

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: 395683	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/05/2026
NAME OF PROVIDER OR SUPPLIER Highlands Rehabilitation and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 918 Main Street Laporte, PA 18626	
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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on clinical record review and staff interview it was determined that the facility failed to provide the correct required notification to a resident whose payment coverage changed for two of three residents reviewed (Residents 109 and 114). Findings include: A review of the form Instructions for the Notice of Medicare Non-Coverage (NOMNC) CMS-10123, (a notice that informs the recipient when care received from the skilled nursing facility is ending; and how to contact a Quality Improvement Organization (QIO) to appeal) revealed instructions that a Medicare provider must ensure that the notice is delivered at least two calendar days before Medicare covered services end. The provider must ensure that the beneficiary or their representative signs and dates the NOMNC to demonstrate that the beneficiary or their representative received the notice and understands the termination of services can be disputed. A review of the Form Instructions Skilled Nursing Facility (SNF) Advanced Beneficiary Notice of Non-coverage (SNFABN) Form CMS-10055 revealed that examples of the common reasons why an extended care stay, or services may not be covered under Medicare might include the beneficiary no longer requires daily skilled care for a medical condition but wants to continue residing in the skilled nursing facility (SNF). The SNF enters a good faith estimate of the cost of the corresponding care that may not be covered by Medicare. In the blank that follows Beginning on ., the skilled nursing facility enters the date on which the beneficiary may be responsible for paying for care that Medicare is not expected to cover. The beneficiary selects an option box to indicate a desire to continue to receive the care or not to continue to receive the care and if there is a desire to have the bill submitted to Medicare for consideration. The beneficiary or their authorized representative must sign the signature box to acknowledge that they read and understood the notice. The SNF must issue this notice when there is a termination of all Medicare Part A services for coverage reasons. If after issuing the NOMNC, the SNF expects the beneficiary to remain in the facility in a non-covered stay, the SNFABN must be issued to inform the beneficiary of potential liability for the non-covered stay. The SNFABN provides information to the beneficiary so that she/he can decide whether or not to get the care that may not be paid for by Medicare and assume financial responsibility. SNFs must use the SNFABN when applicable for SNF Prospective Payment System services (Medicare Part A). SNFs will continue to use the ABN Form CMS-R-131 when applicable for Medicare Part B items and services. Closed clinical record review of census information for Resident 114 revealed that the facility provided services primarily paid for by Medicare starting November 19, 2025. Resident 114's Medicare payment for services ended December 31, 2025, when she discharged to the community. Review of a CMS-10123 notice provided by the facility for Resident 114 revealed that Medicare coverage for skilled nursing services would end on December 30, 2025. Additional information on the form indicated that staff delivered the notice verbally via a telephone conversation with Resident 114's son on December 29, 2025. The notation indicated that Resident 114's last covered day would be December 31, 2025 (not December 30, 2025, as indicated on the first page of the form). Neither Resident 114 nor a responsible party signed the notice. Nursing documentation dated December 31, 2025, at 1:01 PM revealed that staff reviewed discharge paperwork with Resident 114's son (who staff documented the telephone conversation with on December 29, 2025) and Resident 114 left the facility. The documentation did not indicate that the facility staff attempted to (continued on next page)		

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	obtain Resident 114's son's dated signature on the CMS-10123 notice when he was in the facility to transport Resident 114 home. Resident 114's clinical record did not contain evidence that facility staff attempted to contact Resident 114 or her responsible party/son to obtain a dated signature on the form after her discharge from the facility. Interview with the Nursing Home Administrator on February 4, 2026, at 2:00 PM confirmed that the facility did not have a signed CMS-10123 form for Resident 114. Clinical record review of census information for Resident 109 revealed that the facility provided services primarily paid for by Medicare starting July 1, 2025. Resident 109's Medicare payment for services ended July 31, 2025. Resident 109 remained in the facility. The facility did not provide a CMS-10055 notice for Resident 109. The facility provided a CMS-R-131 form that the facility used in place of the CMS-10055 form. Resident 109 signed the CMS-R-131 form on July 29, 2025. The form did not include the date on which Resident 109 would be responsible for paying for care that Medicare was not expected to cover. The graph on the CMS website (Beneficiary Notices Initiative) stipulates that the provider types for the CMS-R-131 form use include independent laboratories, home health agencies, hospices, physicians, practitioners, and providers paid under Medicare Part B. The same graph instructs that skilled nursing facilities are to use the CMS-10055 form. The surveyor reviewed the above concerns regarding Resident 109's Medicare notice during an interview with the Nursing Home Administrator and the Director of Nursing on February 4, 2026, at 2:00 PM. 