

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: 395661	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/06/2026
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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on a review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to follow physician's orders for two of 34 residents reviewed (Residents 4 and 37). Findings include: A facility policy regarding medication orders, dated January 8, 2026, indicated that medications should be administered only upon the signed order of a person lawfully authorized to prescribe. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 4, dated May 21, 2026, revealed that the resident was cognitively intact, required maximum assistance from staff for daily care needs, had diagnoses that included diabetes, and received insulin (a diabetic medication to regulate glucose levels). Physician's orders for Resident 4 dated July 9, 2026, included an order for the resident to receive 6 units insulin aspart 100 units/milliliter (a fast-acting medication to regulate blood sugar levels) at 8:00 a.m. and to hold the medication if the blood sugar level was less than 110 milligram/deciliter (mg/dL). Review of Resident 4's Medication Administration Record (MAR) for July and August 2026 revealed that the resident received 6 units of insulin aspart at 8:00 a.m. on July 13, 2026 when the resident's blood sugar was 92 m/dL; on July 19, 2026 when the resident's blood sugar was 106 mg/dL; on July 21, 2026 when the resident's blood sugar was 105 mg/dL; on July 24, 2026 when the resident's blood sugar was 104 mg/dL; on August 4, 2026 when the resident's blood sugar was 94 mg/dL; and on August 5, 2026 when the resident's blood sugar was 75 mg/dL. Interview with Director of Nursing on August 5, 2026, at 2:30 p.m. confirmed that 6 units of insulin aspart was administered to Resident 4 on the above dates and times and should have been held per physician's orders. A quarterly MDS assessment for Resident 37, dated June 9, 2026, revealed that the resident was cognitively impaired, was dependent on staff for his daily care needs, and had diagnoses that included insulin dependent diabetes. Physician's orders for Resident 37, dated June 3, 2026, included an order for the resident to receive 6 units/mL of Insulin Aspart two times a day with lunch and supper and to hold if the resident's blood sugar was less than 150 mg/dL or the resident ate less than 50 percent of his meal. Review of Resident 37's MAR dated June 2026 revealed no documented evidence of a meal intake for lunch or dinner on June 3 and 6, 2026; for lunch on June 5 and 7, 2026; or dinner on June 8, 2026, but Resident 37 was administered the 6 units of insulin aspart. Interview with the Director of Nursing on June 6, 2026 at 1:18 p.m. confirmed that staff should have obtained Resident 37's meal intake prior to administering the insulin on the dates and times noted above. 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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 34 residents reviewed (Resident 39). Findings include: Review of the facility policy for Restorative Nursing Programs dated May 31, 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 ensure 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. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 39, dated April 24, 2026, indicated that the resident was cognitively intact, was independent with transfers and ambulation, used a walker and a wheelchair, and had diagnoses that included Parkinson's Disease (a brain disorder that can affect movement). A quarterly MDS assessment dated [DATE], indicated that the resident was cognitively intact, used a walker and a wheelchair, and required substantial or maximum assistance from staff for transfers and ambulation. A care plan for restorative nursing dated February 17, 2026 revealed that staff are to report and document any declines in ability to restorative nurse, and to report abnormal assessment findings, decline in function, or complication associated with restorative activities to physician. A restorative nursing program for Resident 39 for February 2026 - August 2026 included for the resident to participate in a restorative nursing program walking 100 feet twice a day, 7 days a week for 15 minutes. A review of the restorative nursing program documentation revealed that in May 2026 the resident participated twice a day for 15 minutes and was able to walk an average of 75 feet each time. In June 2026, the resident participated twice a day from June 1, 2026 - June 10, 2026, and walked an average on 15-50 feet twice a day. From June 11, 2026, to June 30, 2026, there was documented evidence that restorative nursing was offered twice a day for 3 of the days and only once a day for 8 of the days and the resident walked 15 feet each occurrence. In July 2026, the resident was offered restorative nursing twice a day for 3 days and participated for 15 feet each occurrence, once a day for 9 days and walked 15 feet each occurrence. August 1, 2026, to present (August 5, 2026) the resident was not offered restorative nursing. There was no documented evidence of the resident's decline reported to the restorative nurse or physician. Interview with Resident 39 on August 6, 2026, at 9:45 a.m. revealed that he used to be able to walk longer distances two months prior, and nursing staff will sometimes take him for a walk. It depends on how much staff they have and if they have time. Interview with Nurse Aide 3 on August 6, 2026, at 9:52 a.m. revealed that they don't have enough time to ensure that the resident completes his restorative nursing program and they will document NA in his chart when they don't have the time. Interview with Physical Therapist 4 on August 6, 2026, at 10:01 a.m. revealed that the resident has been seen by therapy and was placed on a restorative nursing program to help prevent decline in mobility with his disease process with Parkinson's. Interview with Physical Therapist 5 on August 6, 2026, at 12:01 p.m. revealed that the resident was able to walk 150 feet with a walker in (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	April, and has had a decline in mobility. Interview with the Nursing Home Administrator on August 6, 2026, at 12:05 p.m. revealed that the resident was in and out of therapy and restorative nursing and their Director of Therapy only works 3 days a week which could be the reason why his decline missed being re-evaluated. 28 Pa. Code 211.12(d)(3)(5) Nursing services.		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on review of facility policies, observations, and staff interviews, it was determined that the facility failed to serve food that was palatable and at safe and appetizing temperatures for one of 34 residents reviewed (Resident 51). Findings include: The facility's policy regarding food quality and palatability, dated March 31, 2026, indicated that food is prepared by methods that conserve nutritive value, flavor and appearance. Food is palatable, attractive and served at a safe and appetizing temperature. