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	04/09/2026

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to follow treatment recommendations from wound consultations for one of 55 residents reviewed (Resident 15).Findings include:The facility's wound treatment management policy, dated February 1, 2026, indicated that to promote wound healing of various types of wounds, it was the policy of the facility to provide evidence-based treatments in accordance with current standards of practice and physician orders. Wound treatments would be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change.A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 15, dated January 13, 2026, revealed that the resident was cognitively intact, was dependent on staff for her care needs, had limited range of motion to her upper and lower extremities, and had pressure ulcers.A wound consultation for Resident 15, dated February 3, 2026, revealed that the resident had a Stage 4 (full thickness tissue loss with exposed bone, tendon or muscle) pressure sore on her left ischial tuberosity (bone in your lower pelvis that absorbs weight when you sit) that measured 2.0 x 0.3 x 0.1 centimeters (cm) and an open area on the right gluteus (buttocks) caused from moisture associated dermatitis (MASD) that measured 0.1 x 0.1 x 0.1 cm. The plan was to apply calcium alginate with silver (absorbent wound dressing that had antimicrobial protection) to the wound beds every two days. A wound consultation for Resident 15, dated March 3, 2026, revealed that the Stage 4 pressure sore on her left ischial tuberosity that measured 0.5 x 0.5 x 0.1 cm and the open area on her right buttocks caused from moisture associated dermatitis measured 0.1 x 0.1 x 0.1 cm. The plan was to continue calcium alginate with silver to the wound beds every two days. A review of Resident 15's Treatment Administration Records (TAR's) for February and March 2026 revealed that the treatments to the left ischial tuberosity were completed daily from February 5 through March 30, 2026, and there was no documented evidence that calcium alginate with silver was applied to the resident's right gluteus every two days.Interview with Director of Nursing on April 9, 2026, at 2:11 p.m. confirmed that the treatments for Resident 15's pressure ulcer on the left ischial tuberosity and MASD on the right gluteus were not completed as recommended by the wound consultant and should have been.28 Pa. Code 211.12(d)(5) Nursing Services.

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that physician's orders were followed for two of 55 residents reviewed (Residents 12 and 66) who 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). Findings include: The facility's policy for tube feedings, dated February 1, 2026, indicated that all tube feedings were to have a physician's order and the physician's order for feedings was to be documented on the order recaps, electronic Medication Administration Record, and the tube feeding container.An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 12, dated January 8, 2026, indicated that the resident was cognitively impaired, was dependent on staff for daily care tasks, and had a feeding tube. Physician's orders for Resident 12, dated March 13, 2026, included orders for the resident to receive a bolus feeding (method of delivering nutrition through a feeding tube in meal-sized amounts several times a day) via pump of 240 milliliters/hour of Jevity 1.2 RTH (a tube feeding formula) every five hours between the hours of 9:00 a.m. and midnight.Physician's orders for Resident 12, dated March 24 and 25, 2026, included orders for the resident to receive a house diet with pureed texture and a bolus feeding (method of delivering nutrition through a feeding tube in meal sized amounts several times a day) of Jevity 1.2 RTH (a tube feeding formula) at 9:00 a.m., 2:00 p.m., and 7:00 p.m., if the resident's meal intake was less than fifty percent. The midnight bolus feeding was to be discontinued.A nutrition note for Resident 12, dated April 6, 2026, indicated that the resident was to receive bolus feedings of 240 cubic centimeters (CC's) of Jevity 1.2 RTH scheduled for 9:00 a.m., 2:00 p.m., and 7:00 p.m., and administered if the resident's meal intake was less than fifty percent.The Medication Administration Records (MAR's) for Resident 12 for March and April 2026 revealed that staff administered the resident's tube feeding at 10:00 p.m. on March 24, 30, and 31, and April 2, 4, 5, and 7, 2026.Interview with the Clinical Compliance Certified Registered Nurse Practitioner on April 8, 2026, at 2:59 p.m. confirmed that staff were not following the current physician's order for tube feedings and the resident should not have been receiving the feeding at 10:00 p.m.An annual MDS assessment for Resident 66, dated January 7, 2026, indicated that the resident was severely cognitively impaired, was dependent on staff for daily care needs, and had a feeding tube. Physician's orders for Resident 66, dated December 1, 2025, included orders for the resident to receive Peptamen (a tube feeding formula) continuously at 35 cubic centimeters (cc's) per hour for 20 hours per day via a feeding tube pump. Physician's orders for the resident, dated December 1, 2025, indicated that the tube feeding was to be hung daily and taken down daily, and the feeding was scheduled to be hung at 12:01 a.m. and taken down at 8:00 p.m. A physician's order note for Resident 66, dated April 8, 2026, at 2:03 p.m. indicated that the physician had seen the resident and ordered to hold the resident's tube feeding for six hours and check for residual before resuming the feeding. Physician's orders for Resident 66, dated April 8, 2026, included an order to hold his tube feeding for six hours then resume, and to check for residual before resuming the feeding. Review of Resident 66's MAR for April 2026, revealed that there was no documented evidence that the tube feeding was held as ordered. Interview with the Director of Nursing on April 9, 2026, at 11:33 a.m. confirmed that there was no documented evidence that Resident 66's tube feeding was held as ordered. 