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 201.29(a) Resident rights		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. Based on a review of select facility policies and procedures, clinical record review, and staff interview, it was determined that the facility failed to implement interventions to promote acceptable parameters of nutrition for three of six residents reviewed for nutritional concerns (Residents 1, 2, and 44). Findings include: The facility policy entitled, Weight Assessment and Intervention, last reviewed August 27, 2025, revealed that resident weights are monitored for undesirable or unintended weight loss or gain. Residents are weighed upon admission and at intervals established by the interdisciplinary team. Weights are recorded in each unit's weight record chart and in the individual's medical record. Any weight change of five percent or more since the last weight assessment is retaken the next day for confirmation. If the weight is verified, nursing will immediately notify the dietitian in writing. Unless notified of significant weight changes, the dietitian will review the unit weight record monthly to follow individual weight trends over time. The threshold for significant unplanned and undesired weight loss will be based on the following criteria: One month: five percent weight loss is significant, greater than five percent is severe Three months: 7.5 percent weight loss is significant, greater than 7.5 percent is severe Six months: 10 percent weight loss is significant, greater than 10 percent is severe Care planning for weight loss or impaired nutrition is a multidisciplinary effort and includes the physician, nursing staff, the dietitian, the consultant pharmacist, and the resident or resident's legal surrogate. Individualized care plans shall address to the extent possible: the identified causes of weight loss, goals and benchmarks for improvement, and time frames and parameters for monitoring and reassessment. Interventions for undesirable weight loss are based on careful considerations of resident choice and preferences, nutrition and hydration needs of the resident, functional factors that inhibit independent eating, medications, environmental factors, and end-of-life decisions and advance directives. Clinical record review for Resident 2 revealed the following weight assessments: August 26, 2025, 206.2 poundsAugust 27, 2025, 204.2 poundsSeptember 2, 2025, 202.2 poundsSeptember 16, 2025, 194.4 pounds (an 11.8-pound, 5.7 percent, severe weight loss in less than one month)September 30, 2025, 194.6 poundsOctober 6, 2025, 190.2 pounds (a 16-pound, 7.75 percent, severe weight loss in less than three months; and 12-pound, 5.93 percent severe weight loss in one month)October 7, 2025, 190.2 pounds Nutritional documentation by Employee 1 on October 17, 2025, (a month after the severe weight loss assessed for Resident 2), at 1:40 PM noted Resident 2's weights on October 6 and 7, 2025, which substantiated a 5.9 percent weight loss. Employee 1 documented that Resident 2 was at risk for malnutrition with variable oral intakes of meals. Employee 1 noted that she updated Resident 2's food preferences, encouraged Resident 2 to consume her meals, and recommended weekly weights for four weeks. Employee 1 indicated that she would continue to monitor Resident 2 and follow-up as needed. Staff documented a weight assessment of 172.4 pounds for Resident 2 on November 3, 2025 (which would have reflected an additional 17.8-pound, 9.35 percent severe weight loss in one month, however, a notation by Employee 7 (nurse aide) on November 21, 2025, at 11:50 PM crossed out the entry as incorrect documentation. There were no additional weights documented for Resident 2 until November 18, 2025 (six weeks since her previous weight assessment). The weight assessment documented on November 18, 2025, at 12:18 PM was 168 pounds (a 22.2-pound, 11.67 percent severe weight loss in six weeks). The surveyor reviewed the above concerns regarding Resident 2's weight loss and lack of interdisciplinary response during an interview with the Nursing Home Administrator and the Director of Nursing on February 3, 2026, at 2:00 PM. The surveyor again reviewed the above weight loss concerns for Resident 2 during an interview with the Nursing Home Administrator and the Director of Nursing on February 4, 2026, at 2:00 PM. Interview with the Director of Nursing on February 5, 2026, at 9:56 AM indicated that the nurse aide obtains weight assessments and provides the licensed practical nurse the results who is responsible for entering the information in the resident's electronic medical record; however, this did not occur for Resident 2. There was no evidence that the registered (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dietitian or physician had the information in the resident's medical record to review. There is no evidence that the registered dietitian assessed Resident 2 during the two months between October 17, 2025, and December 18, 2025. The facility provided no additional information regarding the implementation of new interventions to address Resident 2's severe weight loss. Interview with Employee 1 on February 5, 2026, at 10:39 AM confirmed the following: Staff assessed a 5.72 percent severe weight loss for Resident 2 on September 16, 2025; however, there is no evidence of an interdisciplinary response (to include the registered dietitian or the physician) until October 17, 2025. The plan of care on October 17, 2025, was to include weekly weight assessments; however, Resident 2's electronic medical record had no evidence that these were implemented; or that Employee 1 assessed Resident 2 timely (e.g., within a month) to review the findings of the planned weight assessments. There were no weight assessments for six weeks (when Resident 2 was to have weekly weight