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	05/09/2024

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

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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. 47819 Based on observations, as well as staff and resident interviews, it was determined that the facility failed to provide a safe and comfortable homelike environment in one of seven dining rooms (A1). Findings include: The facility's policy for safe and homelike environment, dated February 4, 2024, indicated that the facility, in accordance with residents' rights, will provide a safe, clean, comfortable, and homelike environment. This includes ensuring that the resident can receive care and services safely. An interview with a group of residents on May 7, 2024, at 2:00 p.m. revealed that the A1 dining room tables are peeling and are rough, and they had concerns about skin tears. Observations in the A1 dining room on May 8, 2024, at 9:06 a.m. revealed that eight of eight tables were peeling and had sharp edges. An interview with the Maintenance Director on May 8, 2024, at 9:08 a.m. confirmed that all eight tables located in the A1 dining room were peeling and had sharp edges. An interview with the Director of Nursing on May 8, 2024, at 1:18 p.m. confirmed the tables in the A1 dining room were peeling and that it was not a comfortable, safe and homelike environment. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(b)(1)(e)(1) Management. 28 Pa. Code 201.29(j) Resident Rights.

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: 395435	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024
NAME OF PROVIDER OR SUPPLIER Westmoreland Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 2480 South Grand Blvd Greensburg, PA 15601	

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. 43856 Based on review of facility policies, clinical records, and facility investigation information, as well as staff interviews, it was determined that the facility failed to prevent the misappropriation of medication for one of 48 residents reviewed (Resident 34). Findings include: The facility's policy regarding abuse, dated February 4, 2024, indicated that misappropriation included the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent. An annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 34, dated February 1, 2024, revealed that the resident was cognitively intact, required extensive assistance for daily care needs, and had a diagnosis of chronic pain. Physician's orders for Resident 34, dated February 4, 2024, included an order for the resident to receive one 5-325 milligrams (mg) tablet of Norco (a combination of hydrocodone-acetaminophen) by mouth every eight hours as needed for Moderate-Severe pain of 5-10 (on a scale of 1-10 with 10 being the worst pain), not to exceed 3 gm per 24 hours. Information submitted by the facility, dated March 5, 2024, revealed that on March 2, 2024, at 8:50 p.m. narcotics were delivered by the pharmacy for the B3 nursing unit. Registered Nurse Supervisor 1, who accepted and signed in the narcotics, stated that five cards were delivered to the facility. She documented five new narcotic card entries on the nursing office narcotic accountability form, attached copies of the five proof of use sheets to the delivery manifest, and documented that the narcotics were received in the facility's pharmacy communication. When the shift change occurred at 11:00 p.m. all narcotic cards were counted in the medication carts and compared to the unit narcotic accountability form. The count for narcotic cards was 42, which matched the accountability form. When the next shift change occurred at 7:00 a.m., the narcotic review was completed again per policy. The count again totaled 42 cards. However, at this time there were 43 entries on the narcotic accountability form. An investigation, initiated on March 3, 2024, at 7:00 a.m., determined that after the narcotics were documented and received in the facility by Registered Nurse Supervisor 1, Registered Nurse 2 then took the medications and the forms to the B3 nursing unit. It was determined that four cards were delivered to the nursing unit. Registered Nurse 2 and the B3 Unit registered nurse both recorded that four cards were received. Video footage was reviewed and it was confirmed that Registered Nurse 2 had the narcotics and that she was viewed on camera entering the unit on a few occasions and entering the medication room alone. The investigation was completed on March 7, 2024, at 4:00 p.m. and misappropriation was substantiated. The card of narcotics went missing and Registered Nurse 2 was the last person to be seen, in person and on camera, in possession of the narcotics card. There was no evidence that all five narcotics cards were delivered to the B3 unit. Video footage and statements supported the conclusion that only four cards were delivered and documented as such. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	All appropriate parties were notified and a full audit of all facility narcotics was completed to ensure that all narcotics were accounted for. All residents received their narcotic medications as ordered. No doses were missed as a result of the narcotic card that went missing. Registered Nurse 2 was suspended pending the investigation that began on March 3, 2024, at 7:00 a.m. and completed March 7, 2024, at 4:00 p.m. Registered Nurse 2 was terminated on March 7, 2024. Interview with the Clinical Coordinator on May 9, 2024, at 1:25 p.m. confirmed that the investigation initiated on March 3, 2024, at 7:00 a.m. was completed on March 7, 2024, at 4:00 p.m. and concluded that misappropriation of Resident 34's medication did occur. 28 Pa. Code 201.14(a) Responsibility of License. 28 Pa. Code 201.18(b)(1) Management. 28 Pa. Code 211.12(d)(5) Nursing Services.

