

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/30/2026
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)		
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies, observations, and resident and staff interviews, it was determined that the facility failed to serve food that was palatable and at safe and appetizing temperatures. Findings include: The facility's policy regarding food temperatures, dated May 29, 2026, indicated that all hot foods were to be cooked to appropriate internal temperatures, held, and served at an appropriate temperature. Interview with Resident 2 on July 27, 2026, at 2:39 p.m. revealed that the food is garbage, the vegetables are mush and meat is tough. Observations in [NAME] Courtyard unit for the lunch meal service on July 29, 2026, at 11:47 a.m., revealed the lunch meal consisted of a turkey cutlet or beef tips, a baked sweet potato, and tomato bisque. The last resident to be served in the dining room was at 12:22 p.m. The test tray on July 29, 2026, at 12:33 p.m. revealed that the temperature of the turkey cutlet was 124.5 degrees (F), beef tips were 124.6 degrees (F) baked sweet potato was 142.0 degrees (F) and the tomato bisque was 123.5 degree (F). The tomato bisque and beef tips were not served at the appropriate temperature, and the beef tips were tough to chew and unpalatable. Interview with Culinary Director on July 27, 2026, at 12:57 p.m. confirmed that the tomato bisque was cold and beef tips were cold and difficult to chew. 28 Pa. Code 211.6(f) Dietary 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of policies, as well as observations and staff interviews, it was determined that the facility failed to store and prepare food under sanitary conditions. Findings include: The facility's policy for food storage, dated May 29, 2026, revealed that all opened and partially used foods shall be dated, labeled and sealed before being returned to the storage area. The head cook or designee shall be responsible for checking the refrigerator daily for food items that are expiring and shall discard accordingly. The dining service department along with housekeeping is assigned responsibility for monitoring the designated refrigerator and discarding outdated foods daily. Other staff may also monitor and discard food as appropriate. The facility's policy for dietary employee personal hygiene dated May 29, 2026, revealed that all dietary staff must wear hair restraints (hairnet, hat, and/or beard restraint) to prevent hair from contacting food. Observations in the kitchen dry storage on July 27, 2026, at 09:19 a.m. revealed that there was a quarter bottle of olive oil opened and undated with no lid and covered with an unsecured piece of plastic wrap, a half full gallon of Worcestershire sauce that was opened and undated, and a 3/4 full gallon of cooking [NAME] that was opened and undated. Observations in the kitchenette on [NAME] Garden on July 27, 2026, at 12:07 p.m. revealed a half full half gallon of almond milk opened and undated, a bag of unidentifiable leftover food in to-go containers with an expiration date of July 9, 2026. Observations in the kitchenette on [NAME] Courtyard on July 27, 2026, at 12:19 p.m. revealed six peanut butter and jelly sandwiches and two tuna fish sandwiches with a use by date of July 22, 2026, two containers of applesauce with a use by date of July 22, 2026, a yogurt with a use by date of July 25, 2026, a quart of skim milk 3/4 full opened and undated, and a quart of 2% milk half full opened and undated. Observations in the main kitchen on July 28, 2026, at 12:49 p.m. of Kitchen Staff 5 chopping green peppers and not wearing a beard guard with a fully exposed beard approximately one inch long; Kitchen Staff 6 plating food and not wearing a beard guard, with a fully exposed beard that was approximately four inches long; Kitchen Staff 7 preparing food and not wearing a hair guard with a fully exposed moustache; Kitchen Staff 8 who not wearing a beard guard, with a fully exposed beard approximately one inch long; and observations in the kitchen on July 29, 2026 at 11:49 a.m. revealed Kitchen Staff 9 with a hairnet that only covered her ponytail, leaving approximately four inches of bangs exposed in the front. Interview with the Culinary Director on July 28, 2026, at 12:56 p.m. and July 29, 2026, at 12:10 p.m. confirmed that food items should be labeled and dated properly, expired items should be thrown out, and staff should be wearing beard guards and hairnets properly. 28 Pa. Code 211.6(f) Dietary Services.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and staff interviews, it was determined that the facility failed to provide a clean and home-like environment. Findings include: The facility's cleaning policy, dated May 29, 2026, indicated that all resident rooms including floors and common areas including the dining area are to be swept daily. Observations of the [NAME] courtyard common area on July 27, at 12:30 p.m. and 2:30 p.m.; July 28, 2026, at 12:32 p.m. and 2:45 p.m. revealed that there was a moderate to large amount of dust, dirt, crumbs and debris located around the perimeter floor/wall of the common area and outside room C108. A plastic spoon was located under a chair on the floor in the common area. In addition, on July 28, 2026, at 10:00 a.m. and 2:45 p.m. there were observations under the dining table of approximately 3 quarter sized pieces of yellow eggs. Interview with Housekeeper 1 on July 28, 2026, at 3:02 p.m. confirmed