STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395840	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Patriot Village	495 West Patriot Street Somerset, PA 15501

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 review of clinical records, as well as staff interviews, it was determined that the facility failed to ensure that residents received care and treatment in accordance with professional standards of practice, by failing to ensure that physician's orders were followed for one of 36 residents reviewed (Resident 23). Findings include: A comprehensive significant change in status Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 23, dated December 13, 2025, revealed that the resident was cognitively impaired, required assistance with daily care needs, received hypoglycemic medications including insulin and had a diagnosis of diabetes. Physician's orders for Resident 23, dated December 18, 2025, included orders for the resident to receive accu checks (a test used to monitor blood sugar) twice daily due to the patient receiving lantus insulin (a long-acting insulin used to lower blood sugar levels), with instructions to document if the patient refused. A review of Resident 23's December 2025 Medication Administration Record (MAR) revealed that she did not have any orders for accu checks entered into the electronic health record system for December 18, 2025. A medication entry audit revealed that the orders for Resident 23's accu checks were created by the Registered Nurse (RN) on December 18, 2025, at 7:46 a.m. as a standard order so it did not appear on the MAR to be recorded. The order was confirmed by and revised by the same RN on December 18, 2025, at 7:46 a.m. Physician's orders for Resident 23, dated December 24, 2025, included orders for the resident to receive accu checks twice daily for a diagnosis of diabetes. A review of Resident 23's December 2025 MAR revealed that she did not have any orders for accu checks entered into the electronic health record system for December 24, 2025, until January 5, 2026. A medication entry audit revealed that the orders for Resident 23's accu checks were created by the Nurse Practitioner (NP) as a standard order on December 24, 2025, at 10:12 a.m., so it did not appear on the MAR to be recorded. The order for the accu checks was confirmed by the RN on December 24, 2025, at 10:54 a.m. and revised by the Director of Nursing on January 5, 2026, at 12:47 p.m. There was no documented evidence that Resident 23's accu checks were completed as ordered from December 18, 2025, through January 4, 2026. Interview with the Director of Nursing on January 8, 2026, at 10:01 a.m. and 12:13 p.m. confirmed that Resident 23's orders for the accu checks were entered by the NP as a standard order which would not populate on the MAR for the nurses to complete. She indicated that the nurse confirming the orders do not check that the order was entered for accuracy; they only activate it. 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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide for the safe, appropriate administration of IV fluids for a resident when needed. Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that a long-term intravenous catheter and a midline catheter (a type of peripheral catheter inserted into a large vein in the upper arm used to deliver fluids and/or medications) were flushed prior to and/or after medication administration for two of 36 residents reviewed (Residents 4, 10).Findings include: The facility's policy regarding peripheral and midline IV catheter flushing dated December 31, 2025, included flushing before and after medication or fluid administration by attaching a prefilled saline syringe to the needleless access device to ensure the entire dose of the medication is administered.A significant change Minimum Data Set (MDS) assessment (a federally mandated assessment of a resident's abilities and care needs) for Resident 4, dated November 18, 2025, revealed that the resident was cognitively intact, had an amputation, received intravenous antibiotics, and had intravenous access.Physician's orders for Resident 4, dated October 22, 2025, included an order for the resident to receive 500 milligrams (mg) of Meropenem Intravenous solution (an antibiotic medication) intravenously every twelve hours for osteomyelitis (bone infection) until November 26, 2025.Review of the Medication Administration Record (MAR) for Resident 4 for October 2025, revealed that staff documented administering the 500 mg of Meropenem solution intravenously from October 23 though 30, 2025 at 7:30 a.m. and 7:30 p.m. However, there was no documented evidence that staff flushed Resident 4's peripheral IV before and after the administration of the Meropenem solution.Physician's orders for Resident 4, dated November 11, 2025, included an order for the resident to receive one gram of Meropenem Intravenous solution intravenously every eight hours for an amputation related to osteomyelitis of the left ankle and foot until December 11, 2025. Review of the MAR for Resident 4 for November 2025, revealed that staff documented administering the one gram of Meropenem Intravenous solution intravenously from November 11 through 24, 2025 at 6:30 a.m., 2:30 p.m., and 10:30 p.m. However, there was no documented evidence that staff flushed Resident 4's peripheral IV before and after the administration of the Meropenem solution.Interview with the Director of Nursing on January 7, 2026, at 2:26 p.m. confirmed that there was no documented evidence that Resident 4's peripheral IV was flushed before and after the administration of the Meropenem, on the dates mentioned above per the facility policy. A significant change MDS assessment for Resident 10, dated December 25, 2025, revealed that the resident was cognitively intact, and was dependent on staff for her daily care needs. Physician's orders for Resident 10, dated January 2, 2026, included an order for