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 48941 Based on clinical record reviews, as well as staff interviews, it was determined that the facility failed to ensure that a written notice regarding emergency transfer to the hospital was provided to the resident's responsible party and the Office of the State Long-Term Care Ombudsman for three of 48 residents reviewed (Residents 63, 82, 118). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 63, dated April 24, 2024, indicated that the resident was usually understood and could usually understand, required assist with care needs, received hemodialysis (treatment to remove extra fluid and waste from the blood when the kidneys are not able to), and had diagnoses that included end-stage renal disease (kidneys no longer work as they should). A nursing note for Resident 63, dated April 12, 2024, at 10:03 p.m. revealed that the resident was transferred to the hospital after traumatic removal of her right subclavian dialysis catheter (an indwelling catheter used for exchanging blood to and from the dialysis machine). Bleeding from the site was unable to be stopped and the resident was sent to the emergency room . There was no documented evidence that a written notice of Resident 63's transfer to the hospital was provided to the resident's responsible party and/or to the State Ombudsman. A quarterly MDS assessment for Resident 82, dated March 6, 2024, indicated that the resident was usually understood and usually understands what is being said, had cognitive impairment, required partial to moderate assist with transfers to bed/wheelchair/toilet, had a bed alarm used daily, and had a diagnosis of dementia. A nursing note for Resident 82, dated January 17, 2024, at 6:57 a.m. revealed that the resident was transferred to the hospital after a fall resulting in pain to her right shoulder. There was no documented evidence that a written notice of Resident 82's transfer to the hospital was provided to the resident's responsible party and to the State Ombudsman. A quarterly MDS assessment for Resident 118, dated March 8, 2024, indicated that the resident was rarely or never understood and nonverbal, was cognitively impaired, was dependent for care needs, had a feeding tube (a mechanical device surgically implanted into the stomach to provide nutrition, fluids and medications to a person who is unable to eat or drink by mouth), and had a diagnosis of Huntington's disease (a rare, inherited condition that affects the nerve cells in the brain and causes movement, cognitive and psychiatric problems). A nursing note for Resident 118, dated March 29, 2024, at 10:42 p.m. revealed that the resident was transferred to the hospital after a change in condition resulting in hypoxemia (low levels of oxygen in the blood) and possible ileus (a lack of movement in the intestines that can lead to blockage). (continued on next page)