that there was a large amount of dust, dirt and debris along with a plastic spoon under the chair, and eggs under the table that should not be on the floor in the [NAME] courtyard common area. She indicated that they have four staff in the facility today for eight nursing units, and that her priority is the resident rooms. That she cleaned up to 75 resident rooms in one day and that when she started at the facility two years ago, there were 7 staff for eight units. She further indicated that she is working as fast as she can to keep her nursing units clean, and that the staff on the units also contribute to her workload by not picking up after themselves. Observations of Resident 163 room on July 27, 2026, at 1:36 p.m. and July 28, 2026, at 8:09 a.m. revealed that the resident was seated in his wheelchair and there were potato chip crumbs and a piece of chocolate on the floor on both occasions. Interview with Housekeeper 1 on July 28, 2026, at 11:26 a.m. revealed that she is aware she is not cleaning like she should be and she is missing things due to the fact they are short staffed. She has two and a half units to clean herself, and can't keep up with the job. She confirmed that the floor of Resident 163's room was dirty and should have been cleaned. Interview with the Maintenance/Housekeeping Supervisor on July 29, 2026, at 8:13 a.m. confirmed that the facility should be clean and it was not. He indicated that each staff currently has two units to clean and that they had one staff member leave two weeks ago, and that he has added a weekend shift to help. 28 Pa. Code 201.29(j) Resident Rights. 28 Pa. Code 207.2(a) Administrator's Response .		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on review of facility policy, resident clinical record, and staff interviews it was determined that the facility failed to report an allegation of abuse for one of 38 residents reviewed (Resident 4). Findings include: Review of facility policy for Protection and Prevention Against Resident Abuse, Neglect, and Exploitation dated May 29, 2026, indicated that residents have the right to be free from any verbal, sexual, physical, and mental abuse, corporal punishment, involuntary seclusion, exploitation and misappropriation of resident property. Residents must not be subjected to abuse by anyone including, but not limited to facility staff, other residents, consultants, or volunteers, staff or other agencies serving the individual, family members or legal guardians, friends or other individuals. All staff shall report any systeped residenr abuse, neglect, exploitation, mistreatment or misappropriation of resident property to their supervisor, the director of nursing, the administrator, the corporate compliance officer of via the compliance hot line. A Significant Change Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 4, dated May 2, 2026, revealed that the resident was cognitively impaired, was sometimes understood and could sometimes understand others, was dependent on staff for daily care needs, and had diagnosis that included dementia. A nursing note for Resident 4 dated May 23, 226 at 1:00 p.m. revealed that the resident was slapped by another resident while sitting in the dining area, and she became weepy. A review of the clinical records revealed that there was no documented evidence that the incident was reported to their immediate supervisor, the director of nursing, the administrator, or the corporate compliance officer. Interview with the director of nursing on July 29, 2026, at 9:44 a.m. revealed that he was not made aware of the above incident, and that staff should have reported the incident per policy so that an investigation could have been conducted. 28 Pa Code: 201.14 (a) (c) Responsibility of management 28 Pa Code: 201.18 (b)(1) Management. Findings include: Review of facility policy for Protection and Prevention Against Resident Abuse, Neglect, and Exploitation dated May 29, 2026, indicated that residents have the right to be free from any verbal, sexual, physical, and mental abuse, corporal punishment, involuntary seclusion, exploitation and misappropriation of resident property. Residents must not be subjected to abuse by anyone including, but not limited to facility staff, other residents, consultants, or volunteers, staff or other agencies serving the individual, family members or legal guardians, friends or other individuals. All staff shall report any systeped residenr abuse, neglect, exploitation, mistreatment or misappropriation of resident property to their supervisor, the director of nursing, the administrator, the corporate compliance officer of via the compliance hot line. A Significant Change Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 4, dated May 2, 2026, revealed that the resident was cognitively impaired, was sometimes understood and could sometimes understand others, was dependent on staff for daily care needs, and had diagnosis that included dementia. A nursing note for Resident 4 dated May 23, 226 at 1:00 p.m. revealed that the resident was slapped by another resident while sitting in the dining area, and she became weepy. A review of the clinical records revealed that there was no documented evidence that the incident was reported to their immediate supervisor, the director of nursing, the administrator, or the corporate compliance officer. Interview with the director of nursing on July 29, 2026, at 9:44 a.m. revealed that he was not made aware of the above incident, and that staff should have reported the incident per policy so that an investigation could have been conducted. 