assessments) during which a weight assessment that indicated another severe weight loss was inexplicably crossed out as incorrect documentation without a replacement weight assessment. The next documented assessment by Employee 1 for Resident 2 was not until December 18, 2025 (two months following the acknowledgement of a severe weight loss). On August 26, 2025, Resident 2 weighed 206.2 pounds. On December 4, 2025, Resident 2 weighed 177.6 pounds (a 13.87 percent weight loss in less than six months). A quarterly MDS (Minimum Data Set, an assessment tool completed at specific intervals to determine resident care needs) dated December 10, 2025, assessed Resident 2 as not having a 10 percent or more weight loss in the last six months. Review of a plan of care initiated by Employee 1 on September 3, 2025, to address Resident 2's risk for altered nutritional status revealed no evidence of any revisions to her plan of care despite her severe weight loss since admitted to the facility. Clinical record review for Resident 44 revealed the following weight assessments: June 17, 2025, 166.7 pounds July 1, 2025, 169.9 pounds July 8, 2025, 170.3 pounds July 15, 2025, 162.0 pounds July 22, 2025, 171.8 pounds July 29, 2025, 175.8 pounds (a 9.1-pound, 5.17 percent significant weight gain) August 5, 2025, 174.0 pounds September 3, 2025, 179.4 pounds September 8, 2025, 183.7 pounds September 23, 2025, 187.2 pounds (a 20.5-pound, 10.95 percent significant weight gain) A full nutritional assessment was completed by Employee 1 on June 19, 2025, noted Resident 44 BMI (body mass index, a tool that estimates the amount of body fat by using height and weight measurements), was 28.5 in the overweight category. The next assessment of Resident 44 weights was not until September 19, 2025, noting a 9.7-pound, 5.6 percent significant weight gain in one month, and a 17-pound, 10.2 percent weight gain in three months. Employee 1 recommended weekly weights times four to better track Resident 44's weight gain. Further review of Resident 44's clinical record revealed the facility initiated a care plan on June 19, 2025, indicating Resident 44 is at risk for altered nutritional status related to her diagnosis of dementia. Resident 44's care plan was not updated to reflect any interventions addressing her significant weight gains. Interview with Employee 1 on February 4, 2026, at 11:12 AM revealed that she could provide no further documentation indicating she addressed Resident 44's weight gain until September 19, 2025 (nearly two months after significant weight gain). Employee 1 confirmed Resident 44's care plan was not updated to reflect any interventions addressing her weight gains. The findings for Resident 44 were reviewed with the Nursing Home Administrator and Director of Nursing during a meeting on February 4, 2026, at 2:38 PM Clinical record review for Resident 1 revealed the following weight assessments: July 21, 2025, 224 pounds July 29, 2025, 216.4 pounds August 5, 2025, 216.3 pounds August 19, 2025, 217.8 pounds August 26, 2025, 223.0 pounds September 9, 2025, 222.0 pounds September 16, 2025, 222.5 pounds September 28, 2025, 218.8 pounds November 3, 2025, 208.8 pounds December 3, 2025, 201.1 pounds December 11, 2025, 200.5 pounds December 11, 2025, 203.4 pounds A full nutritional assessment was completed by Employee 1 on October 2, 2025, and noted Resident 1's BMI was 34.3, in the obese category. A nutrition note dated December 18, 2025, at 8:53 AM revealed that Resident 1 was noted to be down 21.6 pounds, (9.7% significant weight loss in 3 months). The note indicated that weekly weights for four weeks would be put in place, and she added (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a fortified food. A nutrition note dated January 8, 2026, at 6:43 PM revealed that Resident 1 refused to be weighed monthly for January weight. Interview with the Employee 1 on February 5, 2026, at 1:15 PM revealed that she did not do her risk assessment in January 2026, because Resident 1 refused to be weighed. When surveyor ask about the weekly weights, Employee 1 indicated that Resident 1 refused them too but there was no evidence in the clinical record related to this. Surveyor asked Employee 1 if she followed up with Resident 1 related to her significant weight loss and she said she did not because there was no new weight for Resident 1. The Director of Nursing was made aware of the concerns with Resident 1's weight loss on February 5, 2026, at 1:30 PM. The facility failed to provide the highest practicable care related to Resident 1's weight loss. 28 Pa. Code 211.10(a)(c) Resident care policies 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 - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and staff interview, it was determined that the facility failed to store food items in a safe and sanitary manner and maintain the environment in a safe and sanitary condition in the facility's main kitchen. Findings include: Observation of the facility's main kitchen on February 2, 2026, at 9:18 AM revealed the following: There were four boxes of thickened coffee packets, three boxes of thickened tea packets, and a sleeve of lids stored in the cabinet under the sink. Two bins with carafes (beverage holder) and lids were stored beside the sink and all the carafes and lids had a white residue on them. There was a silver four tier open shelf. On the bottom shelf there was a large open basin of water/juice pitchers and a large open basin of lids. Observation of the oven revealed the knobs were dirty and there was burnt residue all over the stovetop. Observation of the dry storage room revealed there was a loaf of bread with no use by date, a half loaf of bread not secured, a bag of egg noodles, powdered sugar, vanilla tapioca quick pudding, and pie filling mix opened, with no use by dates. Further observation of the kitchen on February 2, 2026, at 11:28 AM, revealed