28 Pa. Code 211.12(d)(3)(5) Nursing Services.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to inform the resident and/or resident representative in advance of the risks and benefits of psychotropic medications (medications that affect the persons mental state, emotions and behavior) and the treatment alternatives prior to initiating the administration of the medication for one of 55 residents reviewed (Resident 19). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 19, dated January 16, 2026, revealed that the resident was severely cognitively impaired, received psychotropic medications, including, antidepressant medications, antianxiety medications and antipsychotic medication, and had diagnoses including anxiety and dementia. A physician's order note for Resident 19, dated August 11, 2025, at 11:34 a.m. revealed that the Certified Registered Nurse Practitioner assessed the resident and new orders were obtained to increase her clonazepam (an antianxiety medication) to 1 milligram (mg) twice daily prior to a.m. and p.m. care. Physician's orders for Resident 19, dated August 11, 2025, included an order for the resident to receive 1 mg of Klonopin (Clonazepam) twice daily for anxiety and agitation There was no documented evidence in Resident 19's clinical record to indicate that the resident representative was informed in advance of the risks and benefits and treatment alternatives prior to initiating the increased dose of Klonopin (Clonazepam). Interview with the Clinical Compliance Certified Registered Nurse Practitioner on April 8, 2026, at 1:34 p.m. confirmed that there was no documented evidence in Resident 19's clinical record that the resident's representative was informed in advance of the risks and benefits and treatment alternatives prior to initiating the increased dose of Klonopin (Clonazepam). 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(2) Management. 28 Pa. Code 201.29(a): Resident rights.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observations and staff interviews, it was determined that the facility failed to provide a clean and homelike environment for two of 55 residents reviewed (Residents 134 and 135). Findings include: Observations of Resident 135's wheelchair during an interview with the resident on April 6, 2026, at 10:49 a.m. revealed that the left arm rest had a large piece of vinyl torn off of the armrest exposing the foam padding, and the right arm rest was taped up with duct tape. She stated at that time that her wheelchair was old, and she had asked for a new one. Interview with Licensed Practical Nurse 1 on April 7, 2026, at 1:17 p.m. confirmed that the vinyl on the left arm rest of Resident 135's wheelchair was torn with the foam exposed and the right armrest was wrapped with duct tape. She indicated that she believed maintenance repaired issues with the chairs. She contacted maintenance via the phone at that time, and they informed her to put in a work order. Observations of Resident 134's wheelchair during an interview on April 7, 2026, at 1:30 p.m., revealed that the arm rests had vinyl pieces that were peeling off in places. An interview with Maintenance Employee 2 at the time of the observation confirmed that the wheelchair armrests had vinyl pieces peeling off in places. Interview with Maintenance Employee 2 on April 7, 2026, at 1:30 p.m. indicated that normally maintenance repairs wheelchair issues. He indicated that they would receive work orders from nursing or therapy for repairs. He indicated that there were no routine wheelchair checks that he is aware of and stated maybe therapy does that. Interview with the Nursing Home Administrator on April 7, 2026, at 1:40 p.m. revealed that she was aware of the torn wheelchair arm rests for Resident 135 and indicated that maintenance was currently working on them. She was informed that it was confirmed with Maintenance Employee 2 that Resident 134 had worn wheelchair armrests with the vinyl peeled off in places. She indicated that anyone could submit a work order for issues that need repaired, and that the wheelchairs are on a routine cleaning schedule by housekeeping and they would report any issues as well. Interview with the Nursing Home Administrator on April 7, 2026, at 2:44 p.m. revealed that Resident 135 had a wheelchair cleaning done on March 18, 2026, and there was no mention of any repairs needing addressed; however, there was a work order communication submitted in January 2026 for a general wheelchair assessment, but it did not mention anything specific. There was no mention of any work order submitted for Resident 134 related to her wheelchair arm rests needing repaired. 28 Pa. Code 201.29(j) Resident Rights. 28 Pa. Code 207.2(a) Administrator's Responsibility.