28 Pa Code: 201.14 (a) (c) Responsibility of management 28 Pa Code: 201.18 (b)(1) Management.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to notify the resident and the resident's representative, in writing regarding the reason for transfer to the hospital, and to ensure that the ombudsman was notified of the transfer to the hospital, for seven of 38 residents reviewed (Residents 1, 4, 7, 12, 76, 100, 144). Findings include: The facility's policy regarding ombudsman notification, dated May 29, 2026, indicated that the ombudsman would be notified on a monthly basis of any emergent facility initiated discharge or transfer. The facility did not provide a policy regarding providing a written notice to the resident and the resident's representative upon transfer to the hospital. A quarterly MDS assessment for Resident 1, dated May 21, 2026, indicated that the resident was cognitively intact, required assistance from staff for all daily care needs, and had a diagnoses that included malignant neoplasm of the bladder. Nursing notes for Resident 1, dated May 2, 2026, at 4:37 p.m., revealed that the resident presented with an altered mental status and blood in his urine, he was transferred to the hospital and was admitted. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 4 dated February 14, 2026, revealed that the resident was cognitively intact, required partial assistance from staff for daily care needs and had medical diagnoses that included dementia. A nursing note for Resident 4 dated April 2026, at 12:24 pm revealed that the resident was nonverbal and lethargic, and she was sent to the emergency room for evaluation. Review of Resident 4's clinical record revealed that there was no documented evidence that the ombudsman, and resident and/or resident representative were notified in writing of the purpose for the resident's transfer regarding her hospitalization on April 20, 2026. A quarterly MDS for Resident 7 dated January 6, 2026, revealed that the resident was cognitively intact and required assistance from staff for daily care needs. A nursing note for Resident 7 dated March 5, 2026, at 3:13 p.m. revealed the resident had an unwitnessed fall, was sent to the hospital for evaluation and was admitted. Review of Resident 7's clinical record revealed that there was no documented evidence that the ombudsman, and resident and/or resident representative were notified in writing of the purpose for the resident's transfer regarding her hospitalization on March 5, 2026. An admission MDS for Resident 12 dated June 29, 2026, revealed that the resident was cognitively intact and required assistance from staff for daily care needs. A nursing note for Resident 12 dated July 27, 2026, at 12:27 p.m. revealed the resident had a change in condition, was sent to the hospital for evaluation and was admitted. Review of Resident 12's clinical record revealed that there was no documented evidence that the ombudsman, and resident and/or resident representative were notified in writing of the purpose for the resident's transfer regarding his hospitalization on July 27, 2026. A quarterly MDS for Resident 76 dated June 30, 2026, revealed that the resident was cognitively intact and required assistance from staff for daily care needs. A nursing note for Resident 76 dated July 12, 2026, at 1:30 p.m. revealed the resident had difficulty swallowing, was sent to the hospital for evaluation and was admitted. A nursing note for Resident 76 dated July 17, 2026, at 4:29 p.m. revealed the resident continued to have difficulty swallowing, was sent to the hospital for evaluation and was admitted. Review of Resident 76's clinical record revealed that there was no documented evidence that the ombudsman, and resident and/or resident representative were notified in writing of the purpose for the resident's transfer regarding her hospitalization on July 12, 17, 2026. A quarterly MDS for Resident 100 dated April 29, 2026, revealed that the resident was cognitively impaired and was dependent on staff for daily care needs. A nursing note for Resident 100 dated April 22, 2026, at 9:58 a.m. revealed (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident had difficulty breathing, was sent to the hospital for evaluation and was admitted .A nursing note for Resident 100 dated October 26, 2026, at 11:39 p.m. revealed the resident had a choking episode, was sent to the hospital for evaluation and was admitted .Review of Resident 100's clinical record revealed that there was no documented evidence that the ombudsman, and resident and/or resident representative were notified in writing of the purpose for the resident's transfer regarding her hospitalizations on April 22 and October 26, 2026.A quarterly MDS for Resident 144 dated April 1, 2026, revealed that the resident was cognitively intact, was dependent on staff for daily care needs.A nursing note for Resident 144 dated May 23, 2026, at 5:03 a.m. revealed the resident had a large amount of blood in her brief and was being sent to the emergency room for evaluation.Interview with the Director of Nursing on July 29, 2026, at 2:12 p.m. confirmed that for Residents 1, 4, 7, 12, 76, 100, 144, there was no written notification of hospital transfer provided to them or their representatives, and that the ombudsman was not notified of the transfer to the hospital as required. 28 Pa. Code 201.29(j) Resident Rights.		

