STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395577	A. Building B. Wing	04/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Premier Washington Rehabilitation and Nursing Ctr	36 Old Hickory Ridge Rd Washington, PA 15301

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on staff interviews it was determined that the facility failed to employ a qualified Food Service Director to manage the daily operations of the Dietary Department for 12 of 12 months (May 2025 through April 24, 2026). Findings include:During an interview on 4/20/26, at approximately 9:30 a.m., the Dietary Supervisor Employee E6 stated that she was the manager and was currently working on her Certification to become a CDM.During an interview on 4/20/26, at 9:50 a.m., Registered Dietician Employee E7 stated that she can barely get her dietician assessments completed and she has no involvement in the management of the dietary department as that is run by [food service company]. During an interview on 4/20/26, at 12:50 p.m., Regional Certified Dietary Manager Employee E8 and Regional Dietician Employee E9 confirmed that the facility currently does not have a Certified Dietary Manager and the Registered Dietician is not employed by [food service company] so does not manage the dietary department. The Regional Certified Dietary Manger Employee E8 confirmed that the facility failed to provide documented evidence that any staff met the qualifications for the position of Food Service Director.Pa Code: 201.18(e)(6) Management.Pa Code: 211.6(c)(d) 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 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. Based on a review of facility policy, facility documents (five months of Resident Council Meeting Minutes and Food Council Meeting Minutes and six months of Grievances), Resident Council Meeting onsite, resident interviews, staff interviews and observations, it was determined the facility failed to provide the residents with food and drink that is at a safe and appetizing temperatures on six of six nursing units (1 South, 1 West, 2 South, 2 East, 3 South and 3 East nursing units).Findings include: Review of the facility policy Food and Nutritional Services dated 1/6/26, indicated each resident will receive three meals a day that are nourishing, palatable, meets their individual needs and is in accordance with resident needs, physician orders, each resident preferences and plans. During an interview on 4/20/26, with the Ombudsman (government program of a resident advocate to address concerns about quality of life of persons living in long term care) at 9:50 a.m., revealed concerns about the facility meals. The Ombudsman reported receiving multiple resident complaints about the food being cold, meals not provided as ordered and the taste. During a group interview on 4/20/26, at 1:30 p.m., the group consensus was dissatisfaction with the meals and frustration as they voiced concerns with the facility administration not resolving their ongoing issues with their meals. The group stated the meals are cold, meals are inaccurate from what is on the menu, stating when you complete the request for the alternate meal, often you don't receive it. Grievances have been filed, complaints are made to the staff, complaints are made at resident council and at food committee, nothing changes with the food issues. They tell you they are working on it, some of us have been here for years and we only see the meals getting worse, the taste, temperature and selection. Residents voiced dissatisfaction with the Enchiladas and black beans meal served on 4/19/26 for dinner stating this is not what Southwestern Pennsylvanians eat. Residents stated, we go to bed hungry some days. During an interview on 4/20/26, at 11:00 a.m., Residents R81 and R88 stated the food and coffee are always cold and they know the facility is aware, but nothing has been done. During an interview on 4/20/26, at 10:11 a.m., Resident R181 stated cold food and cold coffee, every day. During an interview on 4/20/26, at 1:44 p.m. Confidential Resident R1 stated the vegetables are often water-logged. The family member for Confidential Resident R1 stated that the food is terrible, that her mother doesn't receive her meal choices, that it is never hot. During an interview on 4/20/26, at 2:00 p.m. Confidential Resident R2 stated, Food, Oh here we go. I asked for a grilled cheese sandwich, it comes back greasy and burned. Food tastes terrible. We get the same kind of food all the time. We don't eat the damn shit. Confidential Resident R2 stated she and her roommate often have to buy food from the snack shop. During an interview on 4/21/26, at 7:50 