STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395435	A. Building B. Wing	05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westmoreland Manor	2480 South Grand Blvd Greensburg, PA 15601

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on review of policies, clinical records, and information provided by the facility, as well as staff interviews, it was determined that the facility failed to ensure that a thorough investigation was completed into the resident's grievance for one of six residents reviewed (Resident 5). Findings include: The facility's policy regarding grievances and concerns, dated February 1, 2025, revealed that the facility recognizes that residents have the right to voice grievances to the facility, or other agencies or entities that hear grievances, without discrimination or reprisal and without fear of discrimination or reprisal. Every grievance must include investigative form(s) as necessary, including but not limited to: Witness statements, investigative notes, copies of documentation evidence, summary of investigative process, and summary of investigation findings. Every grievance investigation will be summarized by the Grievance Officer, or designee and findings recorded whether the incident was confirmed or not. A quarterly Minimum Data Set (MDS) assessment (a federally-mandated assessment of a resident's abilities and care needs) for Resident 5, dated April 23, 2025, revealed that the resident was understood, could understand others, and had a diagnosis which included cerebral vascular accident (CVA - commonly referred to as a stroke) with right side hemiplegia (paralysis on one side of the body) and diabetes (a chronic condition where the body either does not produce enough insulin or cannot effectively use the insulin it produces). (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

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Information provided by the facility revealed that Resident 5 filed a grievance via a resident/family grievance form on May 19, 2025, with concerns that last night was the last straw with Licensed Practical Nurse 1. The other nurse (a woman which the resident does not know her name) came to my room about 10:00 p.m. to give me my medication. When I saw the insulin she was going to give me, I stopped her and explained that was not the right insulin. She explained that Licensed Practical Nurse 1 prepared the insulin. I told her it's wrong and I refused to take it. The resident went on to explain that over the course of about one year Licensed Practical Nurse 1 does and says things to her and about her that he knows upsets her. For instance, he will stand outside my bedroom door and say to nobody that he is sorry for kicking her bed. Licensed Practical Nurse 1 told her once that she would be put in jail for violating HIPPA because I told my husband the floor was yellow because someone had COVID. Another time recently she was in the bathroom (unit bathroom) and Licensed Practical Nurse 1 came in and slammed cupboards and made all kind of noise. I think he was trying to scare me. The resident also presented several non-specific interactions that she believes are deliberate, passive-aggressive and attempts to gas light her. The resident also recalled that a little while ago Licensed Practical Nurse 1 told everyone that I hallucinate. I don't hallucinate. Lastly the resident added, I already requested that Licensed Practical Nurse 1 not provide care. I also don't want him preparing my meds. I don't want him to do anything with me or my care. A summary of the grievance investigation, dated May 26, 2025, revealed that a concern was received from Resident 5 listing concerns involving a staff member. The resident stated that a certain staff member does and says things deliberately to gas light her. She also stated that there was a different nurse that attempted to administer the incorrect insulin to her. Resident 5 has had ongoing concerns with the first nurse and every attempt has been made to keep him out of her sight, for instance, he only works down the opposite hall. However, going forward, the nurse has been removed from the nursing unit. Education has been provided to the second nurse regarding checking the order to ensure she has the correct insulin and to not rely on the word of other nurses. The facility's investigation revealed no documented evidence that Resident 5's concerns regarding her issues with Licensed Practical Nurse 1 doing and saying things to her and about her that he knows upsets her were investigated and/or addressed, as well as no documented evidence that a statement was obtained from Licensed Practical Nurse 1 regarding the resident's concerns. Interview with the Director of Nursing on May 29, 2025, at 4:15 p.m. confirmed that there was no documented evidence that Resident 5's concerns regarding her issues with Licensed Practical Nurse 1 doing and saying things to her and about her that he knows upsets her were investigated and/or addressed, as well as no documented evidence that a statement was obtained from Licensed Practical Nurse 1 regarding the resident's concerns. 28 Pa. Code 201.29(i) Resident Rights.

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on review of facility policies, clinical records, and investigation reports, as well as staff interviews, it was determined that the facility failed to ensure that one of six residents reviewed (Resident 3) was free from abuse perpetrated by a resident with aggressive behaviors (Resident 2), resulting in an incident in which one of six residents reviewed suffered a fractured hip (Resident 3). Findings include: The facility's abuse policy, dated February 1, 2025, revealed that the facility would implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation that achieved the identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 2, dated March 7, 2025, revealed that the resident was cognitively impaired, had no behaviors, received anti-psychotic and anti-depressant medications, and had diagnoses that included dementia and depression. A quarterly MDS assessment for Resident 3, dated March 11, 2025, revealed that the resident was cognitively impaired, had verbal behaviors directed towards others and other behaviors not directed towards others, received anti-depressant medications, and had diagnoses that included dementia and depression. The behavior care plan for Resident 2, dated December 4, 2024, and revised on May 29, 2025, revealed that he had diagnoses that included dementia, anxiety, depression, and insomnia. His behaviors included going through/entering others spaces/belongings, rummaging, anxious/restless, agitation, sleeplessness, pacing, refusing care, verbalizing persistent beliefs not true, wandering, picking at self, yelling at others, angry/hostile towards staff, paranoia, delusions, accusatory of others, threatening and inappropriate comments towards staff/others, following others closely on the unit or exit seeking, and having hallucinations of others wanting to harm/kill him. Staff were to monitor and document changes in his mood and behavior and determine if there was a specific trigger to the change, have him seen by the psychiatrist as ordered, redirect and intervene if having behaviors with others, entering others spaces/rooms, getting angry, exit seeking, etc., and provide 1:1 close observation. A behavior note for Resident 2, dated May 14, 2025, at 10:15 a.m. revealed that he pushed Resident 3 causing her to fall. A nursing note for Resident 3, dated May 14, 2025, revealed that at 10:15 a.m. Resident 3 walked down the hall and tapped Resident 2 on his left shoulder and Resident 2 turned around and used both hands to push her to the ground. Resident 3 landed on her right hip and continued to lie on the floor until staff arrived. She was exhibiting signs of severe pain to her right hip with difficulty moving it. The physician was notified and orders were received to transfer the resident to the hospital for evaluation and treatment. She was admitted to the hospital with a right hip fracture. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The facility's investigation, dated May 14, 2025, revealed that video footage was reviewed and Resident 2 was standing near the nurse's station on the unit. Resident 3 was walking up the hallway in the direction of Resident 2 and was nearing Resident 2, when Resident 2 turned and began to walk in the opposite direction. When Resident 3 caught up to Resident 2, she reached forward with her left hand and began to tap Resident 2 on the left arm/shoulder area. When Resident 3 tapped Resident 2 on the shoulder, he turned around quickly and pushed Resident 3, causing her to lose her balance and fall to the ground onto her side. The facility's investigation indicated that abuse was substantiated. Interview with the Director of Nursing on May 29, 2025, at 4:24 p.m. confirmed that Resident 2 pushed Resident 3, which resulted in Resident 3 falling and fracturing her hip, substantiating abuse. 28 Pa. Code 211.12 (d)(5) Nursing Services.