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	There was no documented evidence that a written notice of Resident 118's transfer to the hospital was provided to the resident's responsible party and to the State Ombudsman. Interview with the Nursing Home Administrator on May 9, 2024, at 11:17 a.m. confirmed that there was no documented evidence that a written notice of emergency transfer to the hospital was provided to the resident's responsible party and to the State Ombudsman for Residents 63, 82 and 118. She revealed that she was not aware that the resident's responsible party and the State Ombudsman needed to be notified in writing about emergency transfers to the hospital; therefore, they were not notified as required. 28 Pa. Code 201.14(a) Responsibility of Licensee.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 38012 Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to ensure that care plans were updated to reflect changes in residents' care needs for one of 48 residents reviewed (Resident 66). Findings include: Resident 66's Medication Administration Record (MAR) for May 2024 revealed that the resident was receiving medications at 6:00 a.m. The resident's care plan, dated January 21, 2020, indicated that the resident did not want any medications or care until after 7:00 a.m. Interview with Resident 66 on May 6, 2024, at 10:40 a.m. revealed that she receives early dialysis (medical process of removing toxins from the blood) treatment and that she does not mind getting her medications early. She stated that her care plan was never updated after she switched to the early dialysis time. Interview with the Director of Nursing on May 9, 2024, at 11:51 a.m. confirmed that Resident 66's care plan was old and should have been revised to reflect that her preferences regarding when she received her medications had changed. 28 Pa. Code 201.24(e)(4) Admission Policy.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 19102 Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that residents were provided with weekly showers for one of 48 residents reviewed (Resident 151). Findings include: The facility's policy regarding showers, dated February 4, 2024, indicated that residents would be offered a shower at least once a week. An annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 151, dated April 26, 2024, indicated that the resident was alert and oriented, and it was very important to choose between a tub bath, shower, bed bath, or sponge bath. The resident's care plan, dated July 7, 2023, included that the resident was to receive a shower in the morning. A nursing note, dated April 4, 2024, at 4:59 p.m., revealed that Resident 151 tested positive for COVID-19 and had his room changed. The resident's bathing records for April 1 to 30, 2024, revealed that the resident did not receive a weekly shower on April 5 and 12, 2024, and received a bed bath. Interview with the Director of Nursing on May 8, 2024, at 10:25 a.m. confirmed that Resident 151 was not showered on April 5 and 12, 2024, due to testing positive for COVID-19. 28 Pa. Code 211.12(d)(5) Nursing Services.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 47819 Based on review of policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure the facility policies for a tube feeding were followed for one of 48 residents reviewed (Resident 159). Findings include: The facility's policy regarding feeding tubes (a tube inserted directly into the stomach), dated February 4, 2024, revealed that the formula and tubing must be identified with the date and time it was started and is to be used no longer than 24 hours. An annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 159, dated April 3, 2024, indicated that the resident was cognitively impaired, required assistance of staff for care, had a feeding tube for nutrition, and had diagnoses that included stroke and dementia. A care plan for Resident 159, dated September 2, 2020, indicated that the tube feeding formula, hydration, and flushes were to be administered per order. Current physician's orders for Resident 159 included an order for the resident to receive Isosource 1.5 calories/milliliter (Cal/mL) (a tube feeding formula) at 38 ml/hr for 21 hours. Resident 159's Medication Administration Record (MAR) for May 2024 indicated that the tube feeding was infused at 38 mL/hr for 21 hours. Observations of Resident 159 on May 8, 2024, at 9:26 a.m. revealed that the bag of Isosource 1.5 was hanging on the tube feeding pump; however, the label was blank and did not have the date and time of when the tube feeding bag was prepared. Interview with Registered Nurse 3 at that time confirmed that the label on Resident 159's bag of Isosource 1.5 did not have the date and time of when it was prepared and hung. Interview with the Director of Nursing on May 8, 2024, at 12:44 p.m. confirmed that staff were to ensure the tube feeding labels contained the necessary identifying information such as the date and time the formula was hung. 28 Pa. Code 211.12(d)(5) Nursing Services.