there were three areas on the floor in front of the dishwasher with tiles missing. There was a piece of board and rubber mat on top of these areas. Interviews with Employee 8 (dietary aide) and Employee 9 (cook), revealed the boards and plastic mats are a tripping hazard when they are utilizing the dishwasher. Interview with Employee 4 (maintenance director) on February 5, 2026, at 8:52 AM revealed that the repairs were completed on the kitchen floor on December 23, 2025. He stated he ordered the floor tiles on December 29, 2025, and picked them up from the supplier on January 21, 2026. He confirmed the three areas had approximately 19 tiles missing and were not placed until after the surveyor's questioning. The above information was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on February 4, 2026, at 2:30 PM. 28 Pa. Code 201.14(a) Responsibility of licensee		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, it was determined that the facility failed to ensure that active physician orders incorporated resident wishes related to end-of-life care for one of three residents reviewed for advance directives concerns (Resident 2). Findings include: Clinical record review for Resident 2 revealed an active physician order dated [DATE], that instructed staff to not resuscitate Resident 2 (DNR, do not attempt to resuscitate, do not perform CPR, allow natural death) in the event of no pulse or breathing. Review of a POLST (Pennsylvania Orders for Life Sustaining Treatment, a binding medical order that instructs healthcare providers the specific types of medical treatment a resident wishes to receive at the end of life) form signed by Resident 2's physician on [DATE], and signed by Resident 2 indicated that Resident 2 desired CPR/attempt resuscitation (cardiopulmonary resuscitation, chest compressions and artificial breathing assistance) if there is no pulse or breathing. The surveyor reviewed the above concern that Resident 2's active physician orders did not reflect Resident 2's emergency care wishes during an interview with the Director of Nursing and the Nursing Home Administrator on February 4, 2026, at 2:00 PM. Interview with the Director of Nursing on February 5, 2026, at 10:05 AM confirmed that staff obtained a verbal physician's order following the surveyor's questioning to update Resident 2's active physician orders to reflect Resident 2's wishes for CPR as per the [DATE], POLST.28 Pa. Code 211.12(d)(1)(3)(5) Nursing 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. Based on observations and staff interview, it was determined that the facility failed to provide a clean, comfortable, homelike environment on two of two nursing units (Second and Third Floor Nursing Units, Residents 1, 5, 10, and 11), and provide a safe and clean environment in the facility's main laundry area. Findings include: Observation of the facility's main laundry area on February 4, 2026, at 11:53 AM with Employee 6, Director of Environmental Services, revealed a folded blanket on the floor behind the washing machines and under the wall mounted chemical dispensers. There was an extensive build-up of a dried and flaky substance on the blanket and surrounding floor. The Nursing Home Administrator was informed of the main laundry area findings on February 4, 2026, at 12:02 PM. Observation of Resident 5's room on February 3, 2026, at 9:25 AM revealed that door to the room was all marred and the floor was dirty around the bed and under the dresser near the cove base. Observation of Resident 1's room on February 3, 2026, at 10:30 AM revealed the floor to be dirty with crumbs under the over bed table and by her bed. The door to the room was all marred. Observation of Resident 10's room on February 2, 2026, at 12:44 PM revealed that the door to her room and the bathroom door was all marred. The nursing home administrator and the director of nursing were made aware of the concerns with Resident 1, 5, and 10's environment on February 5, 2026, at 11:00 AM. Observation of Resident 11 on February 2, 2026, at 9:34 AM, and February 3, 2026, at 10:12 AM revealed Resident 11 was seated in the recliner chair in his room. The wall behind Resident 11's recliner was marred. Resident 11 stated it has been like that for a long time. Reviewed the above findings for Resident 11 during a meeting with the Nursing Home Administrator and Director of Nursing on February 4, 2026, at 2:25 PM. 28 Pa. Code 201.18(b)(3)(e)(2.1) 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 clinical record review and resident and staff interview it was determined that the facility failed to provide written notice of transfer and written notice of the facility bed-hold policy to residents' responsible parties at the time of transfer for two of six residents reviewed for hospitalization concerns (Residents 2 and 6). Findings include: Clinical record review for Resident 2 revealed profile information that indicated that she had resident representatives that included her mother, a male emergency contact, and an adult protective services county representative. Nursing documentation dated October 1, 2025, at 1:45 PM revealed that Resident 2 was admitted to the hospital following an above-the-knee amputation. The facility provided a Notice of Transfer or discharge date d October 1, 2025, addressed to Resident 2, that noted the transfer to the hospital on October 1, 2025, was necessary for the surgical procedure of a right above-the-knee amputation. Staff documented a verbal review of the notice with Resident 2 on October 1, 2025. There was no indication that Resident 2 and one of her resident representatives received a written copy of the notice. The facility did not provide evidence that Resident 2 and one of her representatives received written notice which specified the duration of the facility's bed-hold policy within 24 hours of Resident 2's transfer. Nursing documentation dated