a.m., Resident R52 and R74 stated we get eggs every day for breakfast, eggs, eggs every day. During an observation on 4/21/26, from 11:45 a.m., through 12:45 p.m., the following was observed during tray line: Dietary Employee E11 was serving hot foods and was plating Regular plates of food and placing them on a cart next to the tray line service with no plate warmers or covers to keep them warm. When asked why, he stated that they were ahead and now fell behind. During an interview on 4/21/26, at 10:00 a.m. Confidential Resident R5 stated the food is terrible. It's always cold, the meat is too tough, and they have the same things all the time. I just do not eat it. During an interview on 4/21/26, at 10:15 a.m. Confidential Resident R6 stated, Food, Is that what you call it? It's awful. Just everything about it. It's always served cold! During an interview on 4/21/26, at 10:30 a.m. Confidential Resident R7 stated the food is very bad. Can you please do something about it? It's been bad for a while, comes cold and just plain bad. During an observation of the lunch meal on 4/21/26, on the 3 [NAME] nursing unit it was revealed the tray cart was delivered at 11:45 a.m. The last cart was delivered at 12:05 p.m. Five staff members were noted to be delivering trays. Temperatures were noted to be the following: Pork loin 116.8 degrees F (Fahrenheit)Broccoli 110.3 degrees FScalloped potatoes 123.4 degrees FMilk 46 degrees FCoffee 126.7 degrees F During an observation on 4/21/26, at 12:10 p.m. revealed Resident R77's meal tray was delivered with a whole cup of coffee spilled on it. Resident R77 was picking up (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	items dripping in coffee. During an interview on 4/21/26 at 12:30 p.m. Confidential resident R5 revealed the meal was warmer today, but that is because you are here, and we never have that many people passing trays. During an interview on 4/21/26, at 5:27 p.m. Resident R2 stated the food is cold and nasty. Resident R2 stated she is ordered a mechanically altered diet, but gets pureed food often. During an interview on 4/21/26, at 5:34 p.m. when asked about the food, Resident R16 stated it, sucks rocks. During an interview on 4/21/26, at 5:40 p.m. when asked about the food, Resident R203 stated the quality is inconsistent, and her dietary preferences are not honored. Resident R203 stated that often the food is burnt, and there have been times that have run out of milk. During an interview on 4/21/26, at 5:53 p.m. Resident R26 stated, The food is overall not very good at all. I have to make myself eat some of it. During an interview on 4/21/26, at 5:58 p.m. Resident R45 stated the food doesn't taste good. Review of grievances filed revealed the following dates of reported concerns related to meals/food.April 2026 8 grievancesMarch 2026 10 grievancesFebruary 2026 9 grievancesJanuary 2026 3 grievancesDecember 2025 2 grievancesNovember 2025 4 grievances Review of Resident Council minutes revealed the following dates of reported concerns related to meals/food.4/16/263/19/262/19/261/15/2612/30/25 During an interview on 4/20/26, at 12:50 p.m., Regional Dietician Employee E8 and Regional Dietician Employee E9 confirmed that the facility failed to provide the residents with food and drink that is at a safe and appetizing temperatures on six of six nursing units (1 South, 1 West, 2 South, 2 East, 3 South and 3 East nursing units). 28 PA Code: 211.6(b)(c)(d) Dietary services.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on facility policy, resident interviews, observations and staff interviews, it was determined that the facility failed to provide food for a resident in a form to meet the resident's individual needs for 13 of 26 residents reviewed (Residents R81, R55, R1, R142, R2, R203, R26, R45, R175, R106, R224, R29 and R120).Findings include:During an interview on 4/20/26, at approximately 11:00 a.m., Resident R81 stated that she has been upgraded to a mechanical soft diet but keeps getting purred veggies and she is sick of it, she stated that the Speech Therapist has come to her multiple times and he has told the dietary department, but nothing has changed. During an interview on 4/20/26, at 11:29 a.m., Speech Therapist Employee E11 stated that he has discussed this issue with the Dietician and Dietary Supervisor, but nothing has been done. During an interview on 4/20/26, at 12:20 p.m., Nurse Aide Employee E10 was feeding Resident R55 a mechanical soft diet and stated that residents that require mechanical soft foods always have pureed veggies, staff have gone to dietary about it and nothing has been done. During an interview on 4/20/26, at 12:50 p.m., Regional