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 48941 Based on review of facility policy and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that residents were free from unnecessary psychotropic medications for one of 48 residents reviewed (Resident 82). Findings include: The facility's policy regarding psychotropic medication (any medication that affects brain activities associated with mental processes and behavior), dated February 4, 2024, indicated that staff are to utilize non-pharmacological interventions (individualized approaches to care not primarily based on medication) when clinically indicated to reduce the need for psychotropic medication. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 82, dated March 6, 2024, indicated that the resident was usually understood, had cognitive impairment, required partial to moderate assist with transfers to bed/wheelchair/toilet, had a bed alarm used daily, and had diagnoses that included dementia and anxiety. Physician's orders for Resident 82, dated December 26, 2023, included an order for the resident to receive 0.5 milligrams (mg) of Lorazepam (a psychotropic medication to treat anxiety) every six hours as needed for anxiety. A psychiatric evaluation for Resident 82, dated February 21, 2024 recommended to continue positive psychosocial and non-pharmacological approaches to enhance the resident's wellness. Review of the Medication Administration Records (MAR) for Resident 82 for January and February 2024 revealed that the resident was administered 0.5 mg of Lorazepam on January 1, 2024, at 2:42 a.m. and 7:02 p.m.; January 2, 2024, at 5:57 p.m.; January 3, 2024, at 1:00 a.m.; January 4, 2024, at 12:42 a.m. and 9:37 p.m.; January 6, 2024, at 12:11 a.m. and 10:43 p.m.; January 7, 2024, at 7:23 p.m.; January 14, 2024, at 6:26 p.m.; January 20, 2024, at 6:14 a.m.; January 31, 2024, at 6:46 p.m.; February 8, 2024, at 4:02 a.m.; and February 11, 2024, at 5:44 p.m. There was no documented evidence that non-pharmacological interventions were attempted prior to administering Lorazepam on the above-mentioned dates and times. An interview with the Director of Nursing on May 9, 2024, at 11:54 a.m. confirmed that there were no non-pharmacological behavioral interventions attempted for Resident 82 prior to the administration of Lorazepam on the above-mentioned dates and times. 28 Pa. Code 211.12(d)(5) Nursing Services.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 47819 Based on review of manufacturer's instructions and clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure that medications were properly labeled for one of 48 residents reviewed (Resident 25) and failed to label multi-dose containers of insulin with the date they were opened in one of six medication carts reviewed (A1). Findings include: The facility's policy regarding medication label changes, dated February 4, 2024, indicated that in the event that an order change was made, allowing for the administration of the same medication, but requiring a label change, staff were to place an auxiliary label stating Direction Changed over the old directions on the label. Physician's orders for Resident 25, dated March 21, 2024, included an order for the resident to receive 20 units of Lantus insulin one time a day for diabetes. Observations during medication administration on May 8, 2024, at 9:00 a.m. revealed that Resident 25 received 20 units of Lantus insulin; however, the label on the resident's box of Lantus insulin indicated that the resident was to receive 25 units of Lantus insulin at bedtime. Interview with Licensed Practical Nurse 4 on May 8, 2024, at 9:18 a.m. confirmed that the label on Resident 25's bottle of Lantus did not include the morning dose, and a Change in Direction label should have been placed on the bottle. The facility's multi-dose vial storage policy, dated February 4, 2024, indicated that the facility will date all multi-dose vials when opened, for the purpose of infection control and to ensure product stability. Manufacturer's instructions for Humalog and Lantus insulin, dated February 2024, revealed that the insulin vial was to be discarded 28 days after it was opened. Physician orders for Resident 26, dated March 25, 2021, included an order for the resident to receive 8 units of Humalog in the evening. Physician orders for Resident 26, dated March 5, 2024, included an order for the resident to receive 12 units of Lantus at bedtime. Manufacturer's instructions for Lispro insulin, dated February, 2024, revealed that the insulin vial was to be discarded 28 days after it was opened. Physician orders for Resident 74, dated January 8, 2024, included an order for the resident to receive Lispro two times a day. Manufacturer's instructions for Levemir insulin, dated February 2024, revealed that the insulin vial was to be discarded 42 days after it was opened. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Physician orders for Resident 169, dated December 20, 2023, included an order for the resident to receive 6 units of Levemir one time a day. Observations of A1 medication cart on May 9, 2024, at 12:45 p.m. revealed that the Humalog, Lantus, Lispro, and Levemir vials for Residents 26, 74, and 169 were opened and not dated. Interview with Licensed Practical Nurse 5 on May 9, 2024, at 12:45 p.m. confirmed that the insulin vials for Residents 26, 74, and 169 were not dated when opened to indicate the date they expire and should have been. Interview with the Director of Nursing on May 9, 2024, at 1:00 p.m. confirmed that all insulin vials should have been labeled with the dates that they were opened and discarded in accordance with manufacturer's instructions. 28 Pa. Code 211.9(h) Pharmacy Services. 28 Pa. Code 211.12(d)(1) Nursing Services.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 31760 Based on review of facility policies, as well as observations and staff interviews, it was determined that the facility failed to ensure that food was served under sanitary conditions. Findings include: The facility's policy regarding feeding with dignity, dated February 4, 2024, revealed that staff will cleanse hands between residents when direct contact is made. Staff were not to touch food with their bare hands, and they were to wear gloves and wash hands in between glove changes. Observations during the lunch meal in the A3 unit dining room on May 7, 2024, at 12:12 p.m. revealed that Nurse Aide 6 placed Resident 115's plate in front of her. Nurse Aide 6 picked up the top of the hamburger bun from the resident's plate with his bare hand and placed the mechanical soft prepared hamburger from a bowl onto the lower hamburger bun. He then replaced the top of the hamburger bun. The resident then took the hamburger and took a bite of it. Interview with Nurse Aide 6 on May 7, 2024, at 12:59 p.m. confirmed that he touched Resident 115's sandwich without using a glove or a barrier. Interview with the Corporate Compliance/Certified Registered Nurse Practitioner (CRNP - is a registered nurse who has advanced education and clinical training in a health care specialty area) on May 7, 2024, at 3:55 p.m. confirmed that staff were to use gloves or a barrier when touching residents' food items. 28 Pa. Code 211.6(f) Dietary Services.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. 19102 Based on clinical record reviews and staff interviews, it was determined that the facility failed to ensure that the designated interdisciplinary team member obtained the required information from the contracted hospice provider for two of 48 residents reviewed (Residents 97, 228) who were receiving hospice services. Findings include: An annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 97, dated February 7, 2024, indicated that the resident was cognitively impaired and had a diagnosis of malnutrition. Physician's orders for Resident 97, dated March 3, 2022, included an order for the resident to be treated by hospice (end-of-life services). A care plan for Resident 97, dated March 3, 2022, indicated that the resident was receiving hospice services due to a terminal illness related to malnutrition. As of May 9, 2023, there was no documented evidence in the resident's clinical record, or in the hospice provider's clinical record, that the facility obtained updated hospice nurse aide charting. The last hospice nurse aide charting located on the resident's chart was dated January 2024. Interview with the Director of Nursing on May 9, 2024, at 12:55 p.m. confirmed that Resident 97's hospice nurse aide charting was not in the residents' clinical record and/or in the hospice provider's clinical record. An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 228, dated April 30, 2024, indicated that the resident was cognitively intact and had a diagnosis of cerebral vascular accident (an interruption in the flow of blood to the cells in the brain). Physician's orders for Resident 228, dated April 27, 2024, included an order for the resident to be treated by hospice (end-of-life services). A care plan for Resident 228, dated April 25, 2024, indicated that the resident was receiving hospice services due to a terminal illness cerebrovascular disease. As of May 9, 2023, there was no documented evidence in the resident's clinical record, or in the hospice provider's clinical record, that the facility obtained updated hospice registered nurse or nurse aide charting. The last hospice registered nurse charting located on the resident's chart was admission notes dated April 27, 2024. Interview with the Director of Nursing on May 9, 2024, at 12:55 p.m. confirmed that Resident 228's hospice registered nurse and nurse aide charting was not in the residents' clinical record and/or in the hospice provider's clinical record. (continued on next page)