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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. Based on review of facility policies, clinical records, and shower schedules, as well as staff interviews, it was determined that the facility failed to ensure that residents were provided with showers as scheduled for one of 38 residents reviewed (Resident 19). Findings include: The facility policy for showering/bathing dated May 29, 2026, indicated that it is facility policy to safely shower/whirlpool tub bath residents and provide comfort and cleanliness. If it is identified that a resident is unable to shower/bath, the resident refuses the shower/bath or requests another time for a shower/bath notify the unit supervisor. The unit supervisor will discuss the bath/shower with the resident and/or make another arrangement for the shower/whirlpool for the resident. Documentation will be entered into the electronic medical record for the reason a bath/shower was not given or other arrangements/preferences that have been made. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 19, dated May 8, 2026, indicated that the resident was cognitively intact, required assistance from staff for daily care needs, had no behaviors, and had diagnoses that included left sided hemiplegia (complete or partial loss of function on one side of the body) following a stroke. Care plan for Resident 19 dated May 5, 2026, indicated that the resident had a bathing preference for showers. A review of the nurse aide bathing documentation for Resident 19 dated April 2025, May 2025, June 2025, and July 2025 revealed that the resident was to receive a shower every Saturday. Nurse aide documentation revealed that the resident received a bed bath on April 25, May 2, 9, 15, 30, June 6, 27, and July 25. He received a sponge bath on July 4. There was no evidence that the resident was offered or refused a shower on these dates or any alternative dates. Review of the bathing documentation also revealed that on April 11 and July 11, the shower was documented as not applicable. There was no evidence that the resident was offered, provided or refused a shower on these dates or any alternative dates. An interview with Resident 19 on July 29, 2026, at 1:52 p.m. revealed that the resident cannot remember when he was last offered a shower because they don't get him out of bed, however if they did offer him a shower, he would reluctantly agree to get a shower. Interview with the Director of Nursing on July 30, 2026, at 1:36 p.m. revealed there was no documented evidence that Resident 19 was offered or refused showers according to his care schedule during the above-mentioned dates, or any alternative dates. 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 policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that physician's orders for medications were followed for two of 38 residents reviewed (Resident 4, 76).Findings include:A significant change Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 4, dated May 2, 2026, revealed that the resident was cognitively impaired and required assistance from staff for all daily care needs, and had medical diagnoses that included diabetes. A care plan for Resident 4 dated January 8, 2026, revealed that diabetes medication was to be administered per the physician's orders.A physician's note for Resident 4, dated June 20, 2026, at 9:21 p.m. revealed that the resident's blood sugar check is to be completed later between 8:00 p.m. and 9:00 p.m. due to the belief that the blood sugars are not accurate, and are indicative of a post meal blood sugar and not a true bedtime blood sugar resulting in the resident receiving an inaccurate dose of insulin.Physician's orders for Resident 4, dated June 20, 2026, revealed that the resident was to receive NovoLog insulin injection solution 100 unit/milliliter and inject as per sliding scale: if blood glucose read 0-60 give glucose substitute and recheck, 61-200 = 0 units, 201-250 = 2 units, 251-300 4 units, 301-350 = 6 units, 351-400 = 8 units, 401-501 = 10 units, 451+= 10 units recheck in 2 hours subcutaneously before meals and at bedtime. Bedtime blood glucose monitoring to be completed between 8:00 p.m. and 9:00 p.m.Review of the clinical records for Resident 4 revealed that the blood glucose monitoring was completed on June 22, 2026, at 7:27 p.m., July 3, 2026, at 7:57 p.m., on July 5, 2026, at 7:29 p.m., on July 6, 2026, at 7:29 p.m., on July 7, 2026, at 7:25 p.m., on July 10, 2026, at 7:48 p.m., on July 11, 2026, at 7:15 p.m., on July 16, 2026, at 7:11 p.m., on July 17, 2026, at 7:19 p.m., on July 21, 2026, at 7:40 p.m., on July 22, 2026, at 7:21 p.m., on July 24, 2026, at 7:28 p.m., on July 25, 2026, at 7:18 p.m., on July 27, 2026, at 7:06 p.m., on July 28, 2026, at 7:44 p.m.Interview with the Director of Nursing on July 29, 2026 at 9:44 a.m. confirmed that the blood glucose monitoring was completed early and not per physician's orders on the above dates and times.A quarterly MDS assessment for Resident 76, dated June 30, 2026, revealed that the resident was cognitively intact, required assistance from staff for daily care needs, and had diagnoses that included congestive heart failure (a condition where the heart can not pump blood efficiently). Physician's orders for Resident 76, dated October 21, 2025, included an order for the resident to be weighed daily via chair scale. Review of Resident 76's clinical record revealed that there was no documented evidence that Resident 76's weight was obtained on June 6, 11, 13, 21 and 26, 2026. Interview with the Director of Nursing on July 28, 2026 at 12:15 p.m. confirmed that Resident 76's weights were to be obtained per physician's orders on the above dates and they should have been. 28 Pa. Code 211.12(d)(3) Nursing services.		