

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: 395795	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/26/2025
NAME OF PROVIDER OR SUPPLIER Lafayette Manor, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 147 Lafayette Manor Road Uniontown, PA 15401	
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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, resident group meeting, clinical record review, observation, and staff interview, it was determined that the facility failed to accommodate the call bell needs for one of five residents (Residents R). Findings include: Review of facility policy Call Bell/Call Light dated 1/29/25, indicated to ensure resident has a means to summon assistance. To respond to a resident's call for assistance in a timely manner. During the resident group meeting held on 9/25/25, at 1:00 p.m., the resident consensus stated that the facility staff do not respond to call bells timely, they often have to wait, or staff turn off the call bell and say they'll come back and it's often an hour or longer before they return. Review of the clinical record indicated that Resident R1 was admitted to the facility on [DATE], with a most recent re-admission dated of 7/5/25, with diagnoses which included diabetes, heart flutter and pneumonia. Review of Resident R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 7/5/25, indicated diagnoses remained current. Section G0110 (ADL) Assistance with activities of daily living indicated Resident R1 required assistance of two for bed mobility. During an observation on 9/25/25, at 8:31 a.m., Resident R1's call light above her door illuminated, the call light was not responded to until 8:52 a.m., 21 minutes later, when the Assistant Director of Nursing (ADON) responded and the resident stated that she'd been waiting to use the bedpan and now she needed cleaned up as she could not wait any longer. During an interview on 9/25/25, at 8:52 a.m., the ADON confirmed that the facility failed to accommodate Resident R1's call bell needs. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 211.10(d) Resident care policies. 28 Pa. Code: 211.12(d)(1)(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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observations, facility policy and staff interviews, it was determined that the facility failed to provide a safe, clean, comfortable, and homelike environment on one of two nursing units (first floor nursing unit). Findings included: Review of the facility policy Homelike Environment dated 1/29/25, indicated residents are provided with a safe, clean, comfortable and homelike environment. During an observation on 9/23/25 at 9:44 a.m., the left shower room had a broken wall and floor border tiles and the shower room on the right had uneven flooring and broken wall tiles. During an observation on 9/25/25, from 9:30 a.m., through 9:40 a.m., the following was observed: Hall of the 100-room numbers had flooring uneven and lifting Resident R69's room had broken loose floor tiles under sink. Tiles behind bed were warped and the cable wire was hanging such that it could get pulled down and cause potential injury. Resident R6's room had missing floor trim near bathroom leaving broken wall. Resident R70's room had loose, missing floor tiles by heater and flooring to entrance of bathroom and under heater in bathroom Resident R25's room had the bathroom panel under heater loose. During an interview on 9/25/25, at 10:00 a.m., the Nursing Home Administrator confirmed that the facility failed to provide a safe, clean, comfortable, and homelike environment on one of two nursing units (first floor nursing unit). 28 Pa. Code: 207.2(a) Administrator's responsibility. 28 Pa. Code: 201.29(k) Resident rights.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies, observations, and staff interviews, it was determined that the facility failed to properly store medications and/or biologicals in one of two medication rooms (Second Floor Medication Room). Findings include: Review of facility policy Medication Storage in the Facility dated 1/28/25, indicated that medications and biologicals will be removed from the active supply and destroyed in the facility. During an observation on 9/23/25, at 10:25 a.m. of the First Floor Medication Room the following was observed: (14) DualCap IV Pole Strips disinfecting caps for male connectors with an expiration date of 5/4/22(3) [NAME] Binax Now Covid-19 Antigen self-test 2-pack with an expiration date of 5/15/23(5) Volumat VL PR72-11 Primary Infusion Set with 0.2-micron filter with an expiration date of 3/8/25(5) Volumat VL PR72-11 Primary Infusion Set with 0.2-micron filter with an expiration date of 3/17/25(4) Volumat VL PR72-11 Primary Infusion Set with 0.2-micron filter with an expiration date of 4/26/25(3) Volumat VL PR72-11 Primary Infusion Set with 0.2-micron filter with an expiration date of 4/1/25(5) Volumat VL PR72-11 Primary Infusion Set with 0.2-micron filter with an expiration date of 4/5/25(6) Volumat VL PR72-11 Primary Infusion Set with 0.2-micron filter with an expiration date of 5/4/25(13) Statlock PICC Plus Stabilization Device with an expiration date of 5/28/2025(2) [NAME] dressing change tray with an expiration date of 8/31/25 During an interview on 9/23/25, at approximately 2:30 p.m. the Nursing Home Administrator and the Director of Nursing confirmed the facility failed to properly store medications and/or biologicals in one of two medication rooms. 28 Pa. Code: 211.9(a)(1)(j.1)(k) Pharmacy services. 