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	05/08/2025

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 19102 Based on review of the Resident Assessment Instrument User's Manual and clinical records, as well as staff interviews, it was determined that the facility failed to complete accurate Minimum Data Set assessments for four of 58 residents reviewed (Residents 84, 196, 208, 229). Findings include: The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides guidance and instructions for the completion of Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2024, indicated that the intent of Section A was to record the discharge status of the resident. Section A2105 was to be coded with the location of the resident's discharge, indicated that the intent of Section J1900 was to be coded with number of falls of no injury, injury or major injury since admission/entry or reentry or prior assessment whichever is more recent. indicated that the intent of Section N was to record the number of days, during the seven days of the assessment period, that any type of injection, insulin, and/or select medications were received by the resident. Sections N0415I Antiplatelet Medications (medication used to prevent blood from clotting), N0415K anticonvulsant medications was to be coded if the resident took the medication during the seven-day lookback period. A significant change MDS assessment for Resident 84, dated April 8, 2025, revealed that the resident was cognitively intact, required assistance with activities of daily living, and had medical diagnoses that included seizure disorder and cerebral palsy. Physician's orders for Resident 84, dated April 3, 2025, included an order for the resident to receive 150 milligrams (mg) of Oxcarbazepine (an anticonvulsant). A review of the resident's April 2025 Medication Administration Record (MAR) revealed that the resident received Oxcarbazepine during the seven-day look-back period. A quarterly assessment for Resident 196, dated February 18, 2025, revealed that the resident is cognitively intact, required assistance with activities of daily living, and had medical diagnoses that included coronary artery disease, history of heart attack and high blood pressure. Physician's orders for Resident 196, dated October 14, 2023, included an order for the resident to receive 75 mg of Clopidogrel Bisulfate (an antiplatelet) daily for history of heart attack. A review of the resident's February 2025 MAR revealed that the resident received Clopidogrel Bisulfate during the seven-day look-back period. (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Director of Case Management on May 8, 2025. at 11:30 a.m. confirmed that the MDS assessments for Residents 84 and 196 were inaccurately coded. The RAI User's Manual, dated October 2024 revealed that if the assessment was the first assessment since the most recent admission/entry or reentry, then Section A0310E was to be coded (1) Yes. Section J1700, the resident's fall history on admission/entry or re-entry, was to be completed if Section A0310E was coded (1) Yes. If the resident had a fall any time in the month prior to admission/entry or reentry, then Section J1700A was to be coded (1) Yes. If the resident had a fracture related to a fall in the six months prior to admission/entry or re-entry, then Section J1700C was to be coded (1) Yes. A nursing note for Resident 208, dated August 15, 2024, at 7:14 p.m. revealed that the resident was observed on the floor in the dining room and complained of her left upper thigh hurt. She was transferred to the hospital and admitted with a left hip fracture. A quarterly MDS assessment for Resident 208, dated October 3, 2024, revealed that Section A0310E was incorrectly coded (0) No, indicating that this was not the resident's first MDS assessment since being readmitted (from the hospital). By coding Section A0310E as (0) No, the computerized MDS software did not allow Sections J1700A and J1700C to be completed to reflect that the resident had a fall and fracture in the past 30 days. Interview with Director of Case Management on May 7, 2025, at 3:19 p.m. confirmed that Resident 208's MDS was coded incorrectly. A nursing note for Resident 229, dated March 1, 2025, indicated that the resident was discharged to personal care home on that date. However, a discharge tracking MDS for Resident 229, dated March 1, 2025, indicated that Resident 33 was discharged to the hospital. An interview with the Director of Case Management on May 8, 2025, at 3:06 p.m. confirmed that Resident 229's discharge tracking MDS was coded incorrectly. 28 Pa. Code 211.5(f) Clinical Records.