

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395435	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/29/2026
NAME OF PROVIDER OR SUPPLIER  Westmoreland Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0658</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>Based on review of Pennsylvania's Nursing Practice Act, facility policy, clinical records, and facility investigations, as well as staff interviews, it was determined that the facility failed to ensure that nursing services met professional standards of quality by failing to ensure that medications were administered by licensed medical or nursing personnel in accordance with the medical and nursing regulations of Pennsylvania which resulted in the need for transfer to the hospital. This deficiency was cited as past non-compliance. Findings include: The Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, Section 21.145 (a)(1)(i)(2) indicated that the Licensed Practical Nurse is prepared to function as a member of the health-care team by exercising sound nursing judgment based on preparation, knowledge, experience in nursing and competency. The Licensed Practical Nurse participates in the planning, implementation and evaluation of nursing care using focused assessment in settings where nursing takes place. A Licensed Practical Nurse shall communicate with a licensed professional nurse and the patient's health care team members to seek guidance when: The patient's care needs exceed the licensed practical nursing scope of practice. A Licensed Practical Nurse shall obtain instruction and supervision if implementing new or unfamiliar nursing practices or procedures. Section 21.145a (5) indicated that Licensed Practical Nurses are prohibited from administering medications via push or bolus rate (the rapid administration of a concentrated medication or fluid directly into a vein, typically via syringe, over a very short period). Review of a facility policy for Medication Administration: Rights dated February 1, 2026, indicated that to ensure accountability and six rights' (right resident, right drug, right dose, right time, right route, right dosing form), charting guidelines are set. All medications are to be administered by licensed medical or nursing personnel in accordance with the medical and nursing regulations of Pennsylvania. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 2, dated February 5, 2026, indicated that the resident was cognitively intact, required assistance from staff for daily care needs and had diagnosis that included Atherosclerotic heart disease (hardening of your arteries from plaque building up gradually inside them). Review of a nurse's note for Resident 2 dated April 17, 2026, at 10:47 p.m. revealed that the resident had a right upper arm midline (flexible tube inserted into a vein in the upper arm, used for infusion of fluids and medications). Physician's orders for Resident 2 dated April 18, 2026, included for the resident to receive 5 milligrams (mg) of Apixaban (a blood thinner) by mouth two times a day for atrial- fibrillation (an irregular and often very rapid heart rhythm), 100 mg of Gabapentin (used to treat partial seizures and nerve pain) two tablets by mouth three times a day for rheumatoid arthritis (condition that causes pain, swelling and irritation in the joints), 400 mg of magnesium oxide (dietary supplement) by mouth two times a day for magnesium deficiency, and 20 MEQ of potassium chloride extended release (mineral supplement that is used to prevent or treat low levels of potassium) by mouth three times a day for potassium deficiency. Physician's orders dated April 19, 2026, included for the resident to receive 5 mg of midodrine (used to treat low blood pressure) two tablets by mouth three times a day for hypotension (low blood pressure). Review of a facility incident report dated April 23, 2026, at 9:50 p.m. revealed that the resident had an order for oral tablets to be crushed and mixed in pudding, and a right arm intravenous midline for the administration of Zosyn (an antibiotic (continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0658  Level of Harm - Actual harm  Residents Affected - Few	<p>medication). Oral medications to be administered at 6:00 p.m. that included Eliquis 5mg, Gabapentin 100 mg, Magnesium oxide 400 mg, Midodrine 5 mg and potassium 20 MEQ were administered via midline. A witness statement by Registered Nurse 1, dated April 23,2026, revealed that Licensed Practical Nurse 2 admitted to her that he had crushed Resident 2's oral medications, mixed them with warm water, and administered them into the resident's midline catheter. A witness statement by Registered Nurse 3, dated April 23, 2026, revealed that she spoke with Licensed Practical Nurse 2 at approximately 10:30 p.m. and he reported to her that he used the silent knight to crush Resident 2's medications, dissolved them in water and administered them through the resident's midline using a normal saline flush syringe to administer the medications.A respiratory therapist's note for Resident 2 dated April 23, 2026, at 11:25 pm revealed that the resident's oxygen saturation remained between 85% and 87% on 12 Liters of supplemental oxygen. The physician was notified and orders were received to send the resident to the hospital. Physician's note for Resident 2 dated April 24, 2026, at 3:06 p.m. revealed that the resident was given oral medications that were dissolved in water through her midline last evening. The midline has since been removed, and she remains vitally stable on supplemental oxygen. emergency room evaluation revealed hyponatremia (low concentration of sodium in the blood), and otherwise stable.Interview with Registered Nurse 3 on April 28, 2026, revealed that she received a phone call from Registered Nurse 1 on April 