Certified Dietary Manager Employee E8 and Regional Dietician Employee E9 confirmed that the system automatically set the mechanical soft veggies to be pureed, which is not the correct consistency if a mechanical soft diet is ordered. The dietary department does not chop veggies. During an observation on 4/21/26, from 11:45 a.m., through 12:45 p.m., the following was observed:All mechanical soft resident trays had pureed broccoli that was watery.The mashed potatoes were watery.Staff were placing biscuits directly on top of watery food items.During an interview on 4/20/26, at 1:44 p.m. the family member for Confidential Resident R1 stated that the food is terrible, that her mother doesn't receive her meal choices. The family member stated the menu indicated a baked sweet potato was to be provided, but her mother received mashed sweet potatoes.During an observation of the noon meal on 4/21/26, Resident R142 was noted to be missing her white rice from her tray. During an interview on 4/21/26, at 5:27 p.m. Resident R2 stated she is ordered a mechanically altered diet but gets pureed food often.During an interview on 4/21/26, at 5:40 p.m. when asked about the food, Resident R203 stated her dietary preferences are not honored.During an observation of the evening meal on 4/21/26, the following was observed:Resident R26's buttered noodles and water were not present on his meal tray, and the cinnamon applesauce was replaced with plain applesauce. Resident R45's buttered noodles and water were not present on her meal tray. Resident R175's cinnamon applesauce was replaced with plain applesauce. Resident R106's cinnamon applesauce was replaced with plain applesauce. Resident R224's cinnamon applesauce was replaced with plain applesauce. Resident R29's cinnamon applesauce was replaced with plain applesauce. Resident R2's buttered noodles and water were not present on her meal tray and the two chocolate milks were replaced with white milk. During an observation on 4/21/26, at approximately 6:05 p.m. Resident R120 was observed to shove his tray away from him after removing the dome lid. When asked by the surveyor if he had a concern about his food, Resident R120 stated that he asked for hamburgers about two weeks ago and has now received them for both lunch and dinner daily.During an interview on 4/21/26, at 1:00 p.m. the Nursing Home Administrator, Director of Nursing and the Regional Director of Operations Employee E13 were made aware of the above concerns and confirmed that the facility failed to provide food in the form for each resident's individual needs and per physician order. During an interview on 4/22/26, at 10:47 a.m., Regional Director of Operations for Aramark confirmed that the facility failed to provide residents with food identified as their specific need and these needs changed. 28. Pa Code: 211.6 - Dietary Services

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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. Based on observations, and staff interviews, it was determined that the facility failed to maintain sanitary conditions to prevent the potential for cross-contamination or foodborne illness in the main kitchen (Main Kitchen). Findings include:During an observation of the kitchen on 4/20/26, from 9:30 a.m., through 10:06 a.m., the following was observed:The deep freezer and refrigerator had boxes of food stored on floors of areas.During an interview on 4/20/26, at 10:06 a.m., Dietary Supervisor confirmed that the facility failed to maintain sanitary conditions to prevent the potential for cross-contamination or foodborne illness in the main kitchen (Main Kitchen). During an observation on 4/21/26, from 11:45 a.m., through 12:45 p.m., the following was observed: Cook/ Dietary Aide Employee E12 was plating food and setting plates onto a cart, then placed plates into warmer touching surfaces of handle of warmer, then returned to plate foods, touching items that were falling off plates with no hand washing or glove change. During an interview on 4/21/26, at 1:00 p.m., the Nursing Home Administrator and the Director of Nursing were made aware of observations. During an interview on 4/22/26, at 10:47 a.m., the Regional Director of Operations Employee E5 confirmed that observations failed to maintain sanitary conditions to prevent the potential for cross-contamination or foodborne illness in the main kitchen (Main Kitchen). 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 211.6(b)(c)(d) Dietary services.