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) assessment for Resident 51, dated June 27, 2026, revealed that the resident was cognitively impaired, required substantial/maximum assistance with eating, required a mechanically altered diet, and had diagnoses that included cerebral infarction (lack of blood supply to the brain resulting in brain death to parts of the brain). A care plan for the resident, initiated April 6, 2026, indicated that she required cueing and prompting at mealtimes to feed herself as much as possible and staff were to assist as needed. A physician's order for Resident 51, dated March 30, 2026, revealed that the resident received a regular diet, mechanical soft, ground texture with nectar consistency liquids and required supervision and assistance with meals. Observations in the third-floor dining room on August 3, 2026, at 11:43 a.m. revealed that Resident 51 was sitting in her broda chair at a dining room table and staff delivered her lunch tray and uncovered her food. At 11:50 a.m., the resident was sitting in her broda chair in the dining room with her eyes closed and she was not attempting to feed herself. No staff attempted to assist her with her meal, or cue her to eat. At 12:17 p.m., the resident continued to sit at the dining room table with her lunch in front of her and she was not attempting to feed herself. No staff attempted to feed her, or cue her to eat. At 12:22 p.m., the resident continued to sit at the dining room table with her lunch in front of her. No staff attempted to feed her, or cue her to eat. At 12:28 p.m., Nurse Aide 1 sat down to feed the resident. Interview with Nurse Aide 1 on August 3, 2026, at 12:32 p.m. indicated that they are to try and have Resident 51 attempt to feed herself, but she usually needs assistance with feeding. The resident did not attempt to feed herself from the time the tray was served at 11:43 a.m. until Nurse Aide 1 sat down to feed her at 12:28 p.m. No staff attempted to assist her with her meal or cue her to eat. She was receptive to food when Nurse Aide 1 started to feed her. This surveyor requested the Dietary Manager take temperatures of the resident's lunch meal at the time Nurse Aide 1 began to feed the resident. The temperature of the spinach was 103 degrees Fahrenheit. The temperature of the chicken was 108.6 degrees Fahrenheit. The temperature of the sweet potatoes were 102 degrees Fahrenheit and the temperature of the milk was 61 degrees Fahrenheit. Neither the NA or the dietary manager attempted to reheat the residents food or get her another tray. Interview with Nursing Home Administrator on August 3, 2026, at 12:34 p.m. confirmed that staff should have assisted Resident 51 to eat, and should have heated her food or got the resident another tray. Interview with the Regional Dietary Manager on April 20, 2026, at 8:20 a.m. confirmed that the breakfast tray should have been covered and that the eggs were cold and not palatable and should not be served to the residents. 28 Pa. Code 201.18(b)(1)(2)(e) Management. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services. 28 Pa. Code 211.6(c) Dietary Services.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on clinical record review and staff interviews, it was determined that the facility failed to ensure that care and services were provided according to accepted standards of practice for two of 34 residents reviewed (Residents 1 and 55). Findings include: The Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.11 (a)(1)(2)(4) indicated that the registered nurse was to collect complete and ongoing data to determine nursing care needs, analyze the health status of individuals and compare the data with the norm when determining nursing care needs, and carry out nursing care actions that promote, maintain, and restore the well-being of individuals. An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's care needs and abilities) for Resident 1, dated June 3, 2026, revealed that the resident was cognitively intact, required assistance with daily care needs, received insulin (medication used to lower blood sugar levels), and had diagnoses including diabetes. Physician's orders for Resident 1, dated June 9, 2026, and July 1, 2026, included orders for the resident to receive 10 units of Novolog insulin (insulin aspart-a fast-acting insulin) subcutaneously with meals. A review of Resident 1's Medication Administration Record (MAR) for June and July 2026, revealed that 10 units of Novolog insulin was held on June 25 at 5:26 p.m. for a blood sugar of 98 milligrams per deciliter (mg/dl); on July 1 at 5:03 p.m. for a blood sugar of 86 mg/dl; on July 13 at 6:16 p.m. for a blood sugar of 84 mg/dl; and on July 23 at 6:06 p.m. for a blood sugar of 85 mg/dl. Physician's orders for Resident 1, dated June 17, 2026, included orders for the resident to receive 28 units of Lantus insulin (long-acting insulin) subcutaneously every 12 hours. A review of Resident 1's MAR for July 2026, revealed that 28 units of Lantus insulin was held on July 8 at 8:07 p.m. for a blood sugar of 71 mg/dl; and on July 17 at 8:20 p.m. for a blood sugar of 94 mg/dl. Interview with the Nursing Home Administrator on August 5, 2026, at 12:29 p.m. confirmed that Resident 1's Novolog and Lantus insulins were held and there were no physician's orders to hold the insulins, and there was no documented evidence that the physician gave orders to hold the insulins on the above-mentioned dates and times. A quarterly MDS assessment for Resident 55, dated May 6, 2026, indicated that the resident was cognitively impaired, required assistance from staff for daily care needs, and had diagnoses that included hypertension (high blood pressure). Physician's orders for Resident 55, dated January 30, 2026, included an order for Metoprolol Tartrate (blood pressure medication) 25 mg every morning and bedtime. A physician's order dated July 16, 2026 included an order for staff to hold Resident 55's Metoprolol and obtain vital signs twice a day for seven days and for the provider to assess the appropriateness of the Metoprolol by reviewing the resident's vital signs. There was no documented evidence in Resident 55's clinical record to indicate that vital signs were obtained as ordered by the provider to assess the appropriateness of the Metoprolol. Review of Resident 55's Medication Administration Record for July 2026, revealed that the order for Metoprolol was resumed on July 26, 2026 without any communication with the physician. Interview with the Director of Nursing on August 6, 2026, at 8:40 a.m. confirmed that the facility failed to communicate with the provider prior to restarting the order for Metoprolol. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.		

