

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395539	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER Saint Anne Home		STREET ADDRESS, CITY, STATE, ZIP CODE 685 Angela Drive Greensburg, PA 15601	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on clinical record reviews, observations, and staff interviews, it was determined that the facility failed to ensure that each resident received assistance devices to prevent accidents for one of three residents reviewed (Resident 1). Findings include: A wheelchair transport policy dated January 8, 2026, revealed that footrests must be used when staff, family, volunteers and healthcare partners (vendors) are assisting residents who are transported by wheelchair, Broda chair or any other chair with attachable footrests to prevent accident/injury. An annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated February 13, 2026, revealed that the resident was cognitively impaired, required assistance from staff for daily care needs, and had diagnoses that included dementia. An incident investigation dated December 20, 2025, at 10:40 p.m. revealed that Nurse Aide 1 was pushing Resident 1 in her wheelchair to her room without leg rests. The resident leaned forward and fell onto the floor. She sustained a 1.5 by 1.5-centimeter abrasion to the left side of her forehead, a 0.5 by 0.5-centimeter abrasion to left eyebrow and a 3 centimeter by 3-centimeter bruise to the left side of her forehead. A witness statement from Nurse Aide 1, dated December 20, 2025, at 9:14 p.m. revealed that she was pushing Resident 1 in her wheelchair and she leaned forward and fell out of the wheelchair and confirmed that resident did not have leg rests on when she was pushing her. Interview with the Nursing Home Administrator on March 5, 2025, at 3:12 p.m. confirmed that leg rests should have been in place when transporting Resident 1. 28 Pa. Code 211.10(c)(d) Resident Care Policies. 28 Pa. Code 211.12(d)(5) Nursing Services.</p>		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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