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. Based on observations and staff interviews, it was determined that the facility failed to ensure the dish machine was in proper working order in the Main Kitchen and staff had proper education to maintain the dish machine to provide documentation of temperature levels and sanitation levels. Findings include:During an observation of the main kitchen on 4/20/26, from 9:30 a.m., through 11:00 a.m., the following was observed:The dish machine wash and rinse cycle temperature gauges were not functioning; the dish machine is a high temperature machine with a chemical final rinse cycle as a bucket of chemicals was attached to the final rinse hose. The dish machine appeared to be leaking, and the floor drain was unable to drain the water fast enough to keep it from puddling under the machine and the floor had no nonslip mats.During an interview on 4/20/26, at 9:40 a.m., Dietary Supervisor Employee E6 stated that the gauges have not worked consistently and could not identify how to fix the issue.During an interview on 4/20/26, at 11:00 a.m., the Director of Nursing confirmed that the facility failed to ensure the dish machine was in proper working order.During an interview on 4/20/26, at approximately 12:50 p.m., the Regional Certified Dietary Manager Employee E8 confirmed that the staff did not know how to utilize test strips for temperature and chemical concerns for final rinse. Confirmed that the drainage pipe under machine is not sufficient causing puddling of water.During an interview on 4/22/26, at 10:47 a.m., Regional Director of Operations for Aramark confirmed that the dish machine is in need of repair, staff need education of the dish machine working and documenting temperatures and chemical levels for the dish machine. 28 Pa Code: 207.2(a) Administrator's Responsibility

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on review of facility policy, resident council documents, resident group interview, and staff interview it was determined that the facility failed to respond to or address concerns from resident council, food committee, and grievances in a timely manner for five out of six months. Findings include:Review of the facility policy Resident Council Meeting dated 1/6/26. The policy indicates The Resident Council is mandated by law and is the recognized forum established for the resident to voice their ideas and/or concerns regarding their environment and care. This governing body works closely with the administration of the facility and other staff to possibly affect changes and resolve problems within the facility where they reside. Schedule other ad hoc committee meetings as needed i.e. food committee. Address collective concerns using the concern (grievance) form to inform appropriate department of concern in a timely manner. During a group interview on 4/20/26, at 1:30 p.m., the group consensus was dissatisfaction with the meals and frustration as they voiced concerns with the facility administration not resolving their ongoing issues with their meals. The group stated the meals are cold, meals are inaccurate from what is on the menu, stating when you complete the request for the alternate meal, often you don't receive it. Grievances have been filed, complaints are made to the staff, complaints are made at resident council and at food committee, nothing changes with the food issues. They tell you they are working on it, some of us have been here for years and we only see the meals getting worse, the taste, temperature and selection. Residents voiced dissatisfaction with the Enchiladas and black beans meal served on 4/19/26 for dinner stating this is not what Southwestern Pennsylvanians eat. Residents stated, we go to bed hungry some days. During an interview on 4/20/25 with the Ombudsman (government program of a resident advocate to address concerns about quality of life of persons living in long term care) at 9:50 a.m., revealed concerns about the facility meals. The Ombudsman reported receiving multiple resident complaints about the food being cold, meals not provided as ordered and the taste. Review of grievances filed revealed the following monthly reported concerns related to meals/food.April 2026 8 grievancesMarch 2026 10 grievancesFebruary 2026 9 grievancesJanuary 2026 3 grievancesDecember 2025 2 grievancesNovember 2025 4 grievances Review of resident council and food committee minutes revealed the following monthly reported concerns related to meals/food.4/16/263/19/262/19/261/15/2612/30/25During an interview on 4/14/26, at 12:00 p.m. The Director of Nursing confirmed the facility failed to respond to or address concerns from resident council, food committee, and grievances in a timely manner.28 Pa. Code 201.18(b)(1) Management.