November 21, 2025, at 10:34 AM revealed that Resident 2 was lethargic, difficult to arouse, and had a low blood pressure. Staff contacted the physician who instructed staff to send Resident 2 to the emergency room. Nursing documentation dated November 21, 2025, at 11:52 PM revealed that the hospital informed facility staff that Resident 2 was admitted for an infection related to kidney stones and revision of ureteral stents (tubes placed in the vessels from the kidney to the bladder to correct and/or prevent obstruction). The facility provided a Notice of Transfer or discharge date d November 21, 2025, addressed to Resident 2, that noted the transfer to the hospital on November 21, 2025, was necessary due to abnormal laboratory results. Staff documented, resident unable to sign at present, on November 21, 2025. There was no indication that Resident 2 and one of her resident representatives received a written copy of the notice. A Bed Hold Notice form noted, unable to sign at present time, that Resident 2 was contacted by facility staff on November 21, 2025, at 10:00 AM, and that the Bed Hold Election form was mailed to Resident 2 for signature on November 24, 2025 (three days after the transfer to the hospital). The facility did not provide evidence that Resident 2 and one of her representatives received written notice which specified the duration of the facility's bed-hold policy within 24 hours of Resident 2's transfer. The surveyor reviewed the above concerns regarding Resident 2's and her resident representative's receipt of the required notices upon her transfers to the hospital during an interview with the Nursing Home Administrator and the Director of Nursing on February 5, 2026, at 12:25 PM. Interview with Resident 6 on February 2, 2026, at 2:13 PM revealed that she was recently hospitalized after she fell and broke her femur (long leg bone in the thigh area). Census information for Resident 6 confirmed that she was on hospital leave starting December 26, 2025. Review of Resident 6's profile information revealed that her resident representatives included her son. The facility provided a Notice of Transfer or discharge date d December 26, 2025, addressed to Resident 6, that noted the transfer to the hospital on December 26, 2025, was necessary due to a fall with possible fracture. Resident 6 signed the notice on December 26, 2025. There was no evidence that Resident 6's representative received a written copy of the notice. A Bed Hold Notice form noted, verbal (son's name), on December 26, 2025. The section of the Bed Hold Notice that is used to document the mailing or emailing of the notice was left blank. The surveyor reviewed the above concerns regarding Resident 6's representative's receipt of the required notices upon her transfer to the hospital during an interview with the Nursing Home Administrator and the Director of Nursing on February 5, 2026, at 12:25 PM. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.29(a) Resident rights		

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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 clinical record review and staff interview, it was determined that the facility failed to ensure complete and accurate Minimum Data Set (MDS) assessments for two of 22 residents reviewed (Residents 3, and 4). Findings include: Clinical record review for Resident 4 revealed a quarterly MDS (Minimum Data Set, an assessment tool completed at specific intervals to determine resident care needs) dated October 2, 2025, in which facility staff assessed Resident 4 as having no impairments to her upper extremities. The next quarterly assessment completed on January 20, 2026, revealed staff now assessed Resident 4 as having bilateral upper extremity impairments. Review of Resident 4's occupational therapy treatment notes from September 30, 2025, to October 27, 2025, noted Resident 4's range of motion was impaired to her bilateral upper extremities. Interview with Employee 2 (registered nurse assessment coordinator) on February 5, 2026, at 9:21 AM, confirmed the above findings for Resident 4. Employee 2 verified the therapy documentation from the lookback period for October 2, 2025, MDS noted impairments to Resident 4's left and right shoulders with active range of motion limitations. Observation of Resident 3 on February 2, 2026, at 11:30 AM revealed her in bed with bilateral enabler bars on her bed. She indicated that she used the enabler bars to help her turn and move in bed. She also indicated that she can't get out of bed on her own. Review of Resident 3's MDS quarterly assessment date January 8, 2026, revealed that the facility coded her as using bedrails daily as a restraint. Interview with the nursing home administrator and director of nursing on February 3, 2026, at 2:20 PM revealed that this was an MDS coding error and that Resident 3 has enabler bars on her bed, not bedrails that are used as a restraint. 483.20(g) Accuracy of Assessments Previously cited 1/16/25 28 Pa. Code 211.5(f)(ix) Medical records 28 Pa. Code 211.12(d)(1)(5) Nursing services		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on clinical record review and staff interview, it was determined that the facility failed to incorporate the recommendations from the Pre-admission Screening and Resident Review (PASARR) level II determination and the PASRR evaluation report into a resident's assessment, care planning, and transitions of care for one of three residents reviewed (Resident 7). Findings include: Clinical record review revealed the facility admitted Resident 7 on September 26, 2024, with diagnosis including a family history of alcohol abuse and dependence. Review of Resident 7's clinical record revealed a PASARR Level II determination letter dated May 22, 2024, from the Department of Human Services noted based on a review of the information submitted, the Office of Mental Health and Substance