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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 and clinical record reviews, as well as observations and staff interviews, it was determined that the facility failed to provide dependent residents the necessary services to maintain nutritional status for one of 34 residents reviewed (Resident 51). Findings include: A facility policy regarding Activities of Daily Living, dated March 31, 2026, indicated that a resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) assessment for Resident 51, dated June 27, 2026, revealed that the resident was cognitively impaired, required substantial/maximum assistance with eating, required a mechanically altered diet, and had diagnoses that included cerebral infarction (lack of blood supply to the brain resulting in brain death to parts of the brain). A care plan for the resident, initiated April 6, 2026, indicated that she required cueing and prompting at mealtimes to feed herself as much as possible and staff were to assist as needed. A physician's order for Resident 51, dated March 30, 2026, revealed that the resident received a regular diet, mechanical soft, ground texture with nectar consistency liquids and required supervision and assistance with meals. Observations in the third-floor dining room on August 3, 2026, at 11:43 a.m. revealed that Resident 51 was sitting in her broda chair at a dining room table and staff delivered her lunch tray and uncovered her food. At 11:50 a.m., the resident was sitting in her broda chair in the dining room with her eyes closed and she was not attempting to feed herself. No staff attempted to assist her with her meal, or cue her to eat. At 12:17 p.m., the resident continued to sit at the dining room table with her lunch in front of her and she was not attempting to feed herself. No staff attempted to feed her, or cue her to eat. At 12:22 p.m., the resident continued to sit at the dining room table with her lunch in front of her. No staff attempted to feed her, or cue her to eat. At 12:28 p.m., Nurse Aide 1 sat down to feed the resident. Interview with Nurse Aide 1 on August 3, 2026, at 12:32 p.m. indicated that they are to try and have Resident 51 attempt to feed herself, but she usually needs assistance with feeding. The resident did not attempt to feed herself from the time the tray was served at 11:43 a.m. until Nurse Aide 1 sat down to feed her at 12:28 p.m. No staff attempted to assist her with her meal or cue her to eat. She was receptive to food when Nurse Aide 1 started to feed her. Review of Resident 51's ADL documentation for August 1 and 2, 2026, for the breakfast, lunch and supper meals and for August 3, 2026, for the breakfast meal revealed that the resident was dependent on staff for eating assistance. ADL documentation for August 3, 2026, for the 12:30 p.m. lunch meal indicated that the resident required set up assistance for eating when it was observed that the resident did not attempt to feed herself and required total assistance from staff for eating. Interview with Nursing Home Administrator on August 3, 2026, at 12:34 p.m. confirmed that staff should have assisted Resident 51 to eat. Interview with Nurse Aide 1 on August 4, 2026, at 12:28 p.m. confirmed that Resident 51 required total assistance with eating the lunch meal on August 3, 2026. She indicated that they are to set her up, but she needed total assistance with eating, otherwise she would not eat. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on review of facility policies as well as observations and interviews with staff it was determined that the facility failed to serve food in accordance with professional standards for food service safety. Findings include: The facility's policies regarding food handling, dated January 8, 2026, indicated that staff should avoid handling actual unwrapped food items with bare hands. Observations during lunch on August 4, 2026, at 11:54 a.m., of Hospice Registered Nurse 2 preparing resident 56 tray and touching the resident's dinner roll with her bare hands. Interview with Hospice Registered Nurse 2 on August 4, 2026, at 12:36 p.m. confirmed that she should have worn gloves when handling the resident's dinner roll. Interview with the Administration on August 4, 2026, at 3:45 p.m. confirmed that the hospice RN should have worn gloves. 28 Pa. Code 211.6(f) Dietary Services.		