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, observation and resident and staff interviews, it was determined that the facility failed to provide a safe, clean, comfortable, and homelike environment for four of six nursing units and in the therapy gym as required (2 South, 3 South, 3 East and 1 [NAME] nursing units and the therapy gym). Findings included: Review of the facility policy Resident Rights, dated 1/6/26, indicated the facility staff are trained regarding resident rights including the right for a safe and homelike environment. During a group interview on 4/20/26, at 1:30 p.m., the group consensus was dissatisfaction with the cleanliness of their rooms and bathrooms. Multiple statements were provided by the group describing the conditions of the bathrooms being left soiled with urine on the floor and feces on the toilet seat and stains in the toilet bowl as if it was not cleaned often. The group stated most of the rooms have four residents who share a bathroom you can't imagine how dirty it gets every day. During an interview on 4/20/26, with the Ombudsman (government program of a resident advocate to address concerns about quality of life of persons living in long term care) at 9:50 a.m., revealed concerns about cleanliness. The Ombudsman reported receiving multiple resident complaints about the rooms being dirty and bathrooms with feces on the floor and toilet. Review of grievances revealed the following dates of reported concerns related to cleanliness. 2/10/261/5/2611/15/25 Review of Resident Council minutes revealed the following dates of reported concerns related to cleanliness. 4/16/262/19/2612/30/25 Observations on 4/20/26, at 10:38 a.m., through 11:40 a.m., revealed the following: 3 East lounge had resident wheelchairs, a blanket, personal resident items and a package of diapers. the tables were unclean.Resident room [ROOM NUMBER] floor had food debris under bed and under headboard areas, with no can liner in garbage can.Resident room [ROOM NUMBER] floor had food debris and no can liner.Resident room [ROOM NUMBER] D and W beds both had soiled linens and floor had food debris and no can liner. Bathroom had a soiled toilet.Resident room [ROOM NUMBER] had no can liner.Resident room [ROOM NUMBER] W mattress was soiled as linens were not replaced and sunk in in center of mattress. Bathroom for 325/326 was soiled with a used diaper on floor.Resident room [ROOM NUMBER] had food debris on the floor and no can liner.Resident room [ROOM NUMBER] had no can liner. During an interview on 4/20/26, at 1:44 p.m. Confidential Resident R1 stated that housekeeping staff don't empty her trash and motioned her hand to the almost full trash can beside her bed. Confidential Resident R1 stated that her daughter cleans her room. During an observation on 4/21/26, at 4:55 p.m. of Resident R59's room, the room appeared unclean, with dirty clothes on the floor and fruit flies observed. During an observation on 4/21/26, at 5:34 p.m. of Resident R16's room, there was a strong odor of urine. During an observation on 4/22/26, from 11:40 a.m. - 12:35 p.m. observations of 3 South unit identified resident rooms floors throughout unit had food debris and floors appeared very worn and in need of deep cleaning. During an observation on 4/22/26, at 9:23 a.m., of the Therapy gym at 9:23 a.m., identified the floor having debris throughout the gym and soiled equipment. During an interview on 4/22/26, at 9:26 a.m., Therapist Employee E3, confirmed that the Therapy gym was in need of deep cleaning of floors and equipment. During an interview on 4/22/26, at 12:18 p.m., the Housekeeping Supervisor Employee E4, confirmed that the Therapy gym has not been cleaned by housekeeping. During an interview on 4/22/26, at 1:25 p.m., the Nursing Home Administrator and the Director of Nursing confirmed the facility failed to provide a safe, clean, comfortable, and homelike environment for four of six nursing units and in the Therapy gym as required. During an interview on 4/22/26, at 2:45 p.m., confirmed with the facility-contracted Regional Director of Operations of Employee E5 that the facility failed to provide a safe, clean, comfortable, and homelike environment for four of six nursing units and in the therapy gym as required. 28 Pa. Code: 201.29(k) Resident rights.28 Pa. Code: 207.2(a) Administrator's responsibility.