Abuse Services had determined that Resident 7 does not meet the mental health criteria for further review by the office. The letter further stated that although Resident 7 did not meet the criteria for serious mental illness, the documentation submitted indicates that Resident 7 could benefit from drug and alcohol services. Further review of Resident 7's clinical record revealed there was no documentation that the facility recommended and/or provided any drug and alcohol services to Resident 7 as the result of the PASARR II recommendation. Interview with Employee 3 (social worker) on February 4, 2026, at 12:08 PM, confirmed the facility had no documentation that they incorporated the recommendations from Resident 7's PASARR Level II into her care at any time while residing at the facility. The above findings for Resident 7 reviewed with the Nursing Home Administrator and Director of Nursing during a meeting on February 4, 2026, at 2:35 PM There was no evidence at the time of the survey the facility had timely identified and coordinated the provision of specialized services for Resident 7. 28 Pa. Code 211.5(f)(iv)(vi) 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 clinical record review, observation, and staff and resident interview, it was determined that the facility failed to include a resident's representative in participation with care planning for one of 22 residents reviewed (Resident 6), revise a care plan after a resident's change in condition for one of 22 residents reviewed (Resident 2), and revise a care plan related to a pacemaker intervention for one of 22 residents reviewed (Resident 86). Findings include: Clinical record review for Resident 86 revealed the resident had a physician order dated December 26, 2025, that noted a pacemaker (an implanted electronic device to help regulate the beating of the heart). Hospital documentation for Resident 86 dated December 24, 2025, at 1:30 PM revealed that the resident had a permanent pacemaker insertion on February 15, 2023. Observation on February 3, 2026, at 12:14 PM revealed that there was an electronic pacemaker transmittal device on the dresser next to Resident 86's bed. Review of Resident 86's current care plan revealed the resident has an impaired cardiovascular status related to the resident's medical history and presence of a cardiac pacemaker. The care plan did not address the electronic transmittal device (proper placement, troubleshooting any issues, contact information, etc.). The above information for Resident 86's pacemaker was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on February 3, 2026, at 2:00 PM. Clinical record review for Resident 2 revealed that on August 26, 2025, Resident 2 weighed 206.2 pounds. On December 4, 2025, Resident 2 weighed 177.6 pounds (a 13.87 percent weight loss in less than six months). Review of a plan of care initiated by Employee 1 (registered dietitian) on September 3, 2025, to address Resident 2's risk for altered nutritional status revealed no evidence of any revisions to her plan of care despite her severe weight loss since admitted to the facility. The surveyor reviewed concerns regarding Resident 2's weight loss and interdisciplinary response during interviews with the Nursing Home Administrator and the Director of Nursing on February 3, 2026, at 2:00 PM and February 4, 2026, at 2:00 PM. The surveyor reviewed concerns regarding Resident 2's weight loss with Employee 1 (registered dietitian) on February 5, 2026, at 10:39 AM. Interview with Resident 6 on February 2, 2026, at 1:57 PM revealed that she denied knowledge of care plan meetings and denied that her son or daughter-in-law participated in care plan meetings. Clinical record review for Resident 6 revealed profile information that listed her son as her Care Conference Person. Care Plan Note documentation on December 1, 2025, at 1:34 PM; September 4, 2025, at 11:32 AM; June 4, 2025, at 8:45 AM; and March 6, 2025, at 1:56 PM revealed no evidence that the facility attempted to include Resident 6's son to participate with care planning. Interview with the Director of Nursing and the Nursing Home Administrator on February 3, 2026, at 2:00 PM confirmed that the facility could not provide evidence of Resident 6's representative participation in her care planning for the past year. Interview with Employee 3 (social services) on February 4, 2026, at 12:07 PM confirmed that she had no evidence that she attempted to involve Resident 6's son (designated as her care conference contact) when conducting care plan meetings. Social services documentation by Employee 3 dated February 4, 2026, at 4:10 PM (following the surveyor's questioning) revealed that she contacted Resident 6's son regarding care plan scheduling and he would be interested in attending meetings again following Resident 6's recent change in health status due to her surgery on her hip. 483.21 Comprehensive Care Plans Previously cited deficiency 1/16/25 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on clinical record review and staff and resident interview, it was determined that the facility failed to ensure that pain management was provided that was consistent with professional standards of practice for one of one resident reviewed for pain (Resident 1). Findings include: Interview with Resident 1 on February 2, 2026, at 10:51 AM revealed that she has constant pain. She said sometimes it is from her stomach, and sometimes it is her legs or back. Clinical record review for Resident 1 revealed that she has a diagnosis of chronic pain (pain that last for longer than three months or occurring with an ongoing condition, that affects daily life and well-being). Review of Resident 1's current physician's order revealed that she had the following medications ordered for pain: Gabapentin 100 milligrams (mg) one every morning and at bedtime Tramadol 50 mg one every four hours as needed for pain. Tylenol 