinical record failed to reveal notation that the written notice of bed hold notification was provided to the resident or resident representative upon transfer. Review of the clinical record indicated Resident R27 originally admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident R27's MDS dated [DATE], included diagnoses of heart failure (a progressive heart disease that affects pumping action of the heart muscles) and diabetes. Review of a progress note dated 8/28/24, at 11:35 a.m. indicated Resident R27 was transferred to the hospital due to low blood sugar. Review of a progress note dated 10/10/24, at 9:38 p.m. indicated Resident R27 was transferred to the hospital due fever, chills, and fatigue. Review of a progress note dated 1/14/25, at 7:40 p.m. indicated Resident R27 was transferred to the hospital due fever, tremors, and back pain. Review of a progress note dated 2/1/25, at 8:57 a.m. indicated Resident R27 was transferred to the hospital (from an outside appointment) due fever and chills. Review of a progress note dated 4/1/25, at 9:24 a.m. indicated Resident R27 was transferred to the hospital for pain and a firm abdomen. Further review of Resident 27's clinical record failed to reveal notation that the written notice of bed hold notification was provided to the resident or resident representative for any of the above transfers. During an interview on 6/26/25, at approximately 2:00 p.m. the Nursing Home Administrator and the Director of Nursing confirmed the facility failed to ensure that the resident and/or their representative received written notice of the facility bed-hold policy at the time of transfer for five of nine residents reviewed for hospitalization. (continued on next page)

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	28 Pa. Code 201.14(a) Responsibility of licensee

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. Based on review of the Resident Assessment Instrument (RAI) User's Manual, clinical records, and staff interview, it was determined that the facility failed to make certain that comprehensive Minimum Data Set assessments were completed in the required time frame for four of eight residents (Resident R105, R109, R155, and R157). Findings include: The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides instructions and guidelines for completing required Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2024, indicated that an admission MDS assessment was to be completed no later than 14 days following admission. Resident R105 had an admission date of 6/9/25, with an MDS completion date of 6/23/25. Resident R109 had an admission date of 6/6/24, with an MDS completion date of 6/24/25. Resident R155 had an admission date of 6/9/25, with an MDS completion date of 6/23/25. Resident R157 had an admission date of 6/9/25, with an MDS completion date of 6/24/25. During an interview on 6/26/25, at approximately 12:30 p.m. the Director of Nursing confirmed that the above MDS assessments were completed late. During an interview on 6;26 at approximately 2:00 p.m. Nursing Home Administrator confirmed that the facility failed to make certain that MDS assessments were completed in the required time frame for four of eight residents. 28 Pa. Code: 211.5(f) Clinical records.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records and staff interviews, it was determined that the facility failed to notify physicians of increased and decreased capillary blood glucose (CBG) levels for one of four residents (R27). Findings: Review of the facility policy, Physician/Advanced Practice Provider Notification dated 3/12/25, indicated, Upon identification of a patient who has a change in condition, abnormal laboratory values, or abnormal diagnostics, a licensed nurse will: - Perform appropriate clinical observations, - Collect pertinent patient information (e.g., age, diagnoses, prior vital signs, labs, recent changes in medications, previous incidents of a similar nature, code status, etc.), - Report to physician/advanced practice provider (APP). If unable to contact attending physician/APP, the Medical Director will be contacted. Review of the clinical record indicated Resident R27 originally admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident R27's MDS dated [DATE], included diagnoses of heart failure (a progressive heart disease that affects pumping action of the heart muscles) and diabetes. Review of Resident R27's care plan initiated 7/30/22, for diabetes indicated to monitor for signs and symptoms of hyper/hypoglycemia (high/low blood sugar) and report abnormal findings to physician. Review of a physician order dated 6/26/24, indicated to inject Humalog insulin (an injectable medication to treat diabetes) per sliding scale, and indicated if Resident R27's blood sugar level was greater than 500 to call the MD (Doctor of Medicine). Review of Resident R27's blood sugar record revealed the following elevated blood sugar levels without documentation that the provider was notified: 4/18/25, at 5:46 a.m. - 500.0 mg/dL (milligrams per deciliter) 4/23/25, at 9:33 p.m. - 516.0 mg/dL 4/25/25, at 5:57 a.m. - 600.0 mg/dL 4/30/25, at 5:00 p.m. - 508.0 mg/dL 5/02/25, at 12:40 p.m. - 500.0 mg/dL 5/02/25, at 12:47 p.m. - 553.0 mg/dL (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5/28/25, at 1:07 a.m. - 600.0 mg/dL 6/15/25, at 1:29 a.m. - 500.0 mg/dL 6/20/25, at 5:34 a.m. - 500.0 mg/dL During an interview on 6/26/25, at 10:08 a.m. the Director of Nursing confirmed that the clinical record failed to reveal a notification to the provider for the above blood sugar levels. During an interview on 6/26/25, at approximately 2:00 p.m. the Nursing Home Administrator and the Director of Nursing confirmed the facility failed to notify physicians of increased and decreased capillary blood glucose levels for one of four residents. 28 Pa. Code 201.18 (b)(1) Management 28 Pa. Code 211.10 (c)(d) Resident care policies 28 Pa. Code 211.12 (d)(1)(2)(3)(5) Nursing services