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on review of facility policy and clinical records, as well as staff interviews, it was determined that the facility failed to ensure a resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility for one of 38 residents reviewed (Resident 6). Findings include: Review of the facility policy for Restorative Nursing Programs dated May 29, 2026, revealed that it is the policy of the facility to provide maintenance and restorative services designed to maintain or improve a resident's abilities to the highest practicable level. Restorative nursing program refers to nursing interventions that promote the resident's ability to adapt and adjust as independently and safely as possible. This concept actively focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning. The interdisciplinary team, with the support of and guidance from the physician, will assure the ongoing review, evaluation, and decision making regarding the services needed to maintain or improve resident's abilities in accordance with the resident's comprehensive assessment goals and preferences. Review of the Facility Assessment (comprehensive, documented evaluation that a facility must conduct to determine the resources needed to competently care for its residents during day-to-day operations and emergencies) dated April 25, 2026, indicated that the type of care that the resident population required and that the facility provided for the resident population included transfers, ambulation, restorative nursing and contracture prevention/care. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 6, dated May 16, 2026, indicated that the resident was cognitively intact, required supervision or touching assistance with transfers and ambulation, and had diagnoses that included heart failure. Physician's orders for Resident 6 dated November 14, 2026, included for the resident to be discharged from physical therapy services and to refer to restorative nursing program for ambulation with a wheeled walker. Care plan for Resident 6 dated October 24, 2025, indicated that the resident had the potential for decline in range of motion (how far you can move or stretch a part of your body) due to low back pain and that active range of motion (a structured set of exercises where a patient moves their joints independently using their own muscle strength without any external help) was to be provided to all extremities twice a day, six to seven days a week for at least 15 minutes. The resident was to ambulate up to 100 feet with a front wheeled walker and contact guard assist. Staff were to report any significant decline in ambulation to the Restorative Coordinator and reassess quarterly and as needed. Review of nurse aid documentation and Treatment Administration Records for Resident 6 dated April 2026 through July 2026, revealed no documented evidence that the resident was provided active range of motion or assistance with ambulation. Interview with Resident 6 on July 27, 2026, at approximately 10:30 a.m. revealed that she sometimes takes a walk in the hall with her walker, it depends on what staff are available to help her. Interview with the Occupational Therapist on July 30, 2026, at 1:55 p.m. revealed that the facility previously had an active restorative nursing program, however it does not currently have a restorative nursing program in place. No active range of motion or ambulation orders were put into place for Resident 6 because there is no restorative nursing program. Staff are verbally educated on the functional level of the resident upon discharge from therapy services and therapy relies heavily on staff reporting any decline with the resident to therapy so they can be reevaluated. Interview with the Director of Nursing on July 30, 2026, at 3:22 p.m. revealed that the facility does not currently have a restorative nursing program in place, however there should be an active restorative nursing program in place. 28 Pa. Code 211.12(d)(3)(5) Nursing services.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on clinical record reviews, observations, and staff interviews, it was determined that the facility failed to ensure a safe environment for three of 38 residents reviewed (Residents 4, 13, 100). Findings include: A comprehensive minimum data set (MDS) assessment (mandated to assess the resident abilities and care needs) for Resident 4, dated January 18, 2026, revealed that the resident was cognitively intact, was occasionally incontinent of urine, used a manual wheelchair, and required partial assistance to transfer from the bed to a chair. The resident's care plan, updated April 9, 2026, revealed that the resident had actual falls and required her wheelchair to be placed at her bedside facing the bed with brakes locked when the resident is in bed. A nursing note for resident 4 following a fall, dated April 10, 2026, at 9:54 a.m. revealed that the new intervention for fall prevention is to place the resident's wheelchair at bedside facing her bed with brakes locked when the resident is in bed. A nursing note for resident 4 following a fall, dated April 17, 2026, at 12:00 p.m. indicated that Resident 4 was observed lying on the floor beside her bed on her right side. A bruise was observed to her right cheek, and staff were educated to keep the wheelchair at bedside locked when the resident was resting while in bed. A nursing note for Resident 4 dated April 17, 2026, at 1:23 p.m. the resident had complaints of knee pain in both the right and left knees, and new orders were received for X-rays for both legs. A nursing note for Resident 4 dated April 17, 2026, at 5:44 p.m. the resident was complaining of right leg pain and new orders were received for an X-ray of the right hip. A nursing note for Resident 4 dated April 20, 2026, at 12:34 p.m. revealed that the medical director was in to see the resident and review laboratory results. The resident was non-verbal and not acting herself. The resident was sent to the emergency room for evaluation. A nursing note for Resident 4 dated April 20, 2026, at 4:23 p.m. revealed that the resident was admitted to the hospital with a diagnosis of fall and altered mental status, and fractured pelvis. An interview with the Assistant Director of Nursing and Director of Nursing on July 30, 2026, at 9:33 a.m. revealed that the care plan should not have been updated on April 9, 2026, to reflect that her intervention was to place the wheelchair by her bed after the residents fall; however, there was no documented evidence the intervention was in error and no documented evidence of another fall intervention put in place. A quarterly MDS assessment for Resident 13, dated June 26, 2026, revealed that the resident was severely cognitively impaired and needed extensive assistance for all of his care, and had diagnoses that included cerebral palsy with profound intellectual disorders. The resident's care plan, revised on July 1, 2026, revealed that the resident was at risk for falls and was to have dycem (a rubber-like material used to prevent slipping) above and below the seat cushion on his wheelchair. Physician's orders for Resident 13, dated July 1, 2026, included an order