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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. Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that a resident's care plan was updated/revised to reflect the resident's specific care needs for three of 55 residents reviewed (Residents 98, 135, 159). Findings include: A facility policy regarding care plan development, dated February 1, 2026, indicated that the care plan will be reviewed and revised as necessary by the interdisciplinary team at least quarterly after each MDS assessment both comprehensive and quarterly, or more often as changes occur. A facility policy for care plans dated, February 1, 2026, revealed that the care plan will be reviewed and revised as necessary by the Interdisciplinary team at least quarterly after each Minimum Data Set (MDS) (a mandated assessment of a resident's abilities cand care needs) assessment both comprehensive and quarterly, or more often as changes occur. A quarterly MDS assessment (a mandated assessment of a resident's abilities and care needs) for Resident 98, dated March 12, 2026, revealed that the resident was cognitively intact, was dependent on staff for care needs, and has a diagnosis of diabetes mellitus. The care plan for Resident 98 dated January 27, 2027, revealed that the resident was to have her blood sugar checked every Wednesday morning. Physician's orders for Resident 98 dated January 15, 2026, included an order to check blood glucose monitoring in the morning and evening. Interview with the Nursing Home Administrator on April 9, 2026, at 8:15 a.m. revealed that the care plan should have been updated to reflect blood glucose checks being completed twice a day. A significant change MDS assessment for Resident 135, dated January 15, 2026, indicated that the resident was cognitively intact, required assistance with daily care needs, and had diagnoses that included anxiety and bipolar disorder. An interview with Resident 135 on April 6, 2026, at 3:03 p.m. revealed that she receives her shower on Tuesday evenings and would prefer to go back to showers in the morning before breakfast. An interview with Nurse Aide 3 on April 7, 2026, at 11:48 a.m. revealed that Resident 135 had her shower changed from day shift to evening shift because she wanted it changed. She stated that the resident frequently changes her mind related to shower times. Review of Resident 135's shower record for January through April 2026 revealed that she received her showers in the evenings on the evening shift. A care plan for the resident, dated June 9, 2016, indicated that the resident preferred bathing on the day shift after breakfast. Documentation of an interview that occurred between the Assistant Director of Nursing and Resident 135, on April 8, 2026, at 12:10 p.m., revealed that the resident confirmed she was an early shower, but sometimes it was hard to get up in the morning, so she asked to be showered before bed. Interview with the Director of Nursing on April 8, 2026, confirmed the Resident 135's care plan was not revised to reflect the change in her shower preference to evening shift. An annual MDS for Resident 159 dated April 4, 2026, revealed that the resident was cognitively impaired, was dependent on staff for all care needs, and was not out of bed due to medical and safety concerns. Physician's orders for Resident 159, dated March 3, 2026 included orders for the resident to be non-weight bearing, was not to utilize hoyer lifts and was not to be out of bed. However, care plans for Resident 159 dated February 26, 2026, revealed that the resident uses a wheelchair for locomotion; a care plan dated February 23, 2024, revealed that the resident utilizes bilateral assist bars to help transfer in and out of bed; and a care plan dated March 25, 2026, indicated that the resident was to be out of bed to an 18-inch specialty chair as tolerated. Interview with the Director of Nursing on April 9, 2026, at 8:27 a.m. confirmed that Resident 159's care plan was not updated to reflect her current status. 28 Pa. Code 211.12(d)(5) Nursing services.