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on a review of clinical record reviews, resident interviews and observations, and staff interviews, it was determined that the facility failed to provide Activity of Daily Living (ADL) assistance for seven of twelve residents (Confidential Resident R500, R501 and Residents R2, R7, R13, R16, and R104).Findings Include: Review of the facility ADL Care - Bathing (Shower, Tub, Bed, Perineal) dated 1/6/26, indicated it is the policy of the facility to shower residents at least weekly, based on resident preference. During an interview on 4/20/26, at 1:44 p.m. Confidential Resident R500 stated that not all aides do their job, and some only do it halfway. Confidential Resident R500 stated, They can't bathe you because there are only two aides working. Confidential Resident R500 stated that at times she has had to have a bed bath, rather than her preferred shower, because staff told there were not enough aides. Confidential Resident R500 stated staff do not make rounds at night and she has been left in soiled briefs / bed linen, stating that many times she is not assisted after 10:00 p.m. until the next morning at 6:00 a.m. Confidential Resident R500 described an instance that the nurse aide would only change her wet brief, but would not assist in changing the bed linen, leaving her in wet bedding. Confidential Resident R500 requested anonymity, stating, They are the type who will take it out on me. During an interview on 4/20/26, at 2:00 p.m. Confidential Resident R501 stated, I'm laying in my wet diaper with number two (bowel movement) in it. I do number one (urination) and it goes on top of number two, and it leaks out everywhere. We don't get shit in this God damn place. They say ?Wait a minute. Wait a bit.' This place is turning out to be an a**hole. They have to wear their diapers until someone comes in to change them. We have to argue to get somebody to show up to do what they are supposed to do. We lay in our piss. Confidential Resident R501 stated that she is not cleaned well, with staff stating that the aides tell her they are not allowed to clean where the hair is to wipe the number two off there. They don't clean us good. Confidential Resident R501stated she has missed multiple showers, and when she does get them, they are only about five minutes long and she doesn't get fully clean. Confidential Resident R501 was observed to be malodorous, with unbrushed, greasy-appearing hair, and unshaven facial hair. Confidential Resident R501 requested anonymity. During an interview on 4/21/26, at 4:30 p.m. Resident R7 stated that call light responses can be long at times and, They are always short. Two aides for fifty people. It's not fair to us and it's not fair to the aides. During an interview on 4/21/26, at 5:05 p.m. Resident R13 when asked about facility staffing stated, I don't think there are enough. There's only two nurses and two aides. It's been rough to get the aides. When asked about receiving showers, Resident R13 stated, I accept that I can't always get a shower due to staffing. During an interview on 4/21/26, at 5:23 p.m. Resident R106 stated, Sometimes they take too long when I call a button. Resident R106 stated that she has been told she cannot get a shower due to low staffing, and confirmed that she has been left in soiled briefs / bed linen due to long call light responses. Observation at this time revealed Resident R106's fingernails to be unclean. During an interview on 4/21/26, at 5:27 p.m. Resident R2 stated, Lights too long. You can wait three hours for someone to come in. Resident R2 confirmed that she has been left in soiled briefs / bed linen. During an observation on 4/21/26, at 5:31 p.m. Resident R16 was observed with unbrushed hair, long, unclean fingernails, and a strong odor of urine. When asked about call light response, he stated, It varies. Sometimes bad. During an interview on 4/24/26, at approximately 11:30 a.m. the Nursing Home Administator and the Director of Nursing confirmed that the facility failed to provide Activity of Daily Living (ADL) assistance for seven of twelve residents. 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.18(e)(2.1) Management.28 Pa. Code: 211.12(c)(d)(1)(2)(5) Nursing services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395577	A. Building B. Wing	04/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Premier Washington Rehabilitation and Nursing Ctr	36 Old Hickory Ridge Rd Washington, PA 15301