to have dycem above and below the residents wheel chair seat cushion. Observations on July 28, 2026, at 2:41 p.m. and July 29, 2026, at 9:53 p.m. revealed that Resident 13's wheel chair had dycem above his seat cushion, but none below as ordered. An interview with Licensed Practical Nurse 1 on July 29, 2026, at 1:56 p.m. revealed that there was no dycem below the residents wheelchair seat cushion, and there should have been. An interview with the Nursing Home Administrator on July 29, 2026, at 3:23 p.m. confirmed that Resident 13 should have had dycem above and below his seat cushion as ordered and care planned, and he did not. A quarterly MDS assessment for Resident 100, dated April 29, 2026, revealed that the resident was cognitively impaired, and was dependent on staff for daily care needs. A care plan dated October 21, 2025, revealed that the resident was at risk for pressure injuries related to decreased mobility. Physician's orders for Resident 100 dated July 14, 2026, included an order for an air mattress to be in place on her (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bed.Review of Resident 100's clinical record revealed that here was no documented evidence that the use of an air mattress was assessed for potential safety hazards prior to the air mattress being placed on Resident 100's bed.An interview with the Director of Nursing on July 30, 2026, at 10:34 confirmed that Resident 100 did not have an assessment completed regarding potential safety hazards prior to the air mattress being placed on her bed. 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. Based on review of facility policy, clinical records, as well as staff interviews, it was determined that the facility failed to ensure that physician orders were obtained for intravenous (IV) therapy and orders to flush IV catheters (small tube inserted into a vein to deliver fluids or medication) were not obtained for two of 38 residents reviewed (Resident 17, 76). Findings include: The facility's policy regarding IV therapy, dated May 29, 2026, revealed that physician orders are obtained before starting IV therapy and flushing is performed by attaching a 10 milliliter (ml) syringe of normal saline to confirm patency of vascular access device before and after medication administration. A quarterly Minimum Data Set (MDS) assessment (a federally-mandated assessment of the resident's abilities and care needs) for Resident 17, dated June 30, 2026, revealed that the resident was cognitively intact and had a midline intravenous catheter (a soft, medium-length tube inserted into a vein in the upper arm, generally used for one to four weeks) to treat osteomyelitis (infection of the bone). Physician's orders for Resident 17, dated July 13, 2026, included orders to administer 2 grams (gm) of Meropenem (an antibiotic) twice a day thru July 28, 2026. Review of Resident 17's Medication Administration Records (MAR's) for July 2026, revealed that there was no documented evidence of an order to flush the midline and no evidence that staff flushed the midline IV catheter before and after the medication administration. A quarterly MDS assessment for Resident 76, dated June 30, 2026, revealed that the resident was cognitively intact and was required assistance for daily care needs. Observations on July 28, 2026, at 11:14 a.m. revealed that Resident 76 had an IV site in her right forearm. A nursing note for Resident 76, dated July 25, 2026 7:07 p.m. revealed that an IV heparin lock (an IV catheter that is capped off with a port) 22 gauge was inserted into her right forearm. Review of Resident 76's Medication Administration Records (MAR's) for July 2026 revealed no documented evidence that a physician order was obtained for IV therapy and flush orders were not obtained. Interview with the Director of Nursing on July 29, 2026, at 8:45 a.m. confirmed that physician orders should have been obtained for Resident 17 and 76 before starting IV therapy and flush orders should have been obtained. 28 Pa. Code 211.12(d)(1)(5) Nursing services.		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. Based on clinical record review and staff interview, it was determined that the facility failed to ensure that residents were assessed and received trauma-informed care to eliminate or mitigate triggers for residents with the diagnosis of Post Traumatic Stress Disorder (PTSD) (a mental and behavioral disorder that develops related to a terrifying event) for one of 38 residents reviewed (Resident 2). Findings include: A Quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 2, dated May 27, 2026, indicated that the resident was cognitively intact, was dependent on staff for daily care needs, and had diagnoses that included PTSD. A review of Resident 2's care plan, dated October 17, 2025, indicated that the resident had PTSD related to laying on the floor for days. There was no documented evidence the facility identified Resident 2's specific triggers that could re-traumatize the resident or implement measures as to how facility staff could prevent or minimize triggers from occurring. Interview with the Director of Nursing on July 29, 2026, at 3:39 p.m. revealed that the resident was seen by a psychiatrist at the facility and had a new diagnosis of PTSD and the assessment for triggers should have been completed at that time. 28 Pa Code 201.24(e)(4) admission Policy. 28 Pa Code 211.12(a)(d)(3)(5) Nursing Services. 28 Pa. Code 211.16(a) Social Services.		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to respond to a pharmacy recommendation for two of 38 residents reviewed (Resident 4, 5). Findings include: A facility policy related to medication regimen review, dated May 29, 2026, indicated that the consultant pharmacist will conduct medication regimen reviews (MRRs) and will make recommendations based on the information made available in the residents' health record. The consultant pharmacist will provide the residents' MRRs to the facility identified personnel who will ensure that the attending physician, medical director, and other necessary facility staff receive the recommendations. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 4, dated June 13, 2026, revealed that the resident was cognitively impaired, required maximum assistance with care needs, received insulin, and had diagnoses of hypertension (high blood pressure), heart failure, kidney failure, and diabetes. A pharmacy medication regimen review fax for Resident 4, dated April 27, 2026, indicated that irregularities/recommendations were noted, and that a physician's order for ergocalciferol 200 micrograms/milliliter and to give 2 drop by mouth and bedtime was to be clarified to reflect the dose as 2 dropperful= 2 milliliter = 400 micrograms. There was no documented evidence in the residents' clinical record that the order was clarified. A comprehensive MDS for Resident 5, dated June 29, 2021, revealed that the resident was cognitively impaired, was usually understood and could usually understand, had medical diagnoses of high blood pressure, heart failure, kidney failure, and diabetes, and received antipsychotic medications. A review of the clinical record for Resident 5 revealed that the resident was on a pureed or mechanical soft diet, and pills were to be crushed in applesauce for administration. A pharmacy medication regimen review for Resident 5, dated January 29, 2026, revealed that do not crush was to be added to medication orders for 125 milligram (mg) divalproex DR (a delayed release medication to treat seizures), 20 mg Protonix a medication used to gastro-esophageal reflux disease (a chronic condition where stomach acid frequently flows back into the esophagus, irritating its lining), 50mg metoprolol ER (an extended release medication used to treat high blood pressure), and tamsulosin (a medication used to treat an enlarged prostate). There was no documented evidence in the resident's clinical record that do not crush was added to the above orders. Interview with Licensed Practical Nurse 2 on July 30, 2026, at 8:43 a.m. revealed that all medication for Resident 5 is to be crushed, and that they are crushed because there is not a do not crush order in place. A pharmacy medication regimen review for Resident 5, dated March 27, 2026, revealed that the resident needed to have an Abnormal Involuntary Movement Scale (AIMS) (a 12-item, clinician-rated medical exam used to detect and measure the severity of involuntary muscle movements related to long-term anti-psychotic use) completed. There was no documented evidence that an AIMS was completed until April 27, 2026. An interview with the Director of Nursing on July 30, 2026, at 8:43 a.m. confirmed that the recommendation was not appropriately addressed for the above residents. 28 Pa. Code 211.10(c) Resident care policies. 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies, as well as observations and staff interviews, it was determined that the facility failed to properly label and date eye drops in one of four medication carts reviewed ([NAME] courtyard) and failed to store and maintain medications in two of four medication carts reviewed ([NAME] courtyard and [NAME] courtyard).Findings include:The facility's policy regarding medication storage and labeling dated May 29, 2026, revealed that the facility would ensure that multi-dose medications that have been opened or accessed are to be labeled with the date they opened considering the manufacturers' specifications and all medications and biologicals are stored properly, following manufacturers or provider pharmacy recommendations, to maintain their integrity and to support safe effective drug administration.Observations in the [NAME] courtyard medication cart on July 28, 2026, at 11:49 am. revealed that there were 12 loose pills throughout the bottom of the first medication drawer. The pills were as follows; one blue/green capsule, one orange small round tablet, one yellow oblong tablet, two large white round tablets, one small round white tablet, one medium round tan tablet, two small round off white tablets, one tiny white oblong tablet, two half oblong white tablets.Interview with Licensed Practical Nurse 3 on July 28, 2026, at 11:58 a.m. confirmed that the medication cart should not have 12 loose pills in the medication drawer.Interview with the Director of Nursing on July 29, 2026, at 3:33 p.m. confirmed that the [NAME] courtyard medication cart should not have 12 loose pills in the bottom of the drawer. He indicated that the medication cart was on record as being cleaned the previous weekend.Observations in the [NAME] courtyard medication cart on July 29, 2026, at 10:10 am. revealed that there was one bottle of Latanoprost Ophthalmic Solution .005 percent eye drops (used to lower the pressure in the eye) that was opened and not labeled with the date it was opened and 8 loose pills throughout the bottom of the first and second medication drawer. The pills were as follows; one orange small round tablet, one large white round tablet, one large round tan tablet, four small round white tablets, one oblong blue tablet.Interview with Licensed Practical Nurse 4 on July 29, 2026, at 10:12 a.m. confirmed that the bottle of Latanoprost Ophthalmic Solution .005 percent eye drops should have been labeled with the date it was opened and the medication cart should not have 8 loose pills in the bottom of the drawers.Interview with the Director of Nursing on July 29, 2026, at 11:30 a.m. confirmed that the bottle of eye drops should have been labeled with the date it was opened and there should not be 8 loose pills in the bottom of the drawers in the [NAME] courtyard medication cart. 28 Pa. Code 211.9(a)(1) Pharmacy services.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on review of facility policy and clinical records, as well as resident and staff interviews, it was determined that the facility failed to maintain clinical records that were complete and accurately documented for one of 38 residents reviewed (Resident 19).Based on review of facility policy and clinical records, as well as resident and staff interviews, it was determined that the facility failed to maintain clinical records that were complete and accurately documented for one of 38 residents reviewed (Resident 19).Findings include: Facility policy for documentation in the medical record dated May 29, 2026, indicated that each residents' medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation. Licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record in accordance with the state law and facility policy. Documentation shall be factual, objective and resident centered. False information shall not be documented. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 19, dated May 8, 2026, indicated that the resident was cognitively intact, required assistance from staff for daily care needs, had no behaviors, and had diagnoses that included left sided hemiplegia (complete or partial loss of function on one side of the body) following a stroke. Physician's orders for Resident 19 dated July 17, 2026, indicated that the resident was to get out of bed every other day for two hours per day. Review of the Treatment Administration Record (TAR) for Resident 19 dated July 2026 revealed that the resident was out of bed for two hours on July 17, 19, 21, 23, 25, and 27. Review of nurse aide documentation for Resident 19 dated July 2026 revealed that on July 17, 18, 19, 23, 24, and 28, his chair/bed-to-chair transfer ability was documented as not applicable. On July 20, 21, 22, 25, 26, and 27, his chair/bed-to-chair transfer ability was documented as resident refused. An interview with Resident 19 on July 29, 2026, at 1:52 p.m. revealed that staff do not offer to get him out of bed, and he does not believe he has been out of bed in over a month. Interview with the Director of Nursing on July 30, 2026, at 3:15 p.m. confirmed that Resident 19 has not been getting out of bed because he refuses, and that the documentation in Resident 19's TAR indicating that he was out of bed on the above-mentioned dates was inaccurate. 28 Pa Code 211.5(f) Clinical records28 Pa. Code 211.12(d)(5) Nursing services		

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 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 a State Survey and Certification (Department of Health) survey ending June 26, 2026, 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 July 30, 2026, identified repeated deficiencies related to a failure to assure medications were stored/labeled in a proper manner, failed to provide food that was palatable and at appropriate temperatures, failed to date food items as required and failed to wear hair coverings in the kitchen as per policy. The facility's plan of corrections for deficiencies regarding storage/labeling cited during the survey ending June 26, 2025, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F761, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with the labeling/storage of medications. The facility's plan of corrections for deficiencies regarding providing palatable food at appropriate temperatures, cited during the survey ending June 26, 2025, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F804, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure that food was palatable and at appropriate temperatures. The facility's plan of corrections for deficiencies regarding the wearing of appropriate hair coverings in the kitchen, cited during the survey ending June 26, 2025, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F812, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure the wearing of appropriate hair coverings in the kitchen. Refer to F761, 804, 81228 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(e)(1) Management.		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on review of residents' clinical records, as well as staff interviews, it was determined that the facility failed to ensure that each resident received pneumococcal immunizations for one of 38 residents reviewed (Resident 83) and failed to ensure each resident received the influenza vaccine for one of 38 residents reviewed (Resident 6). Findings include: The facility's pneumococcal vaccine policy, dated May 29, 2026, indicated that all residents will receive immunizations and/or vaccinations that aid in preventing infectious disease unless medically contraindicated or the resident refuses. A quarterly Minimum Data Set (MDS) assessments (a mandated assessment of a resident's abilities and care needs) for Resident 83, dated June 18, 2026, revealed the resident was cognitively intact, required assistance from staff for daily care needs, and his pneumococcal vaccination was not up to date, and it was not offered. Pneumococcal Pneumonia Immunization Consent Form for Resident 83 dated March 20, 2026, revealed education was provided to the resident and authorization to administer the pneumococcal vaccine was obtained. Review of clinical records revealed no documented evidence that the pneumococcal vaccine was administered or contraindicated. Interview with the Director of Nursing on July 29, 2026, at 12:15 p.m. confirmed that Resident 83's signed consent for the pneumococcal vaccine on March 20, 2026, however, as of July 29, 2026, there was no documented evidence that it was administered. An annual MDS assessments for Resident 6, dated February 13, 2026, revealed that resident was cognitively intact, required assistance from staff for daily care needs, and that the resident did not receive the influenza vaccine in the facility for that year's influenza vaccination season because it was offered and refused. There was no documented evidence available that the resident was offered the influenza vaccine during the 2025-2026 flu season and/or she refused it. Interview with the Director of Nursing on July 230, 2026, at 3:15 p.m. confirmed that there was no documented evidence that Resident 6 was offered the influenza vaccine and refused it. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.		

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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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on a review facility policies, employee education records, as well as staff interviews, it was determined that the facility failed to ensure that nurse aides completed the required annual education for three of three nurse aides reviewed (Nurse Aides 10, 11, 12). Findings include: The facility's policy regarding continuing education, dated May 29, 2026, indicated that compliance with the facility's standards, policies, and procedures is a condition of employment. This includes compliance with the policies and procedures of this facility's training programs. Review of the employee education file for Nurse Aide 10 revealed that there was no documented evidence of twelve hours of required education completed between 2025-2026. Review of the employee education file for Nurse Aide 11 revealed that there was no documented evidence of twelve hours of required education completed between 2025-2026. Review of the employee education file for Nurse Aide 12 revealed that there was no documented evidence of twelve hours of required education completed between 2025-2026. Interview with the Director of Nursing on July 29, 2026, at 10:34 a.m. confirmed that there was no documented evidence that Nurse Aides 10, 11, and 12 completed the 12 hours of annual training as required. 28 Pa. Code 201.18 (b)(3)(e)(1) Management.		