

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395860	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/20/2025
NAME OF PROVIDER OR SUPPLIER  Loyalhanna Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  535 McFarland Road Latrobe, PA 15650	

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 0600  Level of Harm - Actual harm  Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.  (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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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Based on review of policies, investigation reports, clinical records, and staff education records, as well as staff interviews, it was determined that the facility failed to ensure that residents were free from neglect for one of five residents reviewed (Residents 2), resulting in a fall with a fractured hip. This deficiency was cited as past non-compliance. Findings include: The facility's policy regarding fall prevention, dated September 1, 2024, indicated that each resident will be assessed for their fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. An annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 2, dated August 8, 2025, revealed that the resident was cognitively intact, required substantial to maximum assistance for chair to bed and toilet transfers, used a walker, and had diagnoses that included chronic obstructive pulmonary disease (group of lung diseases that cause ongoing breathing problems). The resident's care plan, dated August 1, 2024, revealed that the resident was at risk for falls. A care plan intervention for Resident 2, dated March 31, 2025, revealed that the resident was to be increased to a two person assist for transfers for improved safety. Physician's orders for Resident 2 dated May 27, 2025, included an order for the resident to be transferred with the assistance of two staff using a wheeled walker. The nurse aide task list dated August 9, 2025, indicated that the resident required two staff for transfers. A nursing note for Resident 2, dated August 11, 2025, at 5:35 p.m. revealed that the nurse aide had showered the resident and took her to the toilet to have her brief placed. The resident stood at the bars without difficulty, and the nurse aide slipped in water on the floor and fell, causing the resident to fall. The resident stated she bumped her head, and an assessment revealed that the resident's right leg was visibly shortened and externally rotated. The physician was notified, and orders were received to transfer the resident to the hospital. A nurse's note dated August 11, 2025, at 11:52 p.m. revealed that the resident was admitted to the hospital with a hip fracture. A nurse's note dated August 14, 2025, at 10:47 a.m. revealed that staff called the hospital for an update on Resident 2 and was informed that she had surgery on August 12, 2025. Investigative documents for Resident 2, dated August 12, 2025, revealed that on August 11, 2025, at approximately 4:00p.m. Nurse Aide 1 had showered Resident 2 and had assisted her to stand at a bar so she could apply a brief. Nurse Aide 1 did not have a second staff member present to assist her with standing or transferring the resident, per physician's orders. Nurse Aide 1 slipped in water and fell, causing Resident 2 to fall and sustain a hip fracture requiring surgery. A written statement from Nurse Aide 1 dated August 11, 2025, revealed that she rolled Resident 2 to the bars so the resident could stand, and the aide could put her brief on. The resident was standing ok, but the nurse aide took a small step and slipped on water taking the resident down with her. Nurse Aide 1 revealed that she was unaware of the change in Resident 2's transfer status to an assist of two staff. Education records for Nurse Aide 1, dated February 23, 2025, revealed that she received education on abuse and neglect. Interview with the Nursing Home Administrator on August 20, 2025, at 4:23 p.m. confirmed that because Nurse Aide 1 did not follow the physician's orders and care plan interventions for Resident 2, the resident had a fall causing a fractured hip. Following the investigation on August 12, 2025, the facility's corrective actions included: Nurse Aide 1 was terminated from employment at the facility. Audits were performed of residents' transfer status. Staff education was provided on following care plans, Kardex information, and orders related to each resident's care. The results of these audits will be brought to Quality Assurance Performance Improvement committee for further analysis and corrective actions if necessary. Review of the facility's corrective actions and interviews completed with staff regarding their re-education revealed that they were in compliance with F600 on August 19, 2025. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(e)(10) Management. 28 Pa. Code 201.24(e)(4) admission Policy. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.</p>		

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F 0689  Level of Harm - Actual harm  Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.  (continued on next page)

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F 0689  Level of Harm - Actual harm  Residents Affected - Few	<p>Based on review of facility policies, clinical records, and facility investigation reports, as well as staff interviews, it was determined that the facility failed to provide an environment that was free of accident hazards for residents who were at risk for falls for one of five residents reviewed (Resident 2) resulting in a fall with a hip fracture. This deficiency was cited as past non-compliance. Findings include: The facility's policy regarding fall prevention, dated September 1, 2024, indicated that each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. A annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 2, dated August 8, 2025, revealed that the resident was cognitively intact, required substantial to maximum assistance for chair to bed and toilet transfers, used a walker, and had diagnoses that included chronic obstructive pulmonary disease (group of lung diseases that cause ongoing breathing problems). The resident's care plan, dated August 1, 2024, revealed that the resident was at risk for falls. A new intervention, dated March 31, 2025, indicated to increase Resident 2's assistance with transfers to two staff members for improved safety. Physician's orders for Resident 2 dated May 27, 2025, included an order for the resident to be transferred with the assistance of two staff using a wheeled walker. The nurse aide task list, dated August 9, 2025, indicated that the resident required two staff for transfers. A nursing note for Resident 2, dated August 11, 2025, at 5:35 p.m. revealed that the nurse aide had showered the resident and took her to the toilet to have her brief placed. The resident stood at the bars without difficulty, and the nurse aide slipped in water that was on the floor and fell, causing the resident to fall. The resident stated she bumped her head. An assessment revealed that the resident's right leg was visibly shortened and externally rotated. The physician was notified, and orders were received to transfer the resident to the hospital. A nurse's note dated August 11, 2025, at 11:52 p.m. revealed that the resident was admitted to the hospital with a hip fracture. A nurse's note dated August 14, 2025, at 10:47 a.m. revealed that staff called the hospital for an update on Resident 2 and was informed that she had surgery on August 12, 2025. Investigative documents for Resident 2, dated August 12, 2025, revealed that on August 11, 2025, at approximately 4:00 p.m. Nurse Aide 1 had showered Resident 2 and assisted her to stand at a bar so she could apply a brief. Nurse Aide 1 did not have a second staff member present to assist her with standing or transferring the resident per physician's orders. Nurse Aide 1 slipped in water and fell, causing the resident to fall which resulted in a hip fracture requiring surgical intervention. A written statement from Nurse Aide 1 dated August 11, 2025, revealed that she rolled Resident 2 to the bars so the resident could stand, and the aide could put her brief on. The resident was standing ok, but the nurse aide took a small step and slipped on water taking the resident down with her. Nurse Aide 1 revealed that she was unaware of the change in Resident 2's transfer status to an assist of two staff. Interview with the Nursing Home Administrator on August 20, 2025, at 4:23 p.m. confirmed that Nurse Aide 1 did not follow the physician's orders and care plan interventions for a two person assist with Resident 2, and the resident had a fall resulting in a fractured hip. Following the investigation on August 12, 2025, the facility's corrective actions included: Nurse Aide 1 was terminated from employment at the facility. Audits were performed of residents' transfer status. Staff education was provided on following care plans, Kardex information, and orders related to each resident's care. The results of these audits will be brought to Quality Assurance Performance Improvement committee for further analysis and corrective actions if necessary. Review of the facility's corrective actions and interviews completed with staff regarding their re-education revealed that they were in compliance with F689 on August 19, 2025. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(e)(10) Management. 28 Pa. Code 201.24(e)(4) admission Policy. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.</p>		