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to ensure that physician's orders were followed for two of 55 residents reviewed (Residents 9, 10). Findings include:A comprehensive Minimum Data Set (MDS) assessment (mandated assessments of a resident's abilities and care needs) for Resident 9, dated January 27, 2026, indicated that the resident had impaired cognition and required help from staff for her daily care needs.Physician's orders for Resident 9, dated April 1, 2026, included an order for the resident to receive 5 milligrams (mg) of Midodrine hydrochlorothiazide (HCL) (a blood pressure medication), three times a day and to hold the medication if the resident's systolic (top number) blood pressure was less than 100.Resident 9's Medication Administration Record (MAR), dated April 2026, revealed that on April 4, 2026 at 5:00 p.m. the resident's blood pressure was 119/75 millimeters of mercury (mmHg) indicating that the Midodrine should have been held, however, it was administered. On April 5, 2026 at 2:00 p.m. the resident's blood pressure was 139/81 mmHg indicating that the Midodrine should have been held, however, it was administered.Interview with the Director of Nursing on April 8, 2026 at 1:34 p.m. revealed that the Midodrine should have been held on the dates mentioned above.An annual MDS assessment for Resident 10, dated February 13, 2025, indicated that the resident was cognitively intact, received insulin, and had diagnoses that included diabetes.Physician's orders for Resident 10, dated November 26, 2025, included an order for the resident to have accu-checks (blood sugar check) before meals and at bedtime. If the resident's blood sugar result was over 300 milligrams/dL, staff were to re-check the resident's blood sugar in two hours, and if the blood sugar was still over 300 mg/dL after the re-check the physician was to be notified.The Medication Administration Records (MARs) for Resident 10 for January, February, and March 2026 revealed that the resident's blood sugar result on January 15 at 4:00 p.m. was 367 mg/dL, on February 13 at 4:00 p.m. was 360 mg/dL, on February 13 at 9:00 p.m. was 311 mg/dL, on February 14 at 9:00 p.m. was 369 mg/dL, and March 8, 2026 at 4:00 p.m. was 400 mg/dL. However, there was no documented evidence that staff re-checked the resident's blood sugar in two hours per the physician's order.Interview with the Director of Nursing on April 9, 2026, at 1:13 p.m. confirmed that staff did not re-check Resident 10's elevated blood sugars in two hours as ordered on the dates and times mentioned above.28 Pa. Code 211.12(d)(1)(5) Nursing Services.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on review of facility policy, clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure that residents who required urinary catheterization (a flexible tube inserted into the bladder to drain urine) was completed as ordered for one of 55 residents reviewed (Resident 16).Findings include: A Quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 16 dated March 18, 2026, revealed that the resident was cognitively intact, required assistance for care needs, had a diagnosis of benign prostatic hyperplasia (a condition in aging men where the prostate gland enlarges causing urinary issues, and received intermittent catheterization. A care plan for Resident 16, dated December 5, 2025, indicated that the resident had benign prostatic hyperplasia, and was to be provided straight catheterization (a medical procedure used to drain urine from the bladder using a thin, flexible tube called a straight catheter) per order. Physician's orders for Resident 16, dated March 6, 2026, included an order for the resident to be straight catheterized every 12 hours after attempted to void if bladder scan shows a residual volume over 300milliliters (ml) and to record all amounts on paper flowsheet. Physician's orders for Resident 16, dated March 25, 2026, included an order for the resident to be straight catharized before bed, attempt to void prior, and to straight catharize if the residual volume is over 300ml. Review of Resident 16's March 2026, treatment administration records (TAR) and paper flowsheet revealed that the resident did not receive straight catheterization on March 17, 2026, on evening shift, March 18, 2026, morning shift, March 22, 2026, evening shift, and March 24, 2026, evening shift. Interview with the Nursing Home Administrator on April 7, 2026, 2:32 p.m. confirmed that there was no documented evidence that Resident 16's straight catheterization was completed as ordered on the dates and shifts noted above. 28 Pa. Code 211.12(d)(5) Nursing Services.