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	04/02/2026

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on a review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that residents medication regimen was free from unnecessary psychotropic medication (drugs that affect a person's mental state, emotions, and behavior) for one of 35 residents reviewed (Resident 8).Findings include:The facility's policy regarding psychotropic medication use, dated January 1, 2026, indicated that psychotropic medications used on a PRN (as needed) basis must have a diagnosed specific condition and indication for use documented in the resident's medical record. Orders for PRN psychotropic medications, excluding antipsychotics, were to be limited to no more than 14 days, unless the attending physician or prescribing practitioner believed it was appropriate to extend the order beyond the 14 days. The medical record was to include documentation from the physician or prescriber for the rationale for the extended time period and was to indicate a specific duration.A quarterly Minimum Data Set (MDS) assessment (a federally mandated assessment of the resident's abilities and care needs) for Resident 8 dated February 28, 2026, indicated that the resident had cognitive impairment, required assistance from staff for daily care needs, received an anti-anxiety medication, and had a diagnosis of dementia.Physician's orders for Resident 8 dated November 27, 2025, included an order for the resident to receive 0.50 milligrams (mg) of Ativan (an antianxiety medication) every four hours as needed for restlessness/anxiety for 14 days.Review of the Medication Administration Records (MAR) for Resident 8 dated December 2025, and January, February and March 2026 revealed that 0.50 mg of Ativan was administered to the resident on December 2, 5-7, 9, 18, 19, 23, 24, and 27, 2025; January 2, 4, 9, 11, 22, 24, 25, 28, and 30; February 4, 5, 7, 9-11, 13, 17, 20, 21, 23-25; and March 2, 4-6, 8, 10, 12, 14, 15, 18-21, and 23, 2026. There was no evidence of a physician's order to continue the as needed Ativan beyond the 14 days ordered on November 27, 2025, and there was no documentation by a practitioner that included the rationale for extending the as needed Ativan beyond 14 days.Interview with the Director of Nursing on April 1, 2026, at 10:02 a.m. confirmed that there was no physician's order to continue the as needed Ativan beyond the initial order of 14 days or documented evidence from a physician or prescriber to indicate the rationale to extend the as needed Ativan for Resident 8 beyond 14 days.28 Pa. Code 211.12(d)(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 policies and clinical records, as well as staff interviews, it was determined that the facility failed to obtain laboratory results as ordered by the physician for one of 35 residents reviewed (Resident 6), failed to ensure that bowel protocols were followed as ordered by the physician for one of 35 residents reviewed (Resident 8), and failed to provide pain medication as ordered by the physician for one of 35 residents reviewed (Resident 9). Findings include:An annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 6, dated February 27, 2026, revealed that the resident was cognitively intact, required assistance from staff for daily care needs, had a diagnosis of end-stage renal disease (ESRD - a permanent condition that occurs when the kidneys are no longer able to function properly), and was receiving dialysis (a procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly). Physician's orders for Resident 6, dated March 17, 2026, included an order to call the dialysis center to obtain most recent lab results.Review of Resident 6's clinical record revealed no documented evidence that lab results were obtained by the facility.Interview with the Director of Nursing on April 1, 2026, at 2:17 p.m. confirmed that the physician's orders to obtain lab results for Resident 6 were not followed.A quarterly MDS assessment for Resident 8, dated February 28, 2026, revealed that the resident was cognitively impaired, was frequently incontinent of bowel movements, and had a diagnosis of dementia.Physician's orders for Resident 8, dated November 21, 2025, included orders for the resident to receive 30 milliliters of Milk of Magnesia as needed for constipation if no bowel movement by the third day; a 10 milligram Bisacodyl suppository rectally as needed if the Milk of Magnesia was not effective ; and a Fleets enema to be given rectally as needed for no bowel movement after the Milk of Magnesia and Bisacodyl suppository was given.Review of Resident 8's bowel records for January and February 2026 revealed that there was no documented evidence that the resident had a bowel movement from January 20 through 23 and February 10 through 13, 2026.Review of the January and February Medication Administration Records (MAR's) for Resident 8 revealed that staff did not initiate or follow the bowel protocol as ordered by the physician.Interview with the Director of Nursing on April 1, 2026, at 2:13 p.m. confirmed that the physician's orders for bowel medications were not followed for Resident 8.The facility's medication administration policy, dated January 1, 2026, indicated that medications were to be administered by licensed nurses, or other staff who were legally authorized to do so in the state, as ordered by the physician and in accordance with professional standards of practice.The facility's policy regarding pain management, dated January 1, 2026, indicated that the facility was to ensure that pain management was provided to residents who required such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences.An annual MDS assessment for Resident 9, dated February 9, 2026, revealed that the resident was moderