

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395661	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2025
NAME OF PROVIDER OR SUPPLIER Casselman Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Hospital Drive Meyersdale, PA 15552	
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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Review of Pennsylvania's Nursing Practice Act and information submitted from the facility, it was determined that the facility failed to ensure that a licensed practical nurse's license remained current for one of one licensed practical nurse's reviewed (Licensed Practical Nurse 2). This was cited as past non-compliance. Findings include: The Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, for the expiration and renewal of licensure revealed that notice of the renewal period of a license will be sent to each active licensee prior to the expiration date of the licensee's license. The applicant for license renewal may complete and submit an application online or may mail a completed application form to the Board's administrative office. When applying for licensure renewal, a registered nurse shall complete and submit the renewal application, including disclosing any license to practice nursing or any allied health profession in any other state, territory, possession or country, pay the biennial renewal fee, verify the completion of mandatory continuing education and child abuse recognition and reporting requirements, disclose any discipline imposed by a state licensing board on any nursing or allied health profession license or certificate in the previous biennial period, and any criminal charges pending or criminal conviction, plea of guilty or nolo contendere, admission into a probation without verdict, or accelerated rehabilitation during the previous biennial period. Information submitted by the facility staff on [DATE], revealed that Licensed Practical Nurse 2's license expired on [DATE], and that she continued to work from [DATE], until a whole house audit on [DATE] revealed that her license had expired. No care concerns were identified during this time. Licensed Practical Nurse 2 was immediately removed from the schedule and not permitted to return to work until she renewed her license on [DATE]. An interview with the Human Resources Director on [DATE] at 11:06 a.m. revealed that the facility suspended License Practical Nurse 2 when they learned that her license had expired and that she was not permitted to return to work until she renewed her licensed on [DATE]. The facility's corrective actions taken following the incident included: 1. An immediate audit of all licensed staff was conducted and results were reviewed. 2. The licensed practical nurse was suspended and disciplined for failing to renew her license timely. 3. Staff education was completed regarding renewing their licenses prior to expiration. All of the staff was educated by [DATE]. 4. Monthly audits will be completed and reviewed at QAPI meetings. 5. Human Resources will now offer reminders to the staff prior to expiration. 6. Human Resources will offer support to staff who may struggle to use the computer to renew. 7. On-going audits will be submitted to the facility's QAPI meetings as appropriate for review. Review of the facility's corrective actions and interviews completed with staff regarding their re-education revealed that they were in compliance with F658 on [DATE]. 28 Pa. Code 201.14(a) Responsibility of license. 28 Pa. Code 201.18(e)(1) Management. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on review of the Resident Assessment Instrument User's Manual and residents' clinical records, as well as staff interviews, it was determined that the facility failed to complete accurate Minimum Data Set assessments for three of 28 residents reviewed (Residents 3, 38, 52). Findings include: The Resident Assessment Instrument (RAI) User's Manual, which gives instructions for completing Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2024, revealed that Section N0415F1 (antibiotic medication) was to be checked if the resident received an antibiotic medication during the seven-day assessment period and Section N0415K1 was to be checked if the resident received an anticonvulsant medication during the seven-day assessment period. Physician's orders for Resident 3 dated May 1, 2025, included an order for the resident to receive 300 milligrams (mg) of Gabapentin two times a day for diabetic neuropathy (nerve damage that can cause pain, numbness, tingling, and weakness in the hands and feet, and sometimes other parts of the body). The resident's Medication Administration Record (MAR) for May 2025 revealed that the resident received Gabapentin twice a day from May 1 through 28, 2025. A quarterly MDS assessment for Resident 3, dated May 24, 2025, revealed that Section N0415K1 was not checked, indicating that the resident did not receive any anticonvulsant medications during the seven days of the assessment period. Physician's orders for Resident 38 dated March 18, 2024, included an order for the resident to receive 100 mg of Pregabalin three times a day for neuropathy. The resident's Medication Administration Record (MAR) for May 2025 revealed that the resident received Pregabalin three times a day from May 1 through 31, 2025. A quarterly MDS assessment for Resident 38, dated May 9, 2025, revealed that Section N0415K1 was not checked, indicating that the resident did not receive any anticonvulsant medications during the seven days of the assessment period. Physician's orders for Resident 53 dated May 1, 2025, included an order for the resident to have 1% Silvadene External Cream (antibiotic) applied to the sacrum gluteal fold (horizontal crease or fold located at the base of the buttocks) every day and evening shift for wounds. The resident's Treatment Administration Records (TAR's) for May 2025 revealed that the resident received Silvadene External Cream every day and evening from May 2 through 10, 2025. A quarterly MDS assessment for Resident 53, dated May 9, 2025, revealed that Section N0415F1 was not checked, indicating that the resident did not receive any antibiotic medications during the seven days of the assessment period. An interview with the Director of Nursing on July 30, 2025, at 2:59 p.m. confirmed that assessments for Residents 3, 38, and 53 were coded incorrectly. 28 Pa. Code 211.5(f) Medical records.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to ensure that a resident's care plan was updated/revised to reflect the resident's specific care needs for two of 28 residents reviewed (Residents 4 and 9). A facility policy for Care Plan Revisions Upon Status Change dated April 7, 2025, indicated that the comprehensive care plan will be reviewed, and revised as necessary, when a resident experiences a status change. A significant change Minimum Data Set (MDS) assessment (a mandated assessment of a resident's care needs and abilities) for Resident 4 dated May 2, 2025, indicated that the resident was cognitively intact, required assistance with daily care needs, and had diagnoses that included Multiple Sclerosis (disease in which the immune system eats away at the protective covering of nerves). The Care plan for Resident 4 dated October 13, 2023, indicated that the resident was receiving diuretic therapy (water pills, to increase urine production and help the body eliminate excess fluid and sodium). Review of the Medication Administration Record (MAR) for Resident 4 dated July 2025, revealed no documented evidence that the resident was receiving a diuretic medication. An interview with Licensed Practical Nurse Assessment Coordinator on July 31, 2025, at 9:53 am confirmed that Resident 4 was not receiving diuretic medications and that Resident 4's care plan should have been revised to reflect that, however it was not. An admission MDS assessment for Resident 9 dated July 2, 2025, indicated that the resident was cognitively intact, required assistance with daily care needs, and had diagnoses that included necrotizing fasciitis (a severe bacterial infection that rapidly destroys skin, fat, and muscle tissue).The Care plan for Resident 9 dated July 3, 2025, indicated that the resident was receiving anticoagulant therapy (medications that prevent blood clots from forming or existing clots from getting larger).Review of the MAR for Resident 9 revealed that the resident had not received any anticoagulant medications since July 8, 2025.An interview with the Nursing Home Administration on July 31, 2025, at 12:04 p.m. revealed that the Resident 9 was no longer receiving anticoagulant medication and that his care plan should have been revised to reflect that, however, it was not. 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 a review of facility policy and clinical records, as well as staff interviews, it was determined that the facility failed to follow physician's orders related to bowel protocols for one of 28 residents reviewed (Resident 42). Findings include: A facility policy for Bowel Movements Monitoring dated April 7, 2025, indicated that all residents' bowel movements will be documented. If a resident has not had a bowel movement for three full days, the licensed nurse will follow bowel protocol as ordered by the physician. All shifts will then monitor for effectiveness. If initial laxative is ineffective, then a second laxative if ordered is given as per order. Resident will be monitored on all shifts for bowel movements to see if second laxative was effective. If the second laxative was ineffective, then an enema will be given per physician order. All three shifts will monitor resident for bowel movement to see if enema was effective. If enema is ineffective, notify the physician. A quarterly MDS assessment for Resident 42 dated July 3, 2025, indicated that the resident was cognitively impaired, required assistance with daily care needs, was always incontinent of bowel, and had diagnoses that included paranoid schizophrenia (a chronic mental health condition characterized by persistent delusions and hallucinations). Physician's orders for Resident 42, dated May 10, 2022, included an order for the resident to receive 30 milliliters (ml) of Milk of Magnesia Suspension (laxative- used to produce a bowel movement) as needed for constipation if no bowel movement by the third day/nine shifts and document effectiveness. Resident 42's bowel movement records dated June 2025 and July 2025 indicated that the resident did not have a bowel movement on June 17, 2025, through June 23, 2025. There was no documented evidence that 30 ml of Milk of Magnesia Suspension was offered to or refused by the resident after the third day/ninth shift of no bowel movement. Review of the Medication Administration Record dated June 2025, revealed 30 ml of Milk of Magnesia Suspension was administered on June 21, 2025, five days after no bowel movement, however, it was ineffective, and no further interventions were provided. Bowel movement records revealed that Resident 42 did not have a bowel movement for five days from July 11, 2025, through July 15, 2025. There was no documented evidence that 30 ml of Milk of Magnesia Suspension was offered or declined after three days/nine shifts of no bowel movement. Bowel movement records revealed that the resident did not have a bowel movement on July 18, 2025, through July 25, 2025, however there was no documented evidence that the resident was offered or declined 30 milliliters (ml) of Milk of Magnesia Suspension after three days/nine shifts of no bowel movement. Interview with the Director of Nursing on July 30, 2025, confirmed that the staff did not follow the facility's bowel policy and physician's orders for Resident 42 on the above-mentioned dates. 28 Pa. Code 211.12(d)(5) Nursing Services.		

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F 0729 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Verify that a nurse aide has been trained; and if they haven't worked as a nurse aide for 2 years, receive retraining. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility job descriptions and personnel files, as well as staff interviews, it was determined that the facility failed to ensure that staff renewed their nurse aide registry to allow individuals to work as a nurse aide for one of three nurse aides reviewed (Nurse Aide 3). Findings include: The facility's job description, undated, revealed that a nurse aide certification was necessary to perform functions of the position. This was cited as past-noncompliance. The personnel file for agency Nurse Aide 3 revealed that her certification on the nurse aide registry expired on [DATE]. The facility was unaware that Nurse Aide 3's certification on the nurse aide registry had expired until they were notified on [DATE], by Nurse Aide 3. Nurse Aide 3 worked in the facility from [DATE] through [DATE] and was immediately removed from the schedule when it was discovered that her registry had expired. Interview with the Director of Human Resources on [DATE] at 11:06 a.m. confirmed that Nurse Aide 3's certification on the nurse aide registry expired on [DATE], and should have been renewed prior to expiring and that she continued to work from [DATE] until [DATE] when it was discovered. The facility's corrective actions taken following the incident included: 1. An immediate audit of all nurse aides was conducted and results were reviewed. 2. The nurse aide was suspended and disciplined for failing to renew her registry timely. 3. Staff education was completed regarding renewing their registry prior to expiration. All of the staff was educated by [DATE]. 4. Monthly audits will be completed and reviewed at QAPI meetings. 5. Human Resources will now offer reminders to the staff prior to expiration. 6. Human Resources will offer support to staff who may struggle to use the computer to renew. 7. On-going audits will be submitted to the facility's QAPI meetings as appropriate for review. Review of the facility's corrective actions and interviews completed with staff regarding their re-education revealed that they were in compliance with F658 on [DATE]. 28 Pa. Code 201.29 Personnel policies and procedures.		

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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. Based on review of policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure that medications were properly labeled for one of 28 residents reviewed (Resident 37). Findings include: The facility's policy regarding labeling of medications, dated April 7, 2025, indicated that all medications and biologicals used in the facility will be labeled in accordance with current state and federal regulations to facilitate consideration of precautions and safe administration of medications. Labels for individual drug containers must include appropriate instructions and precautions. The pharmacy must be informed of any changes or changes in directions for use of the medication. Physician's orders for Resident 37, dated July 1, 2025, indicated that the resident was to receive two 300 milligram (mg) capsules of Gabapentin (a medication used to treat nerve pain) daily and one 300 mg capsule of Gabapentin at bedtime. Observations during the medication administration on July 31, 2025, at 8:24 a.m. revealed that Licensed Practical Nurse 1 obtained Resident 37's blister pack (commonly used as unit-dose packaging for pharmaceutical tablets, capsules or lozenges) containing the resident's Gabapentin. The label on the blister pack containing the Gabapentin revealed that the resident was to receive one 300 mg capsule of Gabapentin daily and two 300 mg capsules of Gabapentin at bedtime. Interview with Licensed Practical Nurse 1 at the time of observation confirmed that the label on the blister pack containing the resident's Gabapentin did not match the resident's current orders for Gabapentin and that there should have been a change in direction sticker (a label used to indicate that a change has been made to the instructions or directions for something, often medication or a process) on the blister pack containing the resident's Gabapentin. Interview with the Director of Nursing on July 31, 2025, at 1:48 p.m. confirmed that there should have been a change in direction sticker on Resident 37's blister pack of Gabapentin to alert staff of the change in orders. 28 Pa. Code 211.9(a)(1) Pharmacy Services. 28 Pa. Code 211.12(d)(3) Nursing Services.		

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to obtain laboratory studies as ordered by the physician for one of 28 residents reviewed (Resident 3). Findings include: The facility's policy regarding laboratory services and reporting, dated April 7, 2025, revealed that the facility would provide or obtain laboratory services when ordered by a physician, physician assistant, nurse practitioner, or clinical nurse specialist in accordance with state law. The facility would provide or obtain laboratory services to meet the needs of its residents. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 3, dated June 25, 2025, revealed that the resident was cognitively intact and had diagnoses that included hypothyroidism (when the thyroid gland doesn't make and release enough hormone into your bloodstream). A pharmacy review for Resident 3, dated May 3, 2025 revealed the resident was taking levothyroxine (medication used to treat hypothyroidism) and to consider monitoring TSH/thyroid panel (thyroid stimulating hormone-hormone produced by the pituitary gland). Physician's orders for Resident 3, dated May 14, 2025, included an order for staff to obtain a TSH level for hypothyroidism when the next labs were drawn. A care plan, dated July 14, 2022, revealed the resident had hypothyroidism and labs were to be obtained as ordered. Laboratory results, dated June 2, 2025, revealed that the TSH level was not included with the laboratory tests that were drawn that day. Interview with Director of Nursing on July 29, 2025, at 3:14 p.m. confirmed that there was no documented evidence that Resident 3's TSH level was drawn as ordered. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.		