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 42079 Based on review of Pennsylvania's Nursing Practice Act and clinical records, as well as staff interviews, it was determined that the facility failed to clarify a provider's orders for one of 58 residents reviewed (Resident 106). Findings include: The Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.11 (a)(1)(2)(4) indicated that the registered nurse was to collect complete and ongoing data to determine nursing care needs, analyze the health status of individuals and compare the data with the norm when determining nursing care needs, and carry out nursing care actions that promote, maintain and restore the well-being of individuals. The facility's policy regarding medication orders, transcription of substituted, dated February 1, 2025, indicated that the registered nurse or licensed practical nurse transcribing the order would be notified by the pharmacy of the substitution and would then discontinue the order for the original brand name medication in the electronic record and enter a new order with the drug substituted by the pharmacy. An annual Minimum Data Set (MDS) assessment (a federally-mandated assessment of a resident's abilities and care needs) for Resident 106, dated April 23, 2025, indicated that the resident was cognitively intact, required assistance from staff for daily care needs, and had diagnoses that included renal failure (kidney failure) and peripheral vascular disease (a condition that affects the blood vessels outside the heart and brain). Physician's orders for Resident 106, dated April 21, 2024, included an order for the resident to be administered 250 milligrams (mg) of calcium citrate twice a day for Vitamin D deficiency. Observations of medication administration on May 7, 2025, at 8:20 a.m. revealed that Resident 106 was administered 950 mg of calcium citrate that contained 200 mg of calcium. Interview with Licensed Practical Nurse 2 on May 7, 2025, at 2:23 p.m. confirmed that the physician's order was to administer 250 mg of calcium citrate, but the card dispensed from the pharmacy was for calcium citrate 950 mg with 200 mg calcium. She was not sure why the pharmacy would have provided a different medication. Interview with the Pharmacy Supervisor for Data Entry on May 8, 2025, at 10:07 a.m. confirmed that a pharmacist had changed the medication, because the previous medication was on backorder. There was no notation in the chart that the pharmacy had informed the facility, and after speaking to the pharmacist it was determined that the dose was not equivalent. The pharmacy should have called the facility to inform them of the change. There was no documented evidence in Resident 106's clinical record to indicate that the medication was clarified with the physician. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Director of Nursing on May 8, 2025, at 8:32 a.m. confirmed that pharmacy changed and sent a medication that was not an equivalent, that the current physician's order did not match the medication that was administered to Resident 106, and that nursing staff should have clarified the order with the physician. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.

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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. 19102 Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to ensure that residents received care and treatment in accordance with professional standards of practice, by failing to ensure that physician's orders were followed for two of 58 residents reviewed (Residents 191, 208). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 191, dated February 21, 2025, revealed that the resident was understood and could understand others. A care plan for the resident, dated September 10, 2024, revealed that the resident has an altered cardiovascular status related to congestive heart failure (CHF - a condition where the heart can not pump enough blood to meet the body's needs, leading to fluid buildup in the lungs, legs, and other parts of the body) and hypertension (high blood pressure). Staff was to administer medications as ordered by the physician. Physician's orders for Resident 191, dated February 20, 2025, and discontinued on April 30, 2025, included an order for the resident to receive one 25 milligram (mg) tablet of Hydralazine (used to treat high blood pressure) every eight hours for hypertension. Staff was to hold the medication for a systolic blood pressure (the top number of the blood pressure) reading of less than 120 millimeters of mercury (mmHg). Physician's orders for Resident 191, dated April 30, 2025, included an order for the resident to receive one 25 mg tablet of Hydralazine two times per day for hypertension. Staff was to hold the medication for a systolic blood pressure reading of less than 120 mmHg. Review of Resident 191's Medication Administration Record (MAR), dated March, April, and May 2025, revealed that the resident's systolic blood pressure was less than 120 mmHg on March 16, 2025, at 10:00 p.m.; March 31, 2025, at 10:00 p.m.; April 3, 2025, at 2:00 p.m.; April 10, 2025, at 2:00 p.m.; May 2, 2025, at 6:00 a.m.; and on May 6, 2025, at 6:00 a.m.; however, there was no documented evidence that Hydralazine was held as ordered by the