28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on review of established infection control guidelines, facility policy, and residents' clinical records, as well as observations and staff interviews, it was determined that the facility failed to follow infection control guidelines from the Centers for Medicare/Medicaid Services (CMS) and the Centers for Disease Control (CDC) to reduce the spread of infections and prevent cross-contamination on one of two nursing units (first floor nursing unit).Findings include:Review of the facility policy Infection Control dated 1/29/25, indicated that staff noted to have a confirmed or suspected viral respiratory infection will be restricted from work until 3 days have passed since symptoms. This guidance supersedes existing CDC and DOH guidance specific to health care personnel.Review of the facility policy Infection Control COVID-19 dated 1/29/25, indicated that the facility will minimize exposures to respiratory pathogens and adhere to CDC's core principles of infection control. The staff and residents will utilize universal source control and wear masks, especially with close contact.During the Entrance Conference held on 9/23/25. at approximately 9:30 a.m., the Nursing Home Administrator indicated that the facility had two staff test positive for Covid-19 on 9/21/25 and staff, visitors and residents of the first-floor nursing unit were to wear masks due to potential exposure. During an observation on 9/24/25, from 8:31 a.m., through 8:56 a.m., Nurse Aide (NA) Employee E9, NA Employee E10 and NA Employee E11 were observed with masks not fully covering their faces going in and out of resident rooms on the first-floor nursing unit.During an interview on 9/24/25, at 8:56 a.m., Assistant Director of Nursing and Infection Control Preventionist Employee E2 confirmed that the facility failed to follow infection control guidelines from the Centers for Medicare/Medicaid Services (CMS) and the Centers for Disease Control (CDC) to reduce the spread of infections and prevent cross-contamination on one of two nursing units (first-floor nursing unit).28 Pa. Code 201.14(a) Responsibility of Licensee.28 Pa. Code 201.18(e)(1) Management.28 Pa. Code 211.12(d)(1)(5) Nursing Services.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review, and staff interview it was determined that the facility failed to provide adequate supervision to prevent elopement for two of three residents (Resident R71 and R73). Findings include: Review of facility policy Elopement reviewed 1/28/25, indicated the facility will provide a safe environment for all residents to the extent possible. The facility will assess residents and their plans of care to prevent accidents related to wandering behavior or elopement within eight hours of admission and on a quarterly basis. The facility defines elopement as When a resident leaves the premises or a safe area without authorization. Review of the clinical record indicated Resident R71 was admitted to the facility on [DATE], with diagnoses that included history of traumatic brain injury, hemiplegia (paralysis of one side of the body), and impulse disorder. Review of a Elopement Risk Determination assessment completed 3/20/25, indicated Resident R71 was not at risk for elopement due to being unable to leave the building without help from staff, and requires assistance with locomotion, and does not wander. Review of a facility reported incident dated 8/18/25, indicated Resident R71 was seen in the dining room sitting in front of his wheelchair. Facility investigation revealed it was unknown how Resident R71 got into the dining room. Staff responded immediately. Review of progress note dated 8/18/25, indicated food service manager observed resident sitting on buttocks in front of her wheelchair when she opened up the dining room door to take supplies to nursing unit. Resident stated she was going to the dining room. Review of a facility investigation note on 8/20/25, indicated Resident R71 did leave her room via wheelchair and exited the floor without being seen. Review of the clinical record indicated Resident R73 was admitted to the facility on [DATE], with diagnoses that included dysphagia (difficulty swallowing) following cerebral infarction (stroke - blood vessel in the brain becomes blocked, cutting off oxygen supply to brain tissue), hemiplegia (paralysis of one side of the body), and muscle weakness. Review of a Elopement Risk Determination assessment completed 8/24/25, indicated Resident R73 was not at risk for elopement due to being unable to leave the building without help from staff, and requires assistance with locomotion, and does not wander. Review of a facility reported incident dated 8/27/25, indicated Resident R73 was seen in the parking lot sitting in front of his wheelchair. Facility investigation revealed Resident R73 was assisted outside by a visitor who then informed staff that he was outside. Staff responded immediately and returned the resident to the facility. During an interview on 9/23/25, at 10:27 a.m. Resident R73 stated he was trying to go home when he left the facility. Resident's spouse was present during interview, and she thinks he followed her out of the facility after she left. She visits every day and leaves around 7:00 p.m.