the resident to have a midline catheter placed for the administration of 1 gram (gm) of Invanz (an antibiotic) intravenously one time a day for seven days for a urinary tract infection. There was no documented evidence that Resident 10's physician was contacted for orders to flush the resident's midline with a saline solution prior to and/or after medication administration. Review of Resident 10's Medication Administration Record (MAR), dated January 2026, revealed that staff administered one gm of Invanz intravenously on January 2, 3 and 4, 2026, at 7:30 p.m. There was no documented evidence that Resident 10's midline was flushed with saline prior to and/or after administration of the Invanz. Interview with the Director of Nursing on January 6, at 2:37 p.m. confirmed that there was no documented evidence that Resident 10's midline was flushed with saline prior to and/or after the Invanz administration on the above-mentioned dates. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure communication between a dialysis provider and the facility's nursing staff for one of 36 residents reviewed (Resident 6). Findings include:The facility's policy regarding dialysis (mechanical cleansing of the blood to remove waste products when the kidneys are not functioning properly), dated December 31, 2025, indicated that The facility would assure that each resident received care and services for the provision of hemodialysis consistent with professional standards of practice. This would include ongoing communication and collaboration with the dialysis facility regarding dialysis care and services. The licensed nurse would communicate to the dialysis facility via telephonic communication or written format, such as a dialysis communication form or other form, that would include, but not limit itself to: timely medication administration (initiated, held or discontinued) by the nursing home and/or dialysis facility; physician/treatment orders, laboratory values, and vital signs; advance Directives and code status; specific directives about treatment choices; and any changes or need for further discussion with the resident/representative, and practitioners; nutritional/fluid management including documentation of weights, resident compliance with food/fluid restrictions or the provision of meals before, during and/or after dialysis and monitoring intake and output measurements as ordered; dialysis treatment provided and resident's response, including declines in functional status, falls, and the identification of symptoms that may interfere with treatments; dialysis adverse reactions/complications and/or recommendations for follow up observations and monitoring, and/or concerns related to the vascular access site; changes and/or declines in condition unrelated to dialysis; and the occurrence or risk of falls and any concerns related to transportation to and from the dialysis facility.A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 6, dated December 12, 2025, revealed that the resident was understood and could understand, and had diagnoses that included end-stage renal disease (the last stage of chronic kidney disease, where the kidneys are only functioning at 10 to 15 percent of their normal capacity). The resident's care plan, dated May 23, 2024, revealed that the resident received dialysis on Monday and Friday, and prior to leaving, staff were to complete the dialysis communication form. Physician's orders, dated June 23, 2025, included orders for the resident to receive dialysis on Monday and Friday. There was no documented evidence of routine collaboration of care and communication between the long-term care facility and the dialysis center, when the resident received dialysis services on November 10, 21, 24, and 28, December 5, 15, 19, 29, 2025, and January 5, 2026. Interview with the Director of Nursing on January 8, 2026, at 2:08 p.m. confirmed that there was no documented evidence that a communication form was completed by the facility and/or dialysis center on the dates mentioned above.28 Pa. Code 211.12(d)(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 observations and staff interviews, it was determined that the facility failed to ensure that food was stored under sanitary conditions. Findings include: The facility's policy for food storage, dated December 31, 2025, indicated that frozen and refrigerated food items will be appropriately stored in accordance with guidelines of the FDA food code. The Dining Services Director/cook(s) ensures that all food items are stored properly in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination. Observations in the main kitchen walk in refrigerator on January 5, 2026, at 9:19 a.m. revealed that there was a bag of hamburger patties that were opened and exposed to air and not dated, and observations of an opened cottage cheese container that was dated with a use-by date of January 3, 2026. Interview with the Dietary Manager at the time of the observation confirmed that the hamburger patties should have been dated when opened, sealed and not exposed to air and the cottage cheese should have been discarded. 28 Pa. Code 211.6(f) Dietary services.