physician. Interview with Clinical Compliance on May 7, 2025, at 12:50 p.m. confirmed that Resident 191's Hydralazine was not held as ordered on the above dates and times. A quarterly MDS assessment for Resident 208, dated April 19, 2025, indicated that the resident was cognitively impaired and had diagnoses that included hypertension (high blood pressure) and dementia. A care plan, dated July 2, 2024, indicated that the resident's medications were to be administered as ordered by physician. Physician's orders for Resident 208, dated February 15, 2025, included an order for the resident to receive 12.5 mg of metoprolol tartrate (treats atrial fibrillation) twice a day. The medication was to be held if the resident's systolic blood pressure (the top number of a blood pressure reading) was less then 130 millimeters of mercury (mmHg), or if the heart rate was less than 60 beats per minute. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 208's Medication Administration Records (MAR's) for February and March 2025 revealed that the resident's systolic blood pressure was less than 130 mmHg at 9:30 a.m. on February 12, 23, 26, and March 2, and 5 and at 6:00 p.m. on February 1, 4, 23, and March 2, 2025; however, there was no documented evidence that metoprolol tartrate was held as ordered by the physician. Interview with Clinical Compliance on May 7, 2025, at 12:50 p.m. confirmed that Resident 208's metoprolol was not held as ordered on the above dates and times. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 31760 Based on a review of facility policies, clinical records, and investigation reports, as well as staff interviews, it was determined that the facility failed to ensure that the environment was free of accident hazards for one of 58 residents reviewed (Resident 48) resulting in a hot liquid spill with injury. This deficiency was cited as past non-compliance. Findings include: The facility policy regarding hot liquids safety, dated February 1, 2025, indicated that in order to promote safety, appropriate precautions will be implemented to maximize choice of beverages while minimizing potential for injury. Hot liquids will be severed at a temperature not greater than 140 degrees Fahrenheit (F). A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 48, dated January 6, 2025, revealed that the resident was understood, could understand others, and had a diagnosis which included cerebral vascular accident (CVA - commonly known as a stroke) with left-side hemiplegia (paralysis on one side of the body). A nursing note for Resident 48, dated February 23, 2025, at 9:55 p.m. revealed that an eight-ounce (oz) cup of coffee was prepared upon the resident's request. The cup was provided with a lid on and placed on the resident's bedside table. The resident prefers drinking his coffee out of an open cup and uses his right dominant hand. The resident removed the lid and proceeded to pick up the cup when it slipped out of his hand. The resident stated it was an accident. The resident is alert and oriented. The resident reported mild pain at time of incident. Light yellow blister on top of his left thigh near his groin measuring two centimeters (cm) by three cm by 0.2 cm. The surrounding tissue was intact with a light-red area measuring five cm by three cm. There was another light-yellow blister that is located to his lateral (to the side of, or away from, the middle of the body) of his left thigh measuring one cm by one cm by 0.2 cm and the surrounding tissue is light red measuring five cm by 1.3 cm. The affected area was cleansed with saline and an adaptic dressing (helps prevent dressing adherence) was applied and then covered with a dry dressing. Staff were to be educated on measuring the temperature before providing heated liquids/foods and ensuring liquids are about 140 degrees F before submitting to the resident. A statement completed by Nurse Aide 1, dated February 23, 2025, revealed that at approximately 8:00 p.m. on February 23, 2025, Resident 48 requested for her to use one of his own K-Cups to brew him a fresh cup of coffee. The nurse aide used the Keurig in the A1 staff room to make it. The resident requested no lid on his coffee cup and to make it black. The nurse aide set his cup on his bedside table where he requested and asked him if he needed anything else, he stated no. Approximately five to ten minutes later the nurse aide heard him yelling out in pain. The nurse aide ran to his room where the resident stated, I dropped my coffee on my hand. The on-shift licensed practical nurse ran in behind the nurse aide, and the resident told her his hand was hurting from spilling his coffee. It was observed that his left thigh had two red areas and blisters forming on the red areas. No red areas or blisters on his hand were seen. The nurse aide was educated at the end of the shift that all drinks from the Keurig should temp at 140 degrees F and below for all residents. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interview with Resident 48 on May 6, 2025, at 12:53 p.m. revealed that he asked staff to get him a cup of coffee using one of his K-Cups that his family provides him, and that he requested that staff not put a lid on the cup and to set it on his over-bed table. He indicated that he was in bed and felt tired that night and the next thing he spilt the cup of coffee onto his left thigh. Interview with Nurse Aide 1 on May 7, 2025, at 3:15 p.m. revealed that she was providing care to Resident 48 and he stated to her not to forget his coffee and that he did not want a lid on the cup. She went to the A1 staff lounge where the Keurig was located and brewed the resident his coffee with the K-Pod he provided. After the coffee was brewed, she did not obtain a temperature on the coffee because this was how they did it in the past. She set the Styrofoam cup containing the coffee on the resident's over-bed table and left. Approximately four to five minutes went by, and she heard him scream and went to investigate. She indicated that she saw that he had spilled his coffee down onto his left thigh. Interview with the Director of Nursing on May 6, 2025, at 2:35 p.m. confirmed that there was no documented evidence that the temperature was obtained on the coffee prior to being served to Resident 48. She indicated that the hot liquid safety policy was for the kitchen staff and not for nursing staff. Following the incident on February 23, 2025, the facility's corrective actions included: Resident 48 was assessed and treatment to his left thigh was obtained. The resident was ordered Kennedy cups (a lightweight spill-proof drinking cup) to receive his hot liquids in. An audit of other residents who receive hot liquids from a Keurig or other electrical devices was completed. Nurse Aide 1 received education on measuring the temperature before providing heated liquids/foods and ensuring liquids are about 140 degrees F before giving to the residents. The facility's policy regarding hot liquid safety was reviewed and revised to include the procedure for temping liquids from a Keurig or other electrical device. The facility's food temperature log was reviewed and revised to include the temperatures of liquids before being served. Facility staff as well as agency staff education on the revised hot liquid safety policy, food temperature log, as well as measuring the temperature before providing heated liquids/foods and ensuring liquids are about 140 degrees F before giving to the residents was completed. Audits to identify any issues with following a resident's care plan for assistance with bed mobility/transfers were started. The results of these audits will be brought to Quality Assurance Performance Improvement committee for further analysis and corrective actions if necessary. Review of the facility's corrective actions and interviews completed with staff regarding their re-education revealed that they were in compliance with F689 on March 24, 2025. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	28 Pa. Code 201.18(b)(1) Management. 28 Pa Code 211.12(d)(5) Nursing Services.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. 19102 Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to ensure that a peripherally-inserted central catheter (PICC - a long, thin tube that is inserted through a vein in the arm and passed through to the larger veins near the heart) was flushed as ordered by the physician for two of 58 residents reviewed (Residents 77, 207). Findings include: The facility's policy regarding flushing intravenous catheters (a thin tube inserted into a vein and used long-term for the administration of fluids and/or medications), dated February 1, 2025, indicated that the catheter was to be flushed with 0.9 percent sodium chloride (sterile salt water solution) before and after medication administration. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 77, dated April 2, 2025, revealed that the resident was cognitively impaired, required assistance for daily care needs, and had diagnoses that included heart failure, high blood pressure, and extended spectrum beta lactamase in the urine (an infection in urine). Physician's orders for Resident 77, dated April 28, 2025, included an order for the resident to receive 500 milligrams of Invanz (intravenous antibiotic medication) for urinary tract infection. Review of the April and May 2025 Medication Administration Record (MAR) for Resident 77 revealed no documented evidence that the resident's PICC line was flushed after the antibiotic was administered as per facility policy. An interview with the Clinical Compliance Officer on May 8, 2025, at 9:41 a.m. confirmed that there was no documented evidence that Resident 77's PICC line was flushed after the antibiotic was administered as per facility policy. A quarterly MDS assessment for Resident 207, dated April 23, 2025, revealed that the resident was cognitively intact, required assistance for daily