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, documents, clinical records, and staff interviews, it was determined that the facility failed to ensure that residents were free from significant medication errors for two of five residents (Resident R4 and R30). Findings include: Review of the United States Food and Drug Administration prescribing information for potassium chloride (extended release) dated October 2010, indicated, To take this medicine following the frequency and amount prescribed by the physician. This is especially important if the patient is also taking diuretics and/or digitalis preparations. Review of facility policy Medication Administration - Orals dated 3/12/25, indicated that medications are administered in an organized, accurate and safe manner. Review of Resident R30's admission record indicated he was admitted to the facility on [DATE]. Review of Resident R30's Minimum Data Set (MDS - mandated assessment of a resident's abilities and care needs) dated 5/2/25, included diagnoses of atrial fibrillation (disease of the heart characterized by irregular and often faster heartbeat) and chronic kidney disease (gradual loss of kidney function). Review of a physician's order dated 4/28/25, indicated for Resident R30 to receive 10 mEq (milliequivalents) of extended-release potassium chloride at 10:00 a.m. and 10:00 p.m. Review of a physician's order dated 6/13/25, indicated for Resident R30 to receive 20 mg (milligrams) of furosemide (a diuretic medication) daily at 8:00 a.m. During an observation of a medication administration on 6/25/25, at approximately 8:44 a.m. Licensed Practical Nurse (LPN) Employee E5 was observed providing medication to Resident R30. During the observation it was noted that the order for potassium chloride was not highlighted, which indicated that it was not the correct time to administer the medication. During the medication administration, LPN Employee E5 provided 10 mEq of potassium chloride to Resident R30. LPN Employee E5 was unable to document that the potassium chloride was provided as the electronic medical record will not allow documentation of administration outside of the appropriate timeframes for the provision of the medication. Review of a medication audit report printed on 6/25/25, at 11:11 a.m. did not show an administration of potassium chloride to Resident R30. Review of Resident R30's medication audit report from 6/20/25, through 6/24/25 revealed the following related to the administration of potassium chloride: 6/20/25: 10:00 a.m. dose documented at 1:39 p.m. 6/22/25: 10:00 a.m. dose documented at 12:38 p.m. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6/23/25: 10:00 a.m. dose documented at 1:10 p.m. 6/24/25: 10:00 a.m. dose documented at 12:24 p.m. Review of Resident R1's admission record indicated admission to the facility on 5/19/24. Review of Resident R1's MDS dated [DATE], included diagnoses of dementia (a group of symptoms that affects memory, thinking and interferes with daily life) and a thyroid disorder. Review of a physician's order dated 5/20/24, indicated for Resident R1 to receive 10 mEq of extended-release potassium chloride daily at 10:00 a.m. Review of a physician's order dated 5/20/24, indicated for Resident R1 to receive 20 mg of furosemide at 8:00 a.m. Review of Resident R1's medication audit report from 6/20/25, through 6/24/25 revealed the following related to the administration of potassium chloride: 6/20/25: all medications scheduled at 8:00 a.m. and 10:00 a.m. were documented as provided at 1:30 p.m. 6/22/25: 10:00 a.m. dose documented at 12:38 p.m. 6/23/25: all medications scheduled at 8:00 a.m. and 10:00 a.m. were documented as provided at 9:21 a.m. and 9:22 a.m. 6/24/25: all medications scheduled at 8:00 a.m. and 10:00 a.m. were documented as provided at 10:09 a.m. and 10:10 a.m. 6/25/25: all medications scheduled at 8:00 a.m. and 10:00 a.m. were documented as provided at 9:09 a.m. and 9:10 a.m. During an interview on 6/26/25, at approximately 9:30 a.m. the Director of Nursing confirmed that the orders for potassium chloride were specifically scheduled outside of the normal medication pass time so the medication would not be given at the same time as the other medications. During an interview on 6/26/25, at approximately 2:00 p.m. the Nursing Home Administrator confirmed that the facility failed to ensure that residents were free from significant medication errors for two of five residents. 28 Pa Code 201.14(a) Responsibility of licensee. 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 0944 Level of Harm - Potential for minimal harm Residents Affected - Some	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. Based on review of facility documents, personnel in-service training records, and staff interview, it was determined that the facility failed to provide training on the Quality Assurance and Performance Improvement (QAPI) program for three of eight staff members (Employee E4, E5, and E6). Findings include: Review of the Facility Assessment dated February 2025, indicated All staff are required to complete mandatory education upon hire and annually based on position designation. Review of facility provided documents and training records revealed the following staff members did not have documented training on QAPI. Nurse Aide Employee E4 had a hire date of 3/18/13, failed to have QAPI in-service education between 3/18/24, and 3/18/25. Licensed Practical Nurse E5 had a hire date of 4/27/16, failed to have QAPI in-service education between 4/27/24, and 4/27/25. Dietary Employee E6 had a hire date of 6/17/19, failed to have QAPI in-service education between 6/17/24, and 6/17/25. During an interview on 6/26/25, at approximately 2:00 p.m. the Nursing Home Administrator and the Director of Nursing confirmed that the facility failed to provide training on QAPI for three of eight staff members. 28 Pa Code: 201.14 (a) Responsibility of licensee. 28 Pa Code: 201.18 (b)(1) Management. 28 Pa Code: 201.20 (a)(c) Staff development.