23, 2026, at 9:36 p.m. reporting that Licensed Practical Nurse 2 gave oral medications via a midline. She told staff to remove Licensed Practical Nurse 2 from the floor. At 9:59 p.m. the physician was made aware and said to monitor the resident's condition. At 10:12 p.m. she interviewed Licensed Practical Nurse 2 via telephone who admitted that he crushed the resident's medication, mixed it in warm water and administered it through her midline. At 10:59 p.m. she interviewed him again and he reportedly stated that he had made a terrible mistake and got confused with giving medications crushed in a gastric tube. Interview with Licensed Practical Nurse 4 on April 28, 2026, at 5:58 p.m. revealed that Resident 2's daughter reported to her that Licensed Practical Nurse 2 put medications in the resident's midline catheter and she questioned if it was appropriate to do. Licensed Practical Nurse 4 revealed that she asked Licensed Practical Nurse 2 if he was crushing the resident's medications and giving them orally and he replied that he was. She was aware of him giving an as needed pain medication by mouth. Licensed Practical Nurse 4 attempted to show Licensed Practical Nurse 2 how to administer antibiotics in the midline for Resident 2 and the medication would not infuse and attempts to flush the midline catheter were unsuccessful despite Licensed Practical Nurse 2 stating he just flushed the midline catheter. Licensed Practical Nurse 4 reported the allegation of improper medication administration to Registered Nurse 1 who reported it to Registered Nurse 3. Licensed Practical Nurse 2 later admitted to Licensed Practical Nurse 4 that he crushed Resident 2's 6:00 p.m. medications and put them in her midline catheter.Interview with the Director of Nursing, Nursing Home Administrator and the facility's Clinical Compliance Certified Registered Nurse Practitioner on April 29, 2026, at 3:25 p.m. confirmed that Licensed Practical Nurse 2 administered medications that were ordered to be given by mouth via a syringe into a midline catheter and should not have. Following the incident on April 23, 2026, the facility's corrective actions included:Licensed Practical Nurse 2, who was involved in the improper administration of medications to Resident 2, was removed from duty, and was reported to the nursing agency that employed him as well as the state board of nursing. A full facility audit of the residents with intravenous access devices was completed and education of staff was initiated regarding the six rights of medication administration with emphasis on the right route, the Pennsylvania Licensed Practical Nurse scope of practice an code of conduct including that Licensed Practical Nurses are not permitted to administer intravenous push medications, adherence to proper routes of administration at all times, and safe practices for IV medication administration, subcutaneous injections, and enteral feeding. The education provided also included competency evaluations. A review of the facility's corrective actions revealed that they were in compliance with F658 on April 27, 2026.Interview with the Clinical Compliance Certified Registered Nurse Practitioner (continued on next page)</p>		

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F 0658  Level of Harm - Actual harm  Residents Affected - Few	on April 29, 2026, at approximately 2:00 p.m. revealed that the facility had initiated audits three times a week for proper medication administration and proper intravenous medication administration. The results of the audits were to be discussed during the monthly Quality Assurance (QA) meeting. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.		

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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>Based on review of facility policy and clinical records, as well as staff interviews, it was determined that the facility failed to provide medication as ordered by the physician, resulting in a significant medication error for one of nine residents reviewed (Resident 2) that resulted in a transfer to the hospital. This deficiency was cited as past non-compliance. Findings include: Review of a facility policy for Medication Administration: Rights dated February 1, 2026, indicated that to ensure accountability and six rights' (right resident, right drug, right dose, right time, right route, right dosing form), charting guidelines are set. All medications are to be administered by licensed medical or nursing personnel in accordance with the medical and nursing regulations of Pennsylvania. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 2, dated February 5, 2026, indicated that the resident was cognitively intact, required assistance from staff for daily care needs and had diagnosis that included Atherosclerotic heart disease (hardening of your arteries from plaque building up gradually inside them). Review of a nurse's note for Resident 2 dated April 17, 2026, at 10:47 p.m. revealed that the resident had a right upper arm midline (flexible tube inserted into a vein in the upper arm, used for infusion of fluids and medications). Physician's orders for Resident 2 dated April 18, 2026, included for the resident to receive 5 milligrams (mg) of Apixaban (a blood thinner) by mouth two times a day for atrial- fibrillation (an irregular and often very rapid heart rhythm), 100 mg of Gabapentin (used to treat partial seizures and nerve pain) two tablets by mouth three times a day for rheumatoid arthritis (condition that causes pain, swelling and irritation in the joints), 400 mg of magnesium oxide (dietary supplement) by mouth two times a day for magnesium deficiency, and 20 MEQ of potassium chloride extended release (mineral supplement that is used to prevent or treat low levels of potassium) by mouth three