STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395860	A. Building B. Wing	03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Loyalhanna Care Center	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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 48941 Based on review of facility policies and clinical records, as well as staff and resident interviews, it was determined that the facility failed to honor a resident's right regarding diet consistency for one of 36 residents reviewed (Resident 8). Findings include: A facility policy regarding Promoting/Maintaining Resident Self-Determination/Resident Right to Refuse, dated January 13, 2025, indicated that it is the practice of the facility to protect and promote resident rights by facilitating resident self-determination through support of resident choice. The facility will ensure that each resident has the opportunity to exercise his/her autonomy regarding those things that are important in his/her life such as interests and preferences. Each resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 8, dated February 5, 2025, revealed that the resident was cognitively intact, was understood and able to understand others, received a therapeutic diet, and had a diagnosis of Multiple sclerosis (MS) (a chronic, autoimmune disease that affects the central nervous system-brain and spinal cord). An interview with Resident 8 on March 17, 2025, at 10:27 a.m. revealed that she was concerned with her diet. She stated that she hated the mechanical diet and fights with speech therapy about it. She indicated that she had no teeth and could not wear dentures due to bone loss but could eat regular food with no issues. Physician's orders for Resident 8, dated December 6, 2023, indicated that she was to receive a mechanical soft, ground meat texture diet. (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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A speech therapy note for Resident 8, dated August 8, 2024, indicated that the resident was referred to therapy due to a recent report of the resident disliking her food/diet textures spanning over the last 10 months. The resident was consuming mechanically soft, ground meat textures without complaints but was open to side-by-side trials to further assess her level of function at that time. Speech therapy had reached out to the medical director to express safety concerns about liberalizing her diet textures to regular per her request, however, that it may be a medical exception he could make for her quality of life per her choice, as she wishes to consume those textures. The medical director had stated that he wanted her to sign a waiver form and/or obtain a modified barium swallow (MBS) study (a test to evaluate swallowing function and identify any abnormalities) before he would consider it. The resident had an MBS scheduled for October 29, 2024, and it was documented that waiver forms were no longer in use. Interview with the Therapy Director on March 20, 2025, at 8:12 a.m. revealed that speech therapy had worked with the resident and had felt it was not appropriate for her to have a regular diet. She indicated that speech therapy had referred back to the Medical Director as she would not recommend the regular diet since it was not safe. The resident had a MBS scheduled for October 29, 2024, and it was rescheduled to December 19, 2024. The results of the MBS indicated that the resident was likely appropriate for a soft diet with thin liquids. There was no documented evidence that the resident was presented the option to sign a waiver. Interview with the Director of Nursing on March 20, 2025, at 12:39 p.m. indicated that she was aware of Resident 8 wanting to eat regular foods and indicated that the Medical Director would not write the order. She was going to check with the Nursing Home Administrator related to this and indicated that she believed she should be able to get the diet she wanted. Interview with the Director of Nursing on March 20, 2025, at 1:26 p.m. indicated that she spoke to the Nursing Home Administrator and that he indicated the new ownership did not do waivers. However, she did indicate that if Resident 8 wanted a diet change, she should be able to have what she wanted and she would be speaking with the Medical Director. 28 Pa. Code 201.29(j) Resident Rights.

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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 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. 47819 Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to develop and implement an individualized care plan for three of 36 residents reviewed (Resident's 12, 21, 75). Findings include: The facility's policy regarding care plans, dated January 13, 2025, indicated that the facility will 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 and all services that are identified in the resident's comprehensive assessment and meet professional standards of quality. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 12, dated February 26, 2025, revealed that the resident was cognitively intact, required assistance with care needs, received an anticoagulant (blood thinner), and had a diagnoses that included a history of thrombosis (formation of a blood clot inside a blood vessel) and embolism (obstruction or blockage in a blood vessel). Physician's orders for Resident 12, dated May 25, 2024, included orders for the resident to receive 2.5 milligrams (mg) of Eliquis (an anticoagulant) twice daily. There was no documented evidence that a care plan was developed to address Resident 12's history of thrombosis and embolism and his need for an anticoagulant. Interview with the Director of Nursing on March 20, 2025, at 11:12 a.m. confirmed that there was no documented evidence that a care plan was developed to address Resident 12's history of thrombosis and embolism and his need for an anticoagulant. A quarterly MDS assessment for Resident 21, dated January 10, 2025, revealed that the resident was cognitively impaired, required assistance with care needs, had a history of falls without injury since the prior MDS assessment, and had a diagnosis of dementia. A fall care plan for Resident 21, dated June 20, 2024, included an intervention for a perimeter mattress to prevent the resident from falling out of bed. Observations of Resident 21's bed on March 20, 2025, at 2:10 p.m. revealed that the resident did not have a perimeter mattress on her bed. Interview with the Director of Nursing on March 20, 2025, at 2:16 p.m. confirmed that Resident 21 did not have a perimeter mattress on her bed as per the resident's plan of care. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A significant change MDS assessment for Resident 75, dated January 20, 2025, revealed that the resident was cognitively intact, required assistance from staff for daily care needs, had an indwelling foley catheter (a soft, flexible plastic tube inserted in the bladder), and had diagnosis that included heart failure, obstructive uropathy, and diabetes mellitus. Physician's orders for Resident 75, dated October 8, 2024, included orders for the resident to have an indwelling foley catheter (a tube inserted directly into the bladder). There was no documented evidence that a care plan was developed to address Resident 75's care needs related to the indwelling foley catheter. The facility's policy for smokeless tobacco, dated January 12, 2025, indicated that all safe smokeless tobacco measures will be documented on each resident's care plan and communicated to all staff, visitors, and volunteers who will be responsible for supervising residents while using smokeless tobacco, if indicated. Supervision will be provided as per the resident's care plan. If a resident is capable of independent smokeless tobacco use, this will be indicated in the plan of care. Observations during the facility tour on March 17, 2025, at 10:50 a.m. revealed that Resident 75 was lying in bed and had two cans of smokeless tobacco on his bedside table. Interview with Licensed Practical Nurse 1 on March 19, 2025, at 11:17 a.m. confirmed that Resident 75 had smokeless tobacco on his bedside. Interview with the Director of Nursing on March 19, 2025, at 1:32 p.m. confirmed that Resident 75 did not have a care plan that addressed the care and services needed for an indwelling foley catheter or the use of smokeless tobacco. 28 Pa. Code 201.24(e)(4) Admission Policy. 28 Pa. Code 211.12(d)(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. 19102 Based on review of facility policies and clinical records, a well as staff interviews, it was determined that the facility failed to ensure that a resident's care plan was updated/revised to reflect the resident's specific care needs for one of 36 residents reviewed (Resident 46). Findings include: The facility's policy regarding care plans, dated January 13, 2025, indicated that the comprehensive care plan would be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 46, dated February 26, 2025, indicated that the resident was moderately cognitively impaired, required staff assistance with care, and had a colostomy (an artificial opening in the bowel). Physician's orders, dated January 28, 2025, included orders for the resident to have a colostomy bag and wafer every shift. The resident's current care plan indicated that the resident had a colostomy and also had a history of placing silverware into her vagina and rectum. A nursing note for Resident 46, dated February 8, 2025, at 9:16 p.m. revealed that the resident had an open area on the end of her colostomy/stoma (an opening in the abdomen that allows waste to exit the body). The note indicated that the resident did dig at her stoma with silverware and had been witnessed by staff doing this. The area had a bright red center and a small amount of bright red, bloody drainage. There was no documented evidence that the resident's care plan was updated to include interventions to prevent Resident 46 from digging at her colostomy/stoma with silverware. Interview with the Director of Nursing on March 20, 2025, at 11:15 a.m. confirmed that Resident 46's care plan was not updated following the incident on February 8, 2025. 28 Pa. Code 211.12(d)(5) Nursing Services.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 47819 Based on review of Pennsylvania's Nursing Practice Act, facility policies, clinical records, and facility investigation documents, as well as staff interviews, it was determined that the facility failed to clarify physician's orders for one of 36 residents reviewed (Resident 17) and failed to ensure that a licensed registered nurse followed professional standards regarding the administration of medications for one of 36 residents reviewed (Resident 75). Findings include: The Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing 21.11 (a)(1)(2)(4) indicated that the registered nurse was responsible for assessing human responses and plans, implementing nursing care, analyzing/comparing data with the norm in determining care needs, and carrying out nursing care actions that promote, maintain and restore the well-being of individuals. The facility's medication administration policy, dated January 13, 2025, revealed that medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. They will ensure the six rights of medication administration are followed: right resident, right drug, right dosage, right route, right time, and right documentation. A quarterly minimum data set (MDS) assessment (mandated to assess the resident abilities and care needs) for Resident 