325 mg two tablets every six hours for mild pain 1-3, (on a 1-10 pain scale). Review of Resident 1's medication administration record for the month of December 2025, revealed that she utilized the as needed Tramadol 50 milligrams 45 times. Review of Resident 1's medication administration record for the month of January 2026, revealed that she utilized the as needed Tramadol 50 milligrams 26 times and she utilized the as needed Tylenol 325 mg two tablets three times. Review of Resident 1's medication administration record for the dates of February 1-3, 2026, revealed that she utilized the as needed Tramadol 50 milligrams five times. There was no evidence in the clinical record indicating Resident 1's physician was made aware of the amount of as needed pain medications she used, or that the physician addressed Resident 1's uncontrolled chronic pain. The Director of Nursing was made aware of the concerns noted above related to Resident 1's pain on February 6, 2026, at 10:45 AM. The facility failed to ensure Resident 1's pain was managed consistent with professional standards of practice. 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services		

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, review of select policies and procedures, and staff interview, it was determined that the facility failed to provide the highest practicable care for one of one resident reviewed for behavioral health related to suicidal ideation. (Resident 82). Findings include: The facility policy entitled, Suicide Prevention and Intervention Guideline, last reviewed without changes on August 27, 2025, revealed it is the policy of the facility that individuals voicing and/or displaying feelings and/or actions which indicated suicidal ideation (thoughts, or preoccupations with ending one's own life, ranging from fleeting, passing thoughts to detailed, active planning), receive services and interventions to help them manage these feeling and maintain their psychosocial well-being. Employees are responsible for monitoring acute mood and behavior changes which may indicate potential suicidal ideation and for reporting these changes to their supervisor for appropriate assessment and interventions. With any verbalization of suicide/self-harm ideation, or suicide attempt, the resident should immediately be placed on one-to-one observation until they are transferred to the hospital or are evaluated by a physician/clinician. An immediate written care plan should be developed and implemented specific to the resident's situation and needs. The plan should outline the interventions and monitoring for the resident to remain safe. The plan should also include visual checks, which should be completed and documented at an interval that is determined by the individualized assessment. A nursing progress note dated January 7, 2026, at 2:21 PM revealed that Resident 82 was making statements that she wanted to be discharged so she could go home and commit suicide. The note indicated that Resident 82 was put on frequent checks and that she was immediately seen by the provider in the facility who felt there was no immediate danger and that there was no medical cause of her comments but the provider felt the resident was more depressed related to her current situation and he wanted her seen by psychiatry. The note also indicated that Resident 82's family was present in the facility and stated that she made comments like this in the hospital and was seen and cleared by psychiatry. Resident 82 was to be seen by psychiatry on Friday (January 9, 2026). A late entry physician progress noted created January 11, 2026, but noted to be effective January 7, 2026, indicated that the physician was seeing Resident 82 for an initial evaluation because she was a new admission on [DATE]. The physician made no mention of Resident 82 having suicidal ideations in his note but did indicate that Resident 82 was seen and evaluated at bedside and there were no additional concerns. The note also indicated that she had a diagnosis of depression. A psychiatry progress noted dated January 9, 2026, revealed that Resident 82 reported that her mood had been good, and she denied depression, anxiety or mood issues, but that staff reported she had made comments about wanting to go home to commit suicide. The note indicated Resident 82 stated she made comments a while ago about that, but she had no recollection of that and denies suicidal ideation at that time. The note also indicated she has very poor insight into her psych issues as she had some delusions such as reporting that she was married three times which the family indicated was not the case. The psychiatrist also indicated that the family does feel Resident 82 is depressed. He also notes that resident did have a daughter that committed suicide. Clinical record review for Resident 82 revealed a nursing progress note dated January 27, 2026, at 8:26 PM that indicated Resident 82 stated to a nurse aide that she was tired, and she was thinking of committing suicide. The note indicated that the writer then approached resident who was in bed and the resident stated she was tired and they would talk in the morning. The nurse then made her aware to use her call light if she needed anything. The note indicated the charge nurse was updated to closely monitor Resident 82, and for social work to follow up tomorrow. There was no social service follow-up noted in the clinical record. A nursing progress note dated January 27, 2026, at 9:11 PM revealed that Resident 82 stated she was fine but really tired and just wanted to sleep. A nursing (continued on next page)		