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, observations, and staff interviews, it was determined that the facility failed to provide appropriate respiratory care and maintain oxygen equipment for four of eight sampled residents (Residents R13, R80, R159, and R256).Findings include: Review of the facility policy Oxygen Administration reviewed on 1/6/26, indicated Date tubing when initiated, and at least every 2 weeks when changed; more often if malfunction or visibly soiled. Review of the facility, BiPAP CPAP Policy and Procedure dated 1/6/26, indicated, BiPAP and CPAP is administered by licensed nurses with a physician's order. Review of Resident R80's admission record indicated she was originally admitted on [DATE]. Review of Resident R80's Minimum Data Set (MDS- a periodic assessment of care needs) dated 4/15/26, indicated the diagnoses of chronic obstructive pulmonary disease (COPD progressive lung disease limiting airflow to the lungs), hypertension (high blood pressure), and anxiety disorder (intense, excessive, and persistent feelings of worry, fear, and uneasiness). Review of Resident R80's current physician orders dated 4/10/26, indicated resident is on 5 liters per minute of oxygen. Change oxygen tubing and set-up weekly every night shift, every Sunday label tubing with date when changed and as needed. Review of Resident R159's admission record indicated she was originally admitted on [DATE]. Review of Resident R159's MDS dated [DATE], indicated the diagnoses of pneumonia (lung infection), malnutrition (imbalance between the nutrients your body needs and the nutrients it gets), and dysphagia (difficulty swallowing food and liquids). Review of Resident R159's current physician orders dated 4/8/26, indicated resident is on 2 liters per minute of oxygen. Change oxygen tubing and set-up weekly on 11-7 Saturday every night shift, every Saturday for oxygen maintenance label tubing with date when changed and as needed. Review of Resident R256's admission record indicated she was originally admitted on [DATE]. Review of Resident R256's MDS dated [DATE], indicated the diagnoses of chronic obstructive pulmonary disease (COPD progressive lung disease limiting airflow to the lungs), hypertension (high blood pressure), and anxiety disorder (intense, excessive, and persistent feelings of worry, fear, and uneasiness). Review of Resident R256's current physician orders dated 4/17/26, indicated resident is on 4-6 liters per minute of oxygen. Change oxygen tubing and set-up weekly every night shift, every Sunday label tubing with date when changed and as needed. Interview and rounds on 4/20/26, with Licensed Practical Nurse (LPN) Employee E2, Resident R80, R159, and 256 were observed, with oxygen tubing connected to their oxygen concentrator that was not labeled and dated. Review of Resident R13's admission record indicated she was originally admitted on [DATE]. Review of Resident R13's MDS dated [DATE], indicated the diagnoses of COPD, heart failure (chronic, progressive condition where the heart muscle cannot pump blood efficiently, often causing fluid buildup in the lungs or body), and diabetes (chronic condition where blood sugar is too high due to insufficient or ineffective insulin production). Review of Resident R13's facility diagnosis list failed to reveal a diagnosis of sleep apnea (disorder where breathing repeatedly stops and starts during sleep, preventing oxygen from reaching the body). Review of Resident R13's care plan since admission failed to reveal a plan of care developed for the use of a CPAP or BiPAP machine. Review of progress notes since the date of admission [DATE]) failed to include mention of sleep apnea. Review of a physician's order dated 8/19/23, indicated the use of a BiPAP for sleep apnea . This order was discontinued on 9/7/23. Review of a progress note dated 11/1/24, at 11:49 a.m. indicated, compliance with CPAP. Review of a progress note dated 10/21/25, at 8:08 a.m. indicated at 3:00 a.m. Resident R13 required assistance due to her BiPAP not functioning. Review of a progress note dated 10/31/25, at 10:46 p.m. indicated, Resident expresses coincer on her ability to reach the power button of her BiPAP. The machine was placed near on teh side of the bed to promote more independence of its use. Review of a progress note dated 2/4/26, at 11:35 a.m. indicated, Resident encouraged to use CPAP per order at HS (hour of sleep). Review of physician's orders for this date failed to reveal an (continued on next page)

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	395577	A. Building B. Wing	04/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Premier Washington Rehabilitation and Nursing Ctr	36 Old Hickory Ridge Rd Washington, PA 15301