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F 0805  Level of Harm - Actual harm  Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.  (continued on next page)

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F 0805  Level of Harm - Actual harm  Residents Affected - Few	<p>Based on review of facility policy, clinical records and investigation documents, as well as staff interviews, it was determined that the facility failed to ensure that residents were provided with the proper food consistency as ordered by the physician for one of five residents reviewed (Resident 1), who choked, requiring a hospital admission for hypoxia and aspiration. Findings include: A facility policy for therapeutic diet orders dated January 13, 2025, indicated that dietary and nursing staff are responsible for providing therapeutic diets in the appropriate form and/or the appropriate nutritive content as prescribed. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated June 27, 2025, indicated that the resident was understood, could sometimes understand others, had a diagnosis of a stroke, and was on a mechanically altered diet (the texture of food is altered by chopping, grinding, blending, or mashing it to make it easier to chew and swallow). Physician's orders for Resident 1, dated May 22, 2025, included an order for the resident to receive a mechanical soft with ground meat texture diet. Physician's orders dated August 17, 2025, included an order for the resident to receive a pureed texture diet. A nursing note for Resident 1, dated August 1, 2025, at 12:25 p.m. revealed that the resident's husband reported to staff that the resident was served a piece of chicken on her lunch tray. The resident's husband cut it up for her to eat and she started choking on it. The resident verbalized that she felt like there was a lump in her throat. A nurse suctioned mucous from the resident's mouth and administered a breathing treatment, however the resident continued to report feeling a lump in her throat. The nurse provided thickened liquids which caused the resident to cough up more froth and mucous. The certified registered nurse practitioner was notified, and orders were received to send the resident to the hospital for evaluation and treatment. A nurse's note dated August 1, 2025, at 5:36 revealed that Resident 1 was admitted to the hospital with hypoxia (low levels of oxygen in your body tissues), anemia (the blood has an abnormally low level of red blood cells), and aspiration (the accidental inhalation of foreign substances, such as food, liquids, or mucus, into the lungs). A nurse's note dated August 3, 2025, indicated that Resident 1 was in the intensive care unit in the hospital. A nurse's note dated August 5, 2025, at 2:00 pm revealed that the resident returned to the facility from the hospital after being advanced to her baseline diet and had appeared to tolerate a mechanical soft diet. A nurse's note for Resident 1 dated August 16, 2025, at 6:02 p. m. revealed that a nurse aide reported to the registered nurse that the resident was choking on a Brussel sprout, and the resident reported having something in her throat. Coughing and suctioning were unsuccessful to relieve the resident's concern of having something in her throat, and the resident was transferred to the hospital. A nurse's note for Resident 1, dated August 16, 2025, at 9:20 p.m. revealed that the resident returned to the facility in stable condition after a choking episode. A witness statement by Nurse Aide 2, dated August 1, 2025, indicated that the nurse aide took Resident 1's meal tray into the resident's room without lifting the lid and verifying that the resident was being served the correct diet. The resident's husband reported that the resident was provided with regular chicken, not all ground up like it should be, so he cut it up in really small pieces for her. The facility's plan to prevent residents from receiving the wrong diet texture included dietary and nursing staff being educated by the facility's regional dietary manager on August 6, 2025 regarding textured modified diets and mechanical soft diet guidelines. The education indicated that on a mechanical soft diet, foods that may be restricted include vegetables with tough skins or membranes and that Brussel sprouts should be avoided. An interview with Resident 1 on August 20, 2025, at 3:25 p.m. revealed that the resident does not eat hard candy because it has always caused her to choke, and she recalled choking on her evening meal on the previous weekend which was very scary. An interview with the dietary manager on August 20, 2025, at 2:50 pm confirmed that the Resident 1 was provided Brussel sprouts during her evening meal on August 16, 2025, and that staff should have followed the guidelines of the most recent education that was provided to them on August 6, 2025, that included avoiding Brussel sprouts on a mechanical diet. 28 Pa. Code 211.12(d)(3)(5) Nursing Services.</p>		