17, dated December 12, 2024, revealed that the resident was cognitively impaired, required assistance from staff for personal care needs, had diagnoses that included anoxic brain injury (due to a lack of oxygen to the brain), and had a gastrostomy (feeding tube). Physician's orders for Resident 17, dated June 10, 2024, included an order for the resident to be NPO (nothing by mouth). The resident also had physician's orders to receive 2 milligrams (mg) of Doxazosin mesylate (medication used for heart disease) 1 tablet by mouth at bedtime, 0.4 mg of Flomax (medication used for difficulty with urination) by mouth at bedtime, 50 mg of metoprolol tartrate (medication used for heart disease) by mouth two times a day, and 50 mg of sertraline (medication used for mood) by mouth one time a day. Interview with the Director of Nursing on March 18, 2025, at 1:44 p.m. confirmed that Resident 17's medications were transcribed incorrectly and that they should have been written to be administered through the feeding tube. A significant change MDS assessment for Resident 75, dated January 20, 2025, revealed that the resident was cognitively intact, required assistance from staff for daily care needs, had an indwelling foley catheter (a soft, flexible plastic tube inserted in the bladder), and had diagnoses that included heart failure, obstructive uropathy, and diabetes mellitus. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nursing note for Resident 75, dated August 20, 2024, at 9:08 a.m., revealed that Registered Nurse 2 reported that the resident received another resident's medications in error. Registered Nurse 2 reported that she went into the wrong room and administered the resident the wrong medications. Resident 75 was given 1 capsule of Vitamin B, 125 milligrams (mg) of cholecalciferol (vitamin for calcium), 800 mg pf sevelamer (medication used for kidney disease), 10 mg of amlodipine (medication for blood pressure), 0.4 mg of tamsulosin (medication used for difficulty with urination), 1 capsule of lactobacillus (medication used to help prevent diarrhea), 2 mg of bumetanide (medication used to excrete excess water), 100 mg bupropion (medication used for mood stabilization), 12.5 mg of carvedilol (medication for blood pressure), 75 mg of Plavix (medication for heart disease), 5 mg of finasteride (medication used for difficulty with urination), 300 mg of gabapentin (medication used for pain), 40 mg of lisinopril (medication for blood pressure), 50 mg of sertraline (medication used for mood stabilization), and 1 mg of Prograf (medication used for preventing organ rejection). The resident was assessed immediately. A nursing note at 9:28 a.m. revealed that the resident stated he felt lightheaded, and blood pressure was taken and was 108/58 mmHg. The physician ordered for the resident to be transferred to the local emergency room . A nursing note, dated August 20, 2024, at 3:57 p.m., revealed that Resident 75 returned to the nursing home from the emergency room with no new orders. Interview with the Director of Nursing on March 19, 2025, at 1:32 p.m. confirmed that the Registered Nurse 2 did not follow the facility's policy when administering medications to a resident. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.

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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. 47819 Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that physician's orders for medications were followed for three of 36 residents reviewed (Residents 1, 21, 75). Findings include: The facility's policy regarding medication administration, dated January 13, 2025, revealed that medications shall be administered in a safe and timely manner, and as prescribed. Vital signs must be checked/verified for each resident prior to administering medications. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated February 18, 2025, revealed that the resident was cognitively intact, required substantial assistance to dependent with care needs, received insulin, and had a diagnosis of diabetes. Physician's order for Resident 1, dated December 20, 2024, included an order for the resident to receive 16 units of Humalog insulin subcutaneously (medication administered into the subcutaneous fat under the skin) one time a day at 11:30 a.m. if the resident ate greater than 50 percent of her meal. Review of Resident 1's meal intakes from December 20, 2024, through March 18, 2025, revealed that her lunch meal intakes were as follows: 0-25 percent on December 20, January 23, March 9 and 12; and 26-50 percent on December 28, 29, January 1, 13, 14, 16, 19, February 1, 2, 3, 7, 9, 10, 13, 15, 17, 27 and March 15 and 18. Review of Resident 1's Medication Administration Record (MAR) for December 20, 2024, through March 18, 2025, revealed that the resident received 16 units of Humalog insulin subcutaneously on the above-mentioned dates. Interview with the Director of Nursing on March 20, 2025, at 11:18 a.m. confirmed that Resident 1's insulin was administered on the above-mentioned dates and not held per the physician's order. A quarterly MDS assessment for Resident 21, dated January 10, 2025, revealed that the resident was cognitively impaired, required assistance with care needs, had a history of falls without injury since the prior MDS assessment, and had diagnoses that included hypertension (high blood pressure). Physician's order for Resident 21, dated September 27, 2024, included an order for the resident to receive 50 milligrams (mg) of Metoprolol Succinate (a medication for high blood pressure) daily and to hold the medication if her systolic blood pressure was equal to or less than 90 mmHg or if her heart rate was equal to or less than 60 beats per minute. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Residents 21's MARs for September 27, 2024, through March 18, 2025, revealed that there was no documented evidence that the resident's blood pressure or heart rate was obtained prior to the administration of Metoprolol Succinate since the medication was ordered on September 27, 2024, through March 18, 2025. An interview with the Director of Nursing on March 20, 2025, at 11:18 a.m. confirmed that there was no documented evidence that Resident 21's blood pressure or heart rate was obtained per physician's orders prior to the administration of Metoprolol Succinate from September 27, 2024, through March 18, 2025. A significant change MDS assessment for Resident 75, dated January 20, 2025, revealed that the resident was cognitively intact, required assistance from staff for daily care needs, had an indwelling foley catheter (a soft, flexible plastic tube inserted in the bladder), and had diagnosis that included heart failure, obstructive uropathy, and diabetes mellitus. Physician's order for Resident 75, dated January 12, 2025, included an order for the resident to receive 50 milligrams of Metoprolol Succinate (a medication for high blood pressure) daily and to hold medication if blood pressure systolic is less than 110 mmHg and heart rate is less than 60 beats per minute. A review of Residents 75's January and February 2025 Medication Administration Record revealed that on January 25 the resident's blood pressure was 98/70 mmHg; on January 27 it was 106/65 mmHg; on January 31 it was 102/55 mmHg; on February 2 it was 106/68 mmHg; on February 10 it was 102/62 mmHg; and on February 18, 2025, it was 101/67 mmHg. An interview with the Director of Nursing on March 20, 2025, at 12:31 p.m. confirmed that physician's orders for Resident 75 were not followed and that the medication should have been held. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 47819 Based on facility policies, clinical record reviews, and staff interviews, it was determined that the facility failed to ensure that gastrostomy tube care was provided as ordered by the physician for one of 36 residents reviewed (Resident 17). The facility's policy regarding gastrostomy tubes (a tube inserted through the belly that delivers nutrition directly to the stomach), dated January 13, 2025, revealed that the facility would ensure that gastrostomy flushes were provided as ordered by the physician. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 17, dated December 12, 2024, indicated that the resident was cognitively impaired, did not speak, was totally dependent on staff for daily care needs, had a gastrostomy tube, and had diagnoses that included anoxic brain injury (due to a lack of oxygen to the brain). Physician's orders for Resident 17, dated June 21, 2024, included orders for the resident to have her gastrostomy tube flushed every four hours with 130 mL (milliliters) of free water. Review of Resident 17's clinical record, including the Treatment Administration Record and progress notes for February and March 2025, revealed that on February 1, 2025, at 1:00 a.m. and 5:00 a.m. the gastrostomy was flushed with 60 ml of free water; March 4, 2025, at 1:00 a.m. the gastrostomy tube was not flushed; March 9, 2025, at 1:00 a.m. and 5:00 a.m. was flushed with 180 ml of free water; March 10, 2025, at 1:00 a.m. was not flushed and at 5:00 a.m. was flushed with 150 ml of free water; March 14 at 1:00 a.m. and 5:00 a.m. was flushed with 120 ml and at 5:00 p.m. was flushed with 60 ml of free water; March 18, 2025, at 1:00 a.m. was not flushed and at 5:00 a.m. was flushed with 180 ml of free water. Interview with the Director of Nursing on March 18, 2025, at 1:44 p.m. confirmed that the gastrostomy tube was not flushed every four hours with 130 mL (milliliters) of free water as ordered by the physician on the dates and times listed above. 28 Pa. Code 211.12(d)(5) Nursing Services.

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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. 43856 Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to flush a peripherally-inserted central catheter (PICC- catheter inserted in a vein used to deliver fluids and/or medications) 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) prior to and/or after medication administration for two of 36 residents reviewed (Residents 1, 283). Findings include: The facility's policy regarding intravenous therapy (administration of fluids and/or medications directly into a person's vein), dated January 13, 2025, included to attach a 5 milliliter (ml) syringe of normal saline and confirm patency of vascular access device as per protocol prior to medication administration. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated February 18, 2025, revealed that the resident was cognitively intact, required substantial assistance to dependent with care needs, had an indwelling/suprapubic catheter (a flexible tube that drains urine from the bladder through the abdomen), and had a diagnosis of neurogenic bladder (bladder lacks control due to nerve or muscle problems). Physician's orders for Resident 1, dated March 15, 2025, included an order for the resident to receive one gram (gm) of Vancomycin (an antibiotic) intravenously (administration of fluids and/or medications directly into a person's vein) every evening. There was no documented evidence that Resident 1's physician was contacted for orders to flush the resident's PICC/midline with a saline solution prior to and/or after medication administration. Review of Resident 1's Medication Administration Record (MAR), dated March 2025, revealed that staff administered the one gm of Vancomycin intravenously on March 15, 16, 17 and 18, 2025, at 12:00 a.m. There was no documented evidence that Resident 1's PICC/midline was flushed with a