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition Based on review of the Resident Assessment Instrument User's Manual and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that a comprehensive significant change Minimum Data Set assessment was completed in the required time frame for one of 36 residents reviewed (Resident 1), and failed to complete a significant change Minimum Data Set assessments for one of 36 residents reviewed (Residents 91). Findings include: The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides instructions and guidelines for completing required Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2025, indicated that the Assessment Reference Date (ARD) was to be no later than the 14th calendar day after determination that a significant change in the resident's status occurred (determination date + 14 calendar days) and the significant change comprehensive MDS assessment was to be completed no later than the 14th calendar day after determination that significant a change in the resident's status occurred (determination date + 14 calendar days). Physician's orders for Resident 1, dated June 3, 2025, included an order for the resident to be admitted to hospice June 3, 2025, with a primary diagnosis of Hypertensive Heart Disease. A significant change Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs) for Resident 1, dated June 4, 2025, revealed that the MDS was documented in section Z0500B as being completed on June 18, 2025, which was two days late. Interview with the Registered Nurse Assessment Coordinator (RNAC - a registered nurse who is responsible for the completion of MDS assessments) on January 7, 2026, at 2:11 p.m. confirmed that the significant change comprehensive MDS assessment for Resident 1 should have been completed by June 16, 2025, and it was not. Review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides guidance and instructions for the completion of Minimum Data Set (MDS) assessments, dated October 2025, revealed 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. The RAI Manual revealed that staff should complete a significant change MDS when a resident has a decline that will not normally resolve itself without interventions by staff, impacts more than one area of the resident's health status, and requires interdisciplinary review and/or revision of the resident's care plan. The RAI Manual revealed that staff should complete a significant change MDS when a terminally ill resident enrolls in a hospice program (Medicare-certified or state-licensed hospice provider) or changes hospice providers and remains a resident at the nursing home. A admission MDS assessment for Resident 91, dated October 6, 2025, revealed that the resident was cognitively impaired, required extensive assistance for daily care needs, and had diagnoses that included heart disease with heart failure. Physician's orders for Resident 91, dated October 30, 2025, included orders to admit the resident to hospice for a diagnosis of heart disease with heart failure. There was no documented evidence in Resident 91's clinical record to indicate that a significant change MDS was completed per the RAI manual. An interview with the Director of Nursing on January 8, 2025, at 3:00 p.m., confirmed that a significant change MDS should have been completed for Resident 91. 28 Pa. Code 211.5(f) Clinical Records. 28 Pa. Code 211.12(d)(5) Nursing services. -------

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of the Resident Assessment Instrument User's Manual and clinical records, as well as staff interviews, it was determined that the facility failed to complete accurate Minimum Data Set assessments for three of 36 residents reviewed (Residents 6, 34, 86). Findings include:The Long-Term Care Facility RAI User's Manual, dated October 2025, revealed that Section O0110J1b was to be checked if the resident was receiving dialysis treatment while a resident at the facility during the past 14 days.A care plan for Resident 6, dated May 23, 2024, revealed that the resident received dialysis on Monday and Friday, and prior to leaving, staff were to complete the dialysis communication form. Physician's orders, dated June 23, 2025, included orders for the resident to receive dialysis on Monday and Friday.A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 6, dated December 12, 2025, revealed that the resident was understood and could understand, and had diagnoses that included end-stage renal disease (the last stage of chronic kidney disease, where the kidneys are only functioning at 10 to 15 percent of their normal capacity).However, section O0110J1b was not checked, indicating that the resident did not receive dialysis treatment while a resident in the facility during the past 14 days.Interview with the Registered Nurse Assessment Coordinator (RNAC-responsible for completing MDS assessments) on January 7, 2026, at 1:31 p.m. confirmed that section O0110J1b of Resident 6's quarterly MDS assessment, dated December 12, 3025, was not checked to indicate that the resident was receiving dialysis treatments while a resident at the facility during the past 14 days and it should have been. The RAI User's Manual, dated October 2024, indicated that Section O0110K1 Hospice care (a specialized form of end-of-life care that provides comfort, support, and medical assistance to terminally ill patients and their families) was to be coded to indicate if the resident was receiving hospice services (a) on admission, (b) while a resident or (c) at discharge. Physician's orders for Resident 34, dated April 28, 2025, included an order for the resident to receive hospice services from UPMC Family Hospice, related to a diagnosis of Alzheimer disease. Review of Resident 34's clinical record, including physician's orders, care plans and nurses' notes, revealed documented evidence that the resident was receiving hospice services during the seven-day look-back period; however, a quarterly MDS assessment for Resident 34, dated October 14, 2025, revealed that Section 0O110K1 was coded no (0) while a resident, indicating that the resident was not receiving hospice services during the seven-day look back-period. Interview with the RNAC on January 6, 2026, at 1:40 p.m. confirmed that Resident 34's MDS, dated [DATE], was coded inaccurately. The RAI User's Manual, dated October 2025, revealed that Section N0410F1 (Antibiotic Medications) was to be checked if the resident received an antibiotic medication during the seven-day assessment period. Physician's orders for Resident 86, dated November 3, 2025, included an order for the resident to have Bacitracin (antibiotic ointment) applied to his suprapubic catheter (medical device used to drain urine from the bladder through a small incision in the abdomen) site, daily and as needed every day shift for suprapubic catheter care.The resident's Treatment Administration Records (TAR's) for December 2025 revealed that the resident received Bacitracin daily to his suprapubic catheter site during the seven day look-back period.A quarterly MDS assessment for Resident 86, dated December 8, 2025, revealed that Section N0410F1 was not checked, indicating that the resident did not receive any antibiotic medications during the seven days of the assessment period.Interview with the RNAC on January 7, 2026, at 1:31 p.m. confirmed that section N0410F1 of Resident 86's quarterly MDS assessment, dated December 8, 3025, was not checked to indicate that the resident received an antibiotic during the seven day look back period.28 Pa. Code 211.5(f) Clinical Records.