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	order for CPAP or BiPAP therapy. During an interview and observation on 4/21/26, at 5:05 p.m. a BiPAP machine was noted to be on Resident R13's bedside table and a gallon jug of distilled water was present on the floor next to the bedside table. Resident R13 confirmed that she uses her BiPAP machine, not every night, but often. During an interview on 4/24/26, at 10:33 a.m. the Director of Nursing confirmed that a physician's order and care plan were not in place for the use or refusal of a CPAP or BiPAP machine. During an interview on 4/21/26, at 11:00 a.m. the Director of Nursing confirmed that the facility failed to provide appropriate respiratory care and maintain oxygen equipment for four of eight residents. 28 Pa. Code 211.10(c)(d) Resident Care Policies.28 Pa. Code 211.12(d)(1)(5) Nursing services.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility policy, clinical records, and staff interview, it was determined that the facility failed to make certain that residents are free of significant medication errors for one of five residents (Resident R7).Findings include:Review of the United States Food and Drug Administration prescribing guidelines for Xtampza ER (an extended-release, abuse-deterrent opioid medication used for severe, chronic pain requiring around-the-clock treatment) dated December 2023 indicated Xtampza ER is administered, twice daily, every 12 hours, and must be taken with food. The oral bioavailability of oxycodone from Xtampza ER is greater when taken with food than when taken in the fasted state. The oral bioavailability is dependent on the food consumed and is greatest following a high-fat and high-calorie meal.Review of the facility policy Medication Administration / Disposition dated 1/6/26, indicated medications shall be administered in a timely manner, and as prescribed by the physician. Medications must be administered within one hour of their prescribed time, unless otherwise specified.Review of the clinical record indicated Resident R was admitted to the facility on [DATE].Review of the Minimum Data Set (MDS - periodic assessment of resident care needs) dated 2/8/26, included diagnoses of cancer, history of a stroke, and chronic pain syndrome.Review of Resident R7's physician order dated 4/14/26, through 4/22/26, indicated Resident R7 was to receive Xtampza ER 9 mg (milligrams) every twelve hours for chronic pain management, at 8:00 a.m. and 8:00 p.m. This order did not include directions that food must be consumed with Xtampza ER.Review of Resident R7's physician order dated 4/22/26, indicated Resident R7 was to receive Xtampza ER 18 mg two times per day for chronic pain management, at 9:00 a.m. and 5:00 p.m.Review of Resident R7's Medication Administration Audit Report indicated Resident R7 received Xtampza ER on the following dates and times:4/14/26 7:23 p.m.4/15/26 10:34 a.m. (approximately 15 hours from previous dose)4/15/26 7:49 p.m. (approximately 9 hours from previous dose)4/16/26 9:33 a.m. (approximately 14 hours from previous dose)4/16/26 7:33 p.m. (approximately 10 hours from previous dose)4/17/26 9:18 a.m . (approximately 16 hours from previous dose)4/17/26 8:49 p.m. 4/18/26 8:24 a.m. 4/18/26 8:42 p.m. 4/19/26 7:39 a.m. 4/19/26 7:38 p.m. 4/20/26 7:53 a.m. 4/20/26 10:21 p.m. (approximately 14 hours from previous dose)4/21/26 8:16 a.m. (approximately 10 hours from previous dose)4/21/26 8:52 p.m. 4/22/26 10:34 a.m. (approximately 14 hours from previous dose)4/22/26 4:22 p.m. (approximately 7 hours from previous dose)4/23/26 9:39 a.m. (approximately 17 hours from previous dose)Review of a wound assessment completed on 4/17/26, indicated Resident R7 has a Stage 4 pressure injury (full-thickness skin and tissue loss) on her sacrum. During an interview on 4/21/26, at approximately 4:30 p.m. Resident R7 stated that she has cancer and my butt hurts and stated she has a wound. Resident R7 stated she receives dressing changes every morning, commenting, My God, the pain. When asked about pain medications, Resident R7 stated, Nothing works. Review of Resident R7's physicians' orders on 4/23/26, at approximately 1:30 p.m. failed to reveal an order for a snack or other food items to be given with the Xtampza ER.During an interview on 4/23/26, at 2:16 p.m. Licensed Practical Nurse (LPN) Employee E1 confirmed that Resident R7's original Xtampza ER order was appropriately timed for every twelve hours but did not include directions to provide food with the evening dose (morning dose scheduled at breakfast time). LPN Employee E1 further confirmed that Resident R7's current Xtampza ER order is timed to be given with meals but is not scheduled every twelve hours as necessary for consistent pain control (current order was eight hours between morning and evening dose, then 16 hours between evening and morning dose).During an interview on 4/24/26, at approximately 10:30 a.m. the Director of Nursing confirmed that the facility failed to make certain that residents are free of significant medication errors for one of five residents.28 Pa Code: 201.18 (b)(1)(3) Management.28 Pa Code: 211.10 (c) Resident care policies.28 Pa. Code 211.12 (d)(1)(2)(5) Nursing Services.