saline solution prior to and/or after administration of the Vancomycin. Interview with the Director of Nursing on March 20, 2025, at 11:18 a.m. confirmed that there was no documented evidence that Resident 1's PICC/midline was flushed with a saline solution prior to and/or after the Vancomycin administration on the above-mentioned dates. An admission MDS assessment for Resident 283, dated March 16, 2025, revealed that the resident was cognitively intact, was independent with her daily care needs, had a PICC/midline catheter (flexible tube inserted into a vein in the upper arm for administering fluids and medication), and had a diagnosis that included sepsis due to pseudomonas (a life threatening condition that occurs when the immune system overreacts to an infection caused by bacteria). Physician's orders for Resident 283, dated March 11, 2025, included an order for the resident to receive two grams (gm) of Cefepime (an antibiotic) intravenously two times a day. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was no documented evidence that Resident 283's physician was contacted for orders to flush the resident's PICC/midline with saline solution prior to and/or after medication administration. Review of Resident 283's Medication Administration Record (MAR), dated March 2025, revealed that staff administered two gm of Cefepime intravenously on March 11 thru 19, 2025, at 8:00 a.m. and 8:00 p.m. There was no documented evidence that Resident 283's PICC/midline catheter was flushed with a saline solution prior to and/or after administration of the Cefepime. Interview with the Director of Nursing on March 19, 2025, at 1:54 p.m. confirmed that there was no documented evidence that Resident 283's PICC/midline was flushed with saline solution prior to and/or after the Cefepime administration on the above-mentioned dates. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 48941 Based on review of facility policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to clarify a resident's continuous oxygen order when not in use for one of 36 residents reviewed (Resident 1). Findings include: The facility's policy regarding oxygen therapy, dated January 13, 2025, indicated that oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences. Staff shall document the initial and ongoing assessment of the resident's condition warranting oxygen and the response to oxygen therapy. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated February 18, 2025, revealed that the resident was cognitively intact, required substantial assistance with care needs, received oxygen therapy, and had a diagnosis of congestive heart failure (the heart can not pump blood well enough to meet the body's needs). Physician's orders for Resident 1, dated November 21, 2024, included an order for the resident to receive continuous oxygen at a flow rate of 0-4 liters per minute via nasal cannula (tubes that deliver oxygen into the nostrils) to maintain pulse oximetry (measures blood oxygen levels) greater than 89 percent. Observations of Resident 1 on March 17, 2025, at 10:53 a.m. revealed that she had an oxygen concentrator (electrical machine that concentrates oxygen from the air) in her room that was turned off and the resident was not receiving oxygen. Interview with Resident 1 at that time indicated that she had stopped using the oxygen after she got back from the hospital. A nursing note for Resident 1, dated March 17, 2025, at 10:02 a.m. indicated that the resident's respirations were even and unlabored at rest and while on supplemental oxygen at 2 liters/minute via nasal cannula. Review of Resident 1's Medication administration record (MAR) for March 2025 revealed documentation that she received oxygen on March 17, 2025, at a flow rate of 3 liters/minute on the day, evening and night shifts. Observations of Resident 1 on March 18, 2025, at 2:38 p.m. revealed that her oxygen concentrator remained off and she was not receiving oxygen at that time. Interview with the Director of Nursing on March 19, 2025, at 1:07 p.m. confirmed that Resident 1's oxygen was ordered continuous, and that she was not receiving it. She also confirmed that the order for continuous oxygen should have been clarified. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 19102 Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to maintain accountability for controlled medications (drugs with the potential to be abused) for one of 36 residents reviewed (Resident 6). Findings include: The facility's policy regarding medication administration, dated January 13, 2025, indicated that staff were to sign the Medication Administration Record (MAR) after administering medications to residents. An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 6, dated January 27, 2025, revealed that the resident had moderate cognitive impairment, had frequent pain, received pain medication as needed, and received an opioid (a controlled pain medication). Physician's orders, dated February 17, 2025, included an order for the resident to receive 50 milligrams (mg) of Tramadol (narcotic pain reliever) every six hours as needed for moderate pain. A controlled drug accountability record for February and March 2025 revealed that 50 mg of Tramadol was signed out on February 24 at 11:54 a.m.; February 28 at 10:00 p.m.; March 7 at 7:56 a.m.; and March 14, 2025, at 8:30 p.m.; however, there was no documented evidence in the MAR that the Tramadol was actually given to the resident. Interview with the Director of Nursing on March 19, 2025, at 1:28 p.m. confirmed that there was no evidence of the Tramadol being administered to Resident 6 and that the nurse was to document on the MAR when the medication was given. 28 Pa. Code 211.9(a)(h) Pharmacy Services. 28 Pa. Code 211.12(d)(3)(5) Nursing Services.