-7:30 p.m. During an interview on 9/24/25, at 12:45 p.m. Licensed Practical Nurse (LPN) Employee E3 stated if they noticed a resident missing, or in a place they should not be, they would get the resident to a safe place, assess the resident for injuries, assess their vital signs (blood pressure, heartrate, breathing and oxygen level), notify administration and the residents responsible party, and document in the progress notes. During an Interview on 9/24/25, at 12:49 a.m. LPN Employee E4 stated they would alert the supervisor, administration, and Assistant Director of Nursing (ADON), search for the missing resident shutting the doors behind me as they go. During an interview on 9/24/25, at 12:51 p.m. LPN Employee E5 stated they would call the supervisor, do a room-to-room search and head count of the residents, call the family and document in the progress notes. During an interview on 9/24/25, at 12:52 p.m. LPN Employee E6 stated they would notify the supervisor immediately, announce the facility elopement code, do an audit of residents, notify the doctor, and document in the clinical record. During an interview on 9/24/25, at 12:58 p.m. Nurse Aide (NA) Employee E7 stated they received elopement training when hired and again the previous week. They would do a head count of the residents. During an interview on 9/24/25, at 1:00 p.m. NA Employee E8 stated they would check the resident's room, (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	notify the supervisor, and continue to search the other resident rooms and all other facility areas for the resident. During an interview on 9/23/25, at 11:00 a.m. Nursing Home Administrator (NHA) stated Resident R73 was a new admission to the facility and did not have previous wandering or elopement attempts. On return to the facility a wander guard was placed around Resident R73's left ankle. During an interview on 9/25/25, at 2:30 p.m. the NHA confirmed that the facility failed to provide adequate supervision to prevent elopement for two of three residents (Resident R71 and R73).		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review, and staff interviews it was determined that the facility failed to obtain a physician order for and care of an urostomy (surgical procedure that creates an opening in the abdomen wall to allow urine to exit the body when the bladder is not functioning properly), and failed to provide resident-centered interventions for urostomy in the care plan for one of three residents reviewed (Resident R8). Findings include: Review of facility policy Suprapubic Catheter / Urological Device Care and Management dated 1/28/25, indicated a physician order for the urological device is obtained including the size of the catheter (a hollow flexible tube that is inserted through a narrow opening in the body cavity for removing fluid), the frequency of the catheter change, flushes, and routine care. Review of facility policy Comprehensive Person-Centered Care Planning dated 1/28/25, indicated a comprehensive person-centered care plan including necessary and appropriate care, attending physician orders, services and accommodations of resident needs and preferences in order for the resident to attain or maintain the highest practical physical, mental, and psychosocial well-being in accordance with the comprehensive assessment, quantifiable objectives for the highest level of functioning the resident may be expected to attain, and steps or approaches for each outcome objective within 21 days of admission. Review of the clinical record indicated that Resident R8 was admitted to the facility on [DATE], with diagnoses which included cancer, scoliosis (condition where the spine curves sideways, often in an S or C shape), and anxiety. Review of the Minimum Data Set (MDS - a mandated assessment of a resident's abilities and care needs) dated 7/22/25, Section H - Bladder and Bowel Question H0100. Appliances indicated Resident R8 had an indwelling catheter and urostomy on admission. Review of the comprehensive care plan initiated 7/16/25, included the following interventions: Monitor and document intake and output as per facility policy. Monitor/record/report to MD (doctor) for s/sx (signs and symptoms) UTI (urinary tract infection). During an interview on 9/26/25, at 9:00 a.m. the Assistant Director of Nursing (ADON) Employee E2 confirmed the facility failed to obtain a physician's order for Resident R8's urostomy and failed to provide a person-centered care plan with interventions for the urostomy.		

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **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 complete a significant change Minimum Data Set (MDS - periodic assessment of resident care needs) assessment for one of five hospice (a special model of care for patients who are in the late phase of an incurable illness and wish to receive end-of-life care) residents reviewed (Residents R8). Findings include: Review of the Resident Assessment Instrument 3.0 User's Manual (reference used to complete an MDS) effective 10/1/2019, indicated that the facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. Review of facility policy Hospice Services reviewed 1/28/25, indicated the facility contracts with hospice provider(s) to afford the resident's an opportunity to elect hospice services when the resident is diagnosed with a terminal condition and meets the requirements of hospice service. A review of the clinical record indicated that Resident R8 was admitted to the facility on [DATE], with diagnoses which included cancer, scoliosis (condition where the spine curves sideways, often in an S or C shape), and anxiety. Review of a physician order dated 8/18/25, indicated Resident R8 was admitted to hospice services on 8/15/25. Review of the MDS failed to indicate a significant change MDS was completed following admission to hospice services. During an interview on 9/26/25, at 8:44 a.m. Licensed Practical Nurse Assessment Coordinator (LPNAC) Employee E1 confirmed the facility failed to complete a significant change MDS within 14 days of Resident R8's hospice admission.		