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on review of facility policies, clinical records, and staff interviews, it was determined that the facility failed to develop a comprehensive care plan that included specific and individualized interventions to address the care needs of residents for one of 36 residents reviewed (Resident 40). Findings include: A facility policy for Care Plans, dated December 31, 2025, indicated that it is the policy of the facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs. An annual Minimum Data Set (MDS) assessment (a federally-mandated assessment of a resident's abilities and care needs) for Resident 40, dated October 14, 2025, revealed that the resident was severely cognitively impaired, had clear speech, sometimes understood and sometimes understands requires moderate assistance from staff with daily care tasks, and had diagnoses that included vascular dementia, anxiety and psychotic mood disturbances.Physician's orders for Resident 40, dated October 23, 2025, included orders for the resident to receive 25 milligrams of Seroquel (an antipsychotic) two times a day for psychosis (a state where a person loses touch with reality, experiencing symptoms like hallucinations and confused thinking) related to vascular dementia.There was no documented evidence that a care plan was developed to address Resident 40's individual care and treatment needs related to the use of her antipsychotic medication.Interview with the Director of Nursing on January 8, 2026, at 1:31 p.m., confirmed that a care plan to address the care needs related to Resident 40's need for antipsychotic medication was not developed, and should have been. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on review of policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure that care plans were updated to reflect changes in residents' care needs for two of 36 residents reviewed (Residents 2, 5). Findings include:The facility's policy regarding care plan revision, dated December 31, 2025, indicated that nursing staff and/or the interdisciplinary team were to initiate and/or update care plans for the resident as warranted. In addition, individualized interventions for trauma survivors that recognizes the interrelation between trauma and symptoms of trauma, as indicated. Trigger-specific interventions will be used to identify ways to decrease the resident's exposure to triggers which re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident.A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's care needs and abilities) for Resident 2, dated December 3, 2025, indicated that the resident was cognitively intact and did not receive a diuretic (water pill) medication during the seven day look back period. A care plan for Resident 2, dated September 15, 2025, indicated that the resident was at risk for dehydration due to receiving a diuretic medication.A review of Resident 2's Medication Administration Record (MAR) for December 2025 and January 2026 revealed no documentation that the resident received a diuretic medication. There was no documented evidence to indicate the care plan was updated to reflect the discontinuation of the diuretic medication.A significant change MDS assessment for Resident 5 dated September 12, 2025, indicated that the resident was cognitively impaired, required extensive assistance from staff for daily care tasks, sometimes understood, sometimes understands, had unclear speech and had diagnoses that included post-traumatic stress disorder (PTSD) (a mental health condition triggered by experiencing or witnessing a terrifying, life-threatening, or traumatic event, leading to intrusive memories (flashbacks, nightmares), negative mood changes (guilt, fear), and heightened arousal (hypervigilance, irritability) that significantly disrupt daily life).Interview with the Social Services Director on January 7, 2026 at 11:10 a.m., indicated that Resident 5 was in the military and suffered from PTSD. She stated his triggers are loud noises and being around too many people. She indicated that she did not include his triggers on the care plan, and in retrospect she should have.Interview with the Director of Nursing on January 7, 2026, at 1:30 p.m. confirmed that Resident 2's care plan was not updated to reflect the discontinuation of her diuretic medication, and Resident 5's care plan was not updated to reflect the triggers associated with his diagnosis of post-traumatic stress disorder, and they should have been.28 Pa. Code 211.11(d) Resident care plan. 28 Pa. Code 211.12(d)(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. Based on clinical record reviews, observations, and staff interviews, it was determined that the facility failed to ensure that each resident received assistance devices to prevent accidents for one of 36 residents reviewed (Resident 1). Findings include: The facility's policy regarding assistive devices and equipment dated December 31, 2025, revealed that the facility maintains and supervises the use of assistive devices and equipment for residents and that if a resident is to be pushed or transported by anyone (staff, family, volunteers) in a wheelchair, bilateral leg rests must be attached to the wheelchair. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated December 3, 2025, revealed that the resident was cognitively impaired, dependent on staff for daily care needs and a wheelchair was used as a mobility device. Observation on January 5, 2026, at 11:48 a.m. revealed that the resident was transported in her wheelchair by Nurse Aide 1 down the hallway to the dining room without the use of leg rests. Interview with Nurse Aide 1 at the time of the observation revealed that the leg rests were in a bag on the back of the wheelchair and she did not apply them to Resident 1's chair prior to transporting the resident and she should have. An interview with the Director of Nursing on January 6, 2026, at 2:37 p.m. confirmed that leg rests should have been in place prior to transporting Resident 1 to the dining room. 28 Pa. Code 211.10(c)(d) Resident Care Policies. 28 Pa. Code 211.12(d)(5) Nursing Services.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to respond to a pharmacy recommendation for one of 36 residents reviewed (Resident 3).Findings include: An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 3, dated November 17, 2025, revealed that the resident was cognitively intact, was independent for most care needs, and had a diagnosis of osteoporosis. Physician's orders for Resident 3, dated November 16, 2025, included orders for the resident to receive 70 milligrams (mg) of Alendronate Sodium (Fosamax) daily every Sunday for osteoporosis. A pharmacy medication regimen note for Resident 3, dated November 11, 2025, indicated that the resident is receiving Fosamax which comes with very specific administration instructions. The pharmacist's recommendations indicated to update the current order to include instructions to administer the medication on an empty stomach before a.m. meals and medications, with water only (at least 8 ounces), and for the resident to remain upright for at least 30 minutes after administration. The physician signed that he agreed with the recommendations on December 2, 2025. There was no documented evidence in the resident's clinical record that the order was updated to reflect the recommendations from the pharmacist. A pharmacy medication regimen note for Resident 3, dated December 23, 2025, indicated that the resident is receiving Fosamax which comes with very specific administration instructions. The pharmacist's recommendations indicated to update the current order to include instructions to administer the medication on an empty stomach before a.m. meals and medications, with water only (at least 8 ounces), and for the resident to remain upright for at least 30 minutes after administration. The physician signed that he agreed with the recommendations on December 23, 2025. There was no documented evidence in the resident's clinical record that the order was updated to reflect the recommendations from the pharmacist. An interview with the Director of Nursing on January 6, 2026, at 12:06 p.m. confirmed that Resident 3's order for Fosamax was not updated to reflect the pharmacist's recommendations as agreed on by the physician. 28 Pa. Code 211.10(c) Resident care policies. 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395840	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Patriot Village	495 West Patriot Street Somerset, PA 15501

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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on review of the facility's plans of correction for previous surveys, and the results of the current survey, it was determined that the facility's Quality Assurance Performance Improvement (QAPI) committee failed to correct quality deficiencies and ensure that plans to improve the delivery of care and services effectively addressed recurring deficiencies. Findings include:.The facility's deficiencies and plans of corrections for a State Survey and Certification (Department of Health) survey ending January 9, 2025, revealed that the facility developed plans of correction that included quality assurance systems to ensure that the facility maintained compliance with cited nursing home regulations. The results of the current survey, ending January 8, 2026, identified repeated deficiencies related to accuracy of MDS (Minimum Data Sets) assessments, revision of residents' care plans, quality of care, and food stored, prepared and served in a sanitary manner.The facility's plan of corrections for deficiencies regarding accuracy of MDS assessments cited during the survey ending January 9, 2025, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F641, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding accuracy of MDS assessments.The facility's plan of correction for deficiencies regarding revising residents' care plans, cited during the survey ending January 9, 2025, revealed that audits of care plans would be completed, and the results would be reported to the QAPI committee for review. The results of the current survey, cited under F657, revealed that the QAPI committee was ineffective in maintaining compliance with the regulation regarding revising residents' care plans. The facility's plan of corrections for deficiencies regarding quality of care, cited during the survey ending January 8, 2025, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F684, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding quality of care. The facility's plan of correction for a deficiency regarding food procurement, store/prepare/serve-sanitary cited during the survey ending January 9, 2025, revealed that food procurement, store/prepare/serve-sanitary would be monitored by QAPI. The results of the current survey, cited under F812, revealed that the QAPI committee was ineffective in maintaining compliance with regulation food procurement, store/prepare/serve-sanitary. Refer to F641, F657, F684, and F812. 28 Pa. Code 201.14(a) Responsibility of licensee.