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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. 19102 Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that the physician responded timely to a pharmacy recommendation for four of 36 residents reviewed (Residents 2, 23, 66, 68). Findings include: The facility's policy regarding medication regimen review, dated January 13, 2025, revealed that the consultant pharmacist was to perform a comprehensive review of each resident's medication regimen and clinical record at least monthly. The medication regimen review (MRR) included evaluating the resident's response to medication therapy to determine that the resident maintains the highest practical level of functioning and preventing or minimizing adverse consequences related to medication therapy. Recommendations were to be acted upon and documented by the facility staff and/or the prescriber. The prescriber was to accept and act upon suggestions or rejected and provided an explanation for disagreeing. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 2, dated December 13, 2024, revealed that the resident was cognitively impaired, received an antidepressant and antipsychotic medication, and had diagnoses that included dementia and depression. Physician's orders for Resident 2, dated May 2, 2024, and June 12, 2024, included orders for the resident to receive 10 milligrams (mg) of Lexapro (antidepressant medication) daily for depression and 2 mg of Quetiapine Fumarate (Seroquel- antipsychotic medication) twice a day for dementia with behavioral disturbances. A monthly pharmacy medication regimen review for Resident 2, dated October 18, 2024, indicated that the resident was receiving Lexapro and Seroquel, had no psychosis or behavioral disturbances, and it was recommended to document the continued necessity/benefit at the current dose or consider reduction, if appropriate, or note that a reduction was clinically contraindicated. There was no documented evidence that the physician responded to the pharmacist's recommendation. An interview with the Director of Nursing on March 19, 2025, at 2:57 p.m. confirmed that there was no documented evidence that the physician responded to the pharmacist's recommendation of Resident 2's medications in October 2024. A quarterly MDS assessment for Resident 23, dated February 4, 2025, revealed that the resident was cognitively intact, required assistance with care needs, and had a diagnosis of congestive heart failure (the heart can not pump blood well enough to meet the body's needs). (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A monthly pharmacy medication regimen review for Resident 23, dated October 18, 2024, revealed recommendations to discontinue as needed Zofran (medication used to treat nausea and vomiting) due to nonuse greater than 90 days. There was no documented evidence that the physician responded to the pharmacist's recommendation. A quarterly MDS assessment for Resident 66, dated January 21, 2025, revealed that the resident was cognitively impaired, required assistance with care needs, and had a diagnosis of cancer. A monthly pharmacy medication regimen review for Resident 66, dated October 18, 2024, revealed recommendations to discontinue the as needed loperamide (medication used to treat diarrhea) due to nonuse greater than 90 days. There was no documented evidence that the physician responded to the pharmacist's recommendation. A quarterly MDS assessment for Resident 68, dated February 7, 2025, revealed that the resident was cognitively impaired, required assistance with care needs, and had a diagnosis of chronic obstructive pulmonary disease. A monthly pharmacy medication regimen review for Resident 68, dated October 18, 2024, revealed recommendations to document the continued necessity/benefit for fluoxetine (medication used to treat depression) or attempt a dosage reduction. There was no documented evidence that the physician responded to the pharmacist's recommendation. An interview with the Director of Nursing on March 20, 2025, at 10:30 a.m. confirmed that there was no documented evidence that the physician responded to the pharmacist's October 2024 recommendations for Residents 23, 66, and 68. 28 Pa. Code 211.12(d)(3) Nursing Services.

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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. 48941 Based on review of facility policies, as well as observations and staff interviews, it was determined that the facility failed to label insulin with the date it was opened, failed to discard an expired insulin pen in one of two medication carts reviewed (North Hall), and failed to provide a separately-locked, permanently-affixed compartment in the refrigerator for the storage of controlled drugs (medications that can be abused). Findings include: The facility's policy regarding medication labeling and storage, dated January 13, 2025, indicated that when the original seal of a manufacturer's container or vial are initially broken, the container or vial will be dated. The nurse shall place a date opened sticker on the medication and enter the date opened and the new expiration date. The expiration date of the vial or container will be 30 days unless the manufacturer recommends another date or regulations/guidelines require different dating. The nurse will check the expiration date of each medication before administering it. All expired medications will be removed from the active supply and destroyed in the facility, regardless of the amount remaining. Controlled substances (medications with the potential to be abused) that require refrigeration are stored within a locked box with the refrigerator. The box must be attached to the inside of the refrigerator. Manufacturer's instructions for Humalog insulin Kwik pens (injectable medication to lower blood sugar levels), dated March 2013, revealed that any unused part of the Humalog insulin pen was to be discarded after 28 days of being opened and manufacturer's instructions for Novolin 70/30 insulin Kwik pens (injectable medication to lower blood sugar levels), dated August 24, 2023, revealed that any unused part of the Novolin 70/30 insulin pen was to be discarded after 28 days of being opened. Observations of the medication cart on North hall on March 19, 2025, at 2:46 p.m. revealed that an opened Humalog insulin Kwik pen for Resident 63 was labeled as being opened on February 3, 2025, and a Novolin 70/30 insulin Kwik pen for Resident 71 was opened and not dated. Interview with Licensed Practical Nurse 3 at that time confirmed that the Humalog Kwik pen for Resident 63 should have been discarded and the Novolin 70/30 Kwik pen for Resident 71 should have been dated when it was opened, and it was not. Observations in the facility's North Hall medication room refrigerator on March 19, 2025, at 2:46 p.m. revealed an unlocked box containing two unopened stock bottles of Ativan (a controlled medication for anxiety). Licensed Practical Nurse 3 attempted to lock the box containing the Ativan but was not able to, indicating it was broken. Interview with Licensed Practical Nurse 3 at that time confirmed that the box was not locked and should have been. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with Director of Nursing on March 20, 2025, at 10:25 a.m. confirmed that the Humalog Kwik pen for Resident 63 should have been discarded, the Novolin 70/30 Kwik pen for Resident 71 should have been dated when it was opened, and also confirmed that the box in the North hall refrigerator containing the Ativan should have been locked and it was not. She indicated that she knew it was faulty and had instructed the nurses to use the other box in the refrigerator for controlled medications. 28 Pa. Code 211.9(a)(1) Pharmacy Services. 28 Pa. Code 211.12(d)(5) Nursing Services.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. 19102 Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to obtain laboratory studies as ordered by the physician for one of 36 residents reviewed (Resident 53). Findings include: The facility's policy regarding laboratory specimens, dated January 13, 2025, revealed that the facility would provide or obtain laboratory services when ordered by a physician, physician assistant, nurse practitioner, or clinical nurse specialist in accordance with state law. The facility would provide or obtain laboratory services to meet the needs of its residents. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 53, dated December 18, 2024, revealed that the resident was cognitively intact, received dialysis services, received an anticonvulsant medication, and had diagnoses that included seizures and kidney failure. Physician's orders for Resident 53, dated September 5, 2021, included an order for staff to obtain a complete blood count with differential (CBC with diff - blood test that measures various components of the blood), complete metabolic panel (CMP - blood test that provides information about your body's chemical balance), Hemaglobin A1C (Hgb A1C- blood test that measures blood sugar over the past 2-3 months), lipid panel (blood test that measures the amount of fats in the blood), and levetiracetam level every three months. A physician's order, dated August 31, 2021, included an order for the resident to receive 500 milligrams (mg) of levetiracetam (anticonvulsant medication used to prevent seizures) daily on Monday, Tuesday, Wednesday, Thursday, Friday and Saturday. There was no documented evidence that staff obtained Resident 53's ordered laboratory tests after August 2024. Interview with Director of Nursing on March 19, 2025, at 1:28 p.m. confirmed that there was no evidence that Resident 53's laboratory studies were obtained as ordered every three months after August 2024. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.

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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. 19102 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 April 11, 2024, as well as a complaint visit on May 22, 2024, 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 March 20, 2025, identified repeated deficiencies related to a failure to develop care plans, care plan timing and revision, services provided to meet professional standards, to follow physician's orders, gastrostomy tube maintenance, oxygen therapy, preventing issues with the accountability of controlled medications (drugs with the potential to be abused), label/store drugs and biologicals, and to ensure proper infection control practices were followed. The facility's plan of correction for a deficiency regarding the development of a comprehensive person-centered care plan, cited during a survey ending April 11, 2024, revealed that audits would be completed. The results of the current survey, cited under F656, revealed that the QAPI committee was ineffective in correcting deficient practices related to the development of a comprehensive person-centered care plan. The facility's plan of correction for a deficiency regarding care plan timing and revision, cited during the survey ending April 11, 2024, 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 F657, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding care plan timing and revision. The facility's plan of correction for a deficiency regarding services provided meet professional standards, cited during the surveys ending April 11, 2024, and May 22, 2024, 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 F658, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding services provided meet professional standards. The facility's plan of correction for a deficiency regarding following physician's orders, cited during the survey ending April 11, 2024, revealed that the facility developed a plan of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F684, revealed that the QAPI committee was ineffective in correcting deficient practices related to following physician's orders. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's plan of correction for a deficiency regarding tube feeding management, cited during the survey ending April 11, 2024, 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 F693, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding tube feeding management. The facility's plan of correction for a deficiency regarding a failure to provide oxygen therapy as ordered by the physician, cited during the survey ending April 11, 2024, revealed that the facility would complete audits and the results would be reviewed as part of quality assurance. The results of the current survey, cited under F695, revealed that the facility's QAPI committee was ineffective in maintaining compliance with the regulation regarding providing oxygen therapy as ordered by the physician. The facility's plans of correction for deficiencies regarding the failure to account for controlled medications, cited during the survey ending April 11, 2024, revealed that the facility would complete audits and the results would be reviewed as part of quality assurance. The results of the current survey, cited under F755, revealed that the facility's QAPI committee was ineffective in correcting deficient practices related to the accountability of controlled medications. The facility's plan of correction for a deficiency regarding label/store drugs and biologicals, cited during the survey ending April 11, 2024, revealed that the facility developed a plan of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F761, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding label/store drugs and biologicals. The facility's plans of correction for deficiencies regarding infection control practices, cited during the survey ending April 11, 2024, revealed that the facility would complete audits and the results would be reviewed as part of quality assurance. The results of the current survey, cited under F880, revealed that the facility's QAPI committee was ineffective in correcting deficient practices related to infection control. Refer to F656, F657, F658, F684, F693, F695, F755, F761, F880. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(e)(1) Management.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 19102 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 for three of 36 residents reviewed (Residents 6, 75, 283). Findings include: CDC guidance on isolation precautions and Implementation of Personal Protective Equipment (PPE) use in Nursing Homes to Prevent Spread of Multidrug-Resistant Organisms (MDRO's - bacteria that have become resistant to certain antibiotics, and these antibiotics can no longer be used to control or kill the bacteria), dated July 12, 2022, indicates that MDRO transmission is common in skilled nursing facilities, contributing to substantial resident morbidity and mortality and increased healthcare costs. Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. CMS updated its infection prevention and control guidance effective April 1, 2024. The recommendations now include the use of EBP during high-contact care activities for residents with chronic wounds or indwelling medical devices, regardless of their MDRO status, in addition to residents who have an infection or colonization with a CDC-targeted or other epidemiologically important MDRO when contact precautions do not apply. The facility's policy regarding EBP, dated January 13, 2025, indicated that the facility will have the discretion in using EBP for residents who do not have a chronic wound or indwelling medical device and are infected or colonized with an MDRO that is currently targeted by CDC may be considered epidemiologically important. An order for enhanced barrier precautions will be obtained for residents with any of the following: Wounds (e. g. chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices (e.g. central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, PICC lines, midline catheters) even if the resident is not known to be infected or colonized with a MDRO. An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 6, dated January 27, 2025, revealed that the resident had moderate cognitive impairment, had a urinary tract infection, and received an antibiotic. Physician's orders for Resident 6, dated February 17, 2025, included orders for the resident to have an indwelling urinary catheter (a tube inserted and held in the bladder to drain urine). Observations of Resident 6 on July 18, 2025, at 12:14 p.m. revealed that the resident was in his room, and there was no signage or notification of the resident being on EBP posted at the resident's room, and there was no PPE observed in or around the resident's room. Interview with Registered Nurse 4 on March 18, 2025, revealed that a sign was usually put up when a resident was on EBP but she was not sure if the resident was on EBP. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395860	A. Building B. Wing	03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Loyalhanna Care Center	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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Director of Nursing on March 18, 2024, at 2:14 p.m. confirmed that the resident should have been on EBP due to having an indwelling urinary catheter. A significant change MDS assessment for Resident 75, dated January 20, 2025, revealed that the resident was cognitively intact, required assistance from staff for daily care needs, had an indwelling foley catheter (a soft, flexible plastic tube inserted in the bladder), and had diagnosis that included heart failure, obstructive uropathy, and diabetes mellitus. Observations during the facility tour on March 17 2025, at 10:50 a.m. revealed that Resident 75 was lying in bed. There was no signage or notification of the resident being on EBP posted at the resident's room, and there was no PPE observed in or around the resident's room. Interview with Licensed Practical Nurse 5 on March 17, 2025, at 11:07 a.m. confirmed that Resident 75 had an indwelling Foley catheter and should have had an EBP sign on his door. Interview with the Director of Nursing on March 19, 2025, at 2:55 p.m. confirmed that Resident 75 should have had an EBP sign on his door. An admission MDS assessment for Resident 283, dated March 16, 2025, revealed that the resident was cognitively intact, was independent with her daily care needs, had a midline catheter (flexible tube inserted into a vein in the upper arm for administering fluids and medication), and had a diagnosis that included sepsis due to pseudomonas (a life threatening condition that occurs when the immune system overreacts to an infection caused by bacteria). Observations during the facility tour on March 17, 2025, at 12:40 p.m. revealed that Resident 283 was sitting on the side of her bed. There was no signage or notification of the resident being on EBP posted at the resident's room, and there was no PPE observed in or around the resident's room. Interview with the Director of Nursing on March 19, 2025, at 1:52 p.m. confirmed that Resident 283 should have an EBP sign on her door as well as PPE for staff to utilize. 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.