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	progress note dated January 28, 2026, at 3:26 am indicated that Resident 82 had no suicidal statements voiced or reported and was resting in bed. Review of Resident 82's care plan revealed that there was no care plan addressing her suicidal ideation until after the surveyor brought it to the facility's attention during a meeting on February 3, 2026, at 2:20 PM, during a meeting with the nursing home administrator and director of nursing. Interview with Employee 3, social service director, on February 4, 2026, at 12:14 PM confirmed the above noted findings that she did not initiate a care plan with individualized interventions related to Resident 82's suicidal ideation until February 3, 2026. There was no evidence in the clinical record to show that the facility initiated one-to-one, more frequent checks, or that individualized interventions were initiated for Resident 82, related to her suicidal ideation on January 7, 2026, or January 27, 2026. The nursing home administrator and director of nursing were made aware of the above noted findings related to Resident 82's suicidal ideation during a meeting on February 4, 2026, at 2:15 PM. 28 Pa. Code 211.12(d)(1)(2)(3) Nursing services		

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on a review of select facility policies and procedures, observation, clinical record review, and family and staff interview, it was determined that the facility failed to provide routine dental care for one of one resident reviewed for dental concerns (Resident 58). Findings include: The facility policy entitled, Dental Consultant, last reviewed August 27, 2025, revealed that dental care shall be provided through the services of a consultant dentist. A consultant dentist is retained by the facility and is responsible for providing a dental assessment of each resident within ninety (90) days of admission and, performing or supervising an annual dental reevaluation for each resident. The policy did not confirm that the facility would provide dental services provided by the State Medicaid plan (e.g., prophylactic dental cleanings every six months). Interview with Resident 58's daughter on February 2, 2026, at 10:12 AM revealed that she believed Resident 58 needed to have her teeth fixed, and that Resident 58 had natural teeth that likely needed to be extracted. Resident 58's daughter stated that she was aware a mobile dentist provided services at the facility and claimed that she received a bill for an initial exam for \$90.00 (ninety dollars). Observation of Resident 58 on February 2, 2026, at 12:29 PM revealed her to have missing teeth. Clinical record review of Resident 58's census information revealed that the facility admitted her on November 7, 2025, and that the State Medicaid plan was her primary payer source. Review of a Consent for Dental Services dated November 9, 2025, indicated that Resident 58's responsible party agreed to the facility's contracted dental provider to perform, an annual dental exam, necessary x-rays, and cleanings. The authorization signed by Resident 58's responsible party noted that, Medicaid recipients are covered for these routine services. The surveyor requested evidence of professional dental services for Resident 58 during an interview with the Nursing Home Administrator and Director of Nursing on February 3, 2026, at 2:00 PM. A letter provided by the facility from the contracted dental provider dated February 4, 2026, indicated that, (Resident 58) is in compliance with annual routine exams. The letter indicated Resident 58's responsible party wanted dental services when her Medicaid plan was active. The letter further noted, Per the facility, her Medicaid became active on January 15, 2026, and (the contracted dental provider) was notified of this change on February 3, 2026. Interview with the Nursing Home Administrator and the Director of Nursing on February 4, 2026, at 2:00 PM confirmed that the contracted dental provider was at the facility on February 4, 2026, however, did not provide services to Resident 58. The interview confirmed that Resident 58 had not received any professional dental services in the 90 days since her admission to the facility. The interview indicated that the contracted dental provider sent Resident 58's responsible party notice that an initial exam would be \$90.00 if not paid by Medicaid, however, Resident 58 was a Medicaid recipient and would not be liable for the \$90.00. Interview with Employee 5 (business office manager) on February 5, 2026, at 1:00 PM revealed that the facility had knowledge that Resident 58's Medicaid application was approved on December 5, 2025 (less than one month after her admission to the facility). Interview with the Director of Nursing on February 5, 2026, at 9:56 AM provided no answer as to how often the contracted dental provider provides services in the facility. Interview with the Nursing Home Administrator and the Director of Nursing on February 5, 2026, at 12:25 PM revealed that the contracted dental provider has no expected frequency of services (e.g., monthly, quarter, etc.); however, Resident 58 would be on the list for services during the next onsite visit. Interview with the Nursing Home Administrator on February 5, 2026, at 1:10 PM confirmed that the facility policy and the consultant dental provider letter did not stipulate that residents would receive routine dental services as provided by the State Medicaid plan. The Nursing Home Administrator indicated that she was not certain of the frequency of routine dental services provided by the State Medicaid plan. Interview with the Director of Nursing on February 5, 2026, at 1:35 PM confirmed that the facility was now aware of the frequency of routine dental services covered under the State plan (e.g., every six months) and would begin educating staff regarding the expectation. 483.55(b)(1)-(5) Dental Services Previously cited deficiency 1/16/25 28 Pa. Code 201.18(d) (continued on next page)		

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Management 28 Pa. Code 211.10(a) Resident care policies 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services		