care needs, received antibiotics, received IV medications, and had diagnoses that included peripheral vascular disease (poor circular of the extremities), and diabetes. A nursing note, dated April 17, 2025, revealed the resident returned from the hospital following amputation of her left big toe and had a PICC line in her right arm. Physician's orders for Resident 207, dated April 18, 2025, included an order for the resident to receive 1500 mg of Vancomycin (antibiotic) intravenously (IV) daily until April 23, 2025, and the IV access site was to be flushed with 10 ml of normal saline solution before and after medication administration at bedtime. Physician's order for Resident 207, dated April 22, 2025, included an order for the resident to receive 1750 mg of Vancomycin intravenously daily until April 24, 2025. A care plan, dated April 21, 2025, indicated that IV flushes were to be provided as ordered. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 207's MAR's for April 2025 indicated that the resident received IV Vancomycin intravenously daily at 10:00 a.m., and not at bedtime, from April 18 through 24, 2025; however, there was no documented evidence that staff flushed the resident's IV catheter with saline solution before and after any of the IV administrations of Vancomycin. Interview with the Clinical Corporate Officer on May 7, 2025, at 12:44 p.m. confirmed that there was no documented evidence that Resident 207's PICC line was flushed with saline solution before and after every administration of antibiotics. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 42079 Based on review of manufacturer's instructions, facility policies, and clinical records, as well as observations and staff interviews, it was determined that the facility failed to maintain a medication error rate of less than five percent. Findings include: The facility's policy regarding medication administration: rights, dated February 1, 2024, indicated that when administering the medication, the electronic medical record should be checked against the prescription label for each resident. To ensure accountability and the six 'rights' (right resident, right drug, right dose, right time, right route, right dosing form), guidelines were set for medication administration. Observations during medication administration on August 21, 2024, revealed that two medication administration errors were made during 30 opportunities for error, resulting in a medication administration error rate of 6.67 percent. An annual Minimum Data Set (MDS) assessment (a federally-mandated assessment of a resident's abilities and care needs) for Resident 106, dated April 23, 2025, indicated that the resident was cognitively intact, required assistance from staff for daily care needs, and had diagnoses that included renal failure (kidney failure) and peripheral vascular disease (a condition that affects the blood vessels outside the heart and brain). Physician's orders for Resident 106, dated April 21, 2024, included an order for the resident to be administered 250 milligrams (mg) of calcium citrate twice a day for Vitamin D deficiency. Observations of medication administration on May 7, 2025, at 8:20 a.m. revealed that Resident 106 was administered 950 mg of calcium citrate. Interview with Licensed Practical Nurse 2 on May 7, 2025, at 2:23 p.m. confirmed that the physician's order was to administer 250 mg of calcium citrate, but the card dispensed from the pharmacy was for 950 mg of calcium citrate. A quarterly MDS assessment for Resident 147, dated April 2, 2025, indicated that the resident was cognitively intact, required assistance from staff for daily care needs, and had diagnoses that included multiple sclerosis (a chronic, progressive disease of the central nervous system that can affect the brain, optic nerves, and spinal cord). Physician's orders for Resident 147, dated July 18, 2022, included an order for the resident to be administered two drops into each eye of artificial tears solution one percent (carboxymethylcellulose sodium) three times a day for dry eyes. (continued on next page)

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations of medication administration on May 7, 2025, at 8:40 a.m. revealed that Resident 147 was administered one drop of artificial tears solution one percent (carboxymethylcellulose sodium). Interview with Licensed Practical Nurse 2 at that time confirmed that she was finished with her medication administration to Resident 147, and that she instilled one drop into each eye. At 8:44 a.m. Licensed Practical Nurse 2 confirmed that she should have administered two drops in each eye. Interview with the Director of Nursing on May 8, 2025, at 8:32 a.m. confirmed that the current physician's order did not match the medication that was administered to Resident 106, and that the correct number of eye drops were not administered to Resident 147 and should have been. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.