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	05/09/2024

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.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code 211.12(d)(3)(5) Nursing Services.

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 05/09/2024
NAME OF PROVIDER OR SUPPLIER Westmoreland Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 2480 South Grand Blvd Greensburg, PA 15601	

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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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 47819 Based on review of the facility's plans of correction for previous surveys, and the results of the current survey, it was determined that the facility's Quality Assurance Performance Improvement (QAPI) committee failed to correct quality deficiencies and ensure that plans to improve the delivery of care and services effectively addressed recurring deficiencies. Findings include: The facility's deficiencies and plans of corrections for State Survey and Certification (Department of Health) survey ending June 13, 2023; August 15, 2023; and August 29, 2023, revealed that the facility developed plans of correction that included quality assurance systems to ensure that the facility maintained compliance with cited nursing home regulations. The results of the current survey, ending May 9, 2024, identified repeated deficiencies related accuracy of assessments, tube feeding management, label/store drugs and biologicals, and infection prevention and control. The facility's plan of correction for a deficiency regarding accuracy of assessments, cited during the survey ending June 13, 2023, revealed that accuracy of assessments would be monitored by QAPI. The results of the current survey, cited under F641, revealed that the QAPI committee was ineffective in maintaining compliance with regulation regarding accuracy of assessments. The facility's plan of correction for a deficiency regarding tube feedings, cited during the survey ending August 15, 2023, revealed that tube feeding would be monitored by QAPI. The results of the current survey, cited under F693, revealed that the QAPI committee was ineffective in maintaining compliance with regulation regarding tube feeding. The facility's plan of correction for a deficiency regarding labeling and storage of drugs and biologicals, cited during the survey ending June 13, 2023, revealed that labeling and storage of drugs and biologicals would be monitored by QAPI. The results of the current survey, cited under F761, revealed that the QAPI committee was ineffective in maintaining compliance with regulation regarding label and storage drugs and biologicals. The facility's plan of correction for a deficiency regarding infection prevention and control, cited during the survey ending August 29, 2023, revealed that infection prevention and control would be monitored by QAPI. The results of the current survey, cited under F880, revealed that the QAPI committee was ineffective in maintaining compliance with infection prevention and control. Refer to F641, F693, F761, F880. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(e)(1) Management.