times a day for potassium deficiency. Physician's orders dated April 19, 2026, included for the resident to receive 5 mg of midodrine (used to treat low blood pressure) two tablets by mouth three times a day for hypotension (low blood pressure). Review of a facility incident report dated April 23, 2026, at 9:50 p.m. revealed that the resident had an order for oral tablets to be crushed and mixed in pudding, and a right arm intravenous midline for the administration of Zosyn (an antibiotic medication). Oral medications to be administered at 6:00 p.m. that included Eliquis 5mg, Gabapentin 100 mg, Magnesium oxide 400 mg, Midodrine 5 mg and potassium 20 MEQ were administered via midline. A witness statement by Registered Nurse 1, dated April 23, 2026, revealed that Licensed Practical Nurse 2 admitted to her that he had crushed Resident 2's oral medications, mixed them with warm water, and administered them into the resident's midline catheter. A witness statement by Registered Nurse 3, dated April 23, 2026, revealed that she spoke with Licensed Practical Nurse 2 at approximately 10:30 p.m. and he reported to her that he used the silent knight to crush Resident 2's medications, dissolved them in water and administered them through the resident's midline using a normal saline flush syringe to administer the medications. A respiratory therapist's note for Resident 2 dated April 23, 2026, at 11:25 pm revealed that the resident's oxygen saturation remained between 85% and 87% on 12 Liters of supplemental oxygen. The physician was notified and orders were received to send the resident to the hospital. Physician's note for Resident 2 dated April 24, 2026, at 3:06 p.m. revealed that the resident was given oral medications that were dissolved in water through her midline last evening. The midline has since been removed, and she remains vitally stable on supplemental oxygen. emergency room evaluation revealed hyponatremia (low concentration of sodium in the blood), and otherwise stable. Interview with Registered Nurse 3 on April 28, 2026, revealed that she received a phone call from Registered Nurse 1 on April 23, 2026, at 9:36 p.m. reporting that Licensed Practical Nurse 2 gave oral medications via a midline. She told staff to remove Licensed Practical Nurse 2 from the floor. At 9:59 p.m. the physician was made aware and said to monitor the resident's condition. At 10:12 p.m. she interviewed Licensed Practical Nurse 2 via telephone who admitted that he crushed the resident's medication, mixed it in warm water and administered it through her midline. At 10:59 (continued on next page)</p>		

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F 0760  Level of Harm - Actual harm  Residents Affected - Few	<p>p.m. she interviewed him again and he reportedly stated that he had made a terrible mistake and got confused with giving medications crushed in a gastric tube. Interview with Licensed Practical Nurse 4 on April 28, 2026, at 5:58 p.m. revealed that Resident 2's daughter reported to her that Licensed Practical Nurse 2 put medications in the resident's midline catheter and she questioned if it was appropriate to do. Licensed Practical Nurse 4 revealed that she asked Licensed Practical Nurse 2 if he was crushing the resident's medications and giving them orally and he replied that he was. She was aware of him giving an as needed pain medication by mouth. Licensed Practical Nurse 4 attempted to show Licensed Practical Nurse 2 how to administer antibiotics in the midline for Resident 2 and the medication would not infuse and attempts to flush the midline catheter were unsuccessful despite Licensed Practical Nurse 2 stating he just flushed the midline catheter. Licensed Practical Nurse 4 reported the allegation of improper medication administration to Registered Nurse 1 who reported it to Registered Nurse 3. Licensed Practical Nurse 2 later admitted to Licensed Practical Nurse 4 that he crushed Resident 2's 6:00 p.m. medications and put them in her midline catheter. Interview with the Director of Nursing, Nursing Home Administrator and the facility's Clinical Compliance Certified Registered Nurse Practitioner on April 29, 2026, at 3:25 p.m. confirmed that Licensed Practical Nurse 2 administered medications that were ordered to be given by mouth via a syringe into a midline catheter and should not have. Following the incident on April 23, 2026, the facility's corrective actions included: Licensed Practical Nurse 2, who was involved in the improper administration of medications to Resident 2, was removed from duty, and was reported to the nursing agency that employed him as well as the state board of nursing. A full facility audit of the residents with intravenous access devices was completed and education of staff was initiated regarding the six rights of medication administration with emphasis on the right route, the Pennsylvania Licensed Practical Nurse scope of practice and code of conduct including that Licensed Practical Nurses are not permitted to administer intravenous push medications, adherence to proper routes of administration at all times, and safe practices for IV medication administration, subcutaneous injections, and enteral feeding. The education provided also included competency evaluations. A review of the facility's corrective actions revealed that they were in compliance with F760 on April 27, 2026. Interview with the Clinical Compliance Certified Registered Nurse Practitioner on April 29, 2026, at approximately 2:00 p.m. revealed that the facility had initiated audits three times a week for proper medication administration and proper intravenous medication administration. The results of the audits were to be discussed during the monthly Quality Assurance (QA) meeting. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.</p>		