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

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 43856 Based on review of facility policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure that proper hand washing/hand hygiene was completed during wound care for one of 48 residents reviewed (Resident 122) and failed to ensure proper infection control practices while handling soiled linens after resident care (Resident 228). Findings include: The facility's policy regarding dressings changes and clean technique, dated February 4, 2024, revealed that clean technique is to be used for all dressing changes unless otherwise ordered by the physician. Washing of hands and application of non-sterile gloves is to be performed prior to removal of soiled dressing, after removal of soiled dressing and before cleansing the wound, and after cleansing the wound and before application of clean wound treatment. Gloves are to be removed and hands washed after completion of treatment and discarding waste. An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 122, dated April 23, 2024, revealed that the resident was cognitively intact, required assistance with care needs, had a Stage 3 pressure ulcer (pressure wound involving the fat layers beneath the skin) to the right proximal great toe, a Stage 4 pressure ulcer (pressure wound with full thickness tissue loss with exposed bone, tendon or muscle) to the right distal great toe, a venous ulcer to the right lower leg present, was receiving intravenous (administered into a vein) antibiotic medication for an infection of his right foot, and had diagnoses that included osteomyelitis and chronic peripheral venous insufficiency. Physician's orders for Resident 122, dated April 18, 2024, included an order to wash the proximal right great toe tip with normal saline solution (NSS-a sterile solution used for the moistening of wound dressings and wound debridement), pat dry, then apply adaptic (a non-adherent dressing) (cut to fit) then dry dressing every day shift. Physician's orders, dated April 18, 2024, included an order to wash the posterior left lower extremity with NSS, pat dry, apply adaptic then dry dressing every day shift and as needed for soilage/displacement. Physician's orders, dated April 19, 2024, included an order to irrigate the distal right great toe tip with NSS, apply Nu gauze (gauze inserted into wounds) packing strip to wound cavity depth and undermining, cover with dry dressing and kling (roll gauze used to secure dressings) every day shift and as needed for soilage/displacement. Physician's orders, dated April 19, 2024, included an order to apply Amlactin external lotion to lower extremities topically every day shift. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations during wound care on May 8, 2024, at 11:55 a.m. revealed that Registered Nurse 7 and Licensed Practical Nurse 8 gathered supplies for Resident 122's wound care and placed them on the top of the treatment cart and placed a red garbage bag to collect soiled materials. Registered Nurse 7 and Licensed Practical Nurse 8 put gloves on their hands and gowned due to the resident being on Enhanced Barrier Precautions (precautions to prevent spread of infection). Registered Nurse 7 removed the old kling wrap and dressing from the resident's left lower extremity and placed it in the red bag then proceeded to attempt to measure the wound but could not visualize it well due to it being on the back of the resident's leg (the resident was sitting in his wheelchair). Licensed Practical Nurse 8 switched places with Registered Nurse 7 and measured the wound. He then cleaned the wound and gave the dirty gauze to Registered Nurse 7, at which time she threw it in the red bag. With the same gloved hands, Registered Nurse 7 gave Licensed Practical Nurse 8 the clean dressing and he placed the clean dressing on the wound then wrapped it with kling gauze. Licensed Practical Nurse 8 and Registered Nurse 7 changed their gloves. The dressings to the two areas on Resident 122's right great toe came off in his sock when it was removed to do his treatments. Licensed Practical Nurse 8 measured the areas to Resident 122's right great toe and Registered Nurse 7 proceeded to clean the areas to the right great toe. The soiled gauze was discarded in the red bag. Registered Nurse 7 handed Licensed Practical Nurse 8 a sterile Q-tip and the packing gauze strip and he proceeded to pack to distal right great toe using the stick end of the sterile Q-tip to pack the wound. When he was finished, Registered Nurse 7 cut the gauze packing strip. Registered Nurse 7 then placed a dressing over the toe wounds, wrapped the toes with kling gauze, and applied the Amlactin external lotion to lower extremities. Registered Nurse 7 removed her gloves and gown. Licensed Practical Nurse 8 removed his gown and kept his gloves on and took the red bag to discard it. Registered Nurse 7 exited the room and proceeded up the hall with the treatment cart. At no point during the entire process of Resident 122's wound care did Registered Nurse 7 or Licensed Practical Nurse 8 use antibacterial hand sanitizer or wash their hands after removing their soiled gloves and before reapplying clean gloves, between handling soiled dressings and applying clean dressings, and between treatments to left lower extremity and areas to right great toe. Interview with Registered Nurse 7 and Licensed Practical Nurse 8 on May 8, 2024, at 12:12 p.m. confirmed that each time they changed their gloves during wound care for Resident 122, they should have washed their hands prior to putting on new gloves, but they did not. Interview with the Director of Nursing on May 8, 2024, at 3:12 p.m. confirmed that each time Registered Nurse 7 and Licensed Practical Nurse 8 changed their gloves during wound care for Resident 122, they should have washed their hands prior to putting on new gloves, but they did not. An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 228, dated April 30, 2024, revealed that the resident was cognitively intact and required extensive assistance for daily care needs. Observations on May 6, 2024, at 11:01 a.m. revealed that Nurse Aide 9 gave Resident 228 a bed bath and threw a soiled towel and wash cloth on the floor while providing care. Interview with Nurse Aide 9 on May 6, 2024, at 11:27 a.m. confirmed that she should not throw soiled linen on the floor while providing care and that the soiled items should be placed in bags and taken to the dirty utility room. (continued on next page)

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Clinical Coordinator on May 7, 2024, at 2:14 p.m. confirmed that soiled linen should not be thrown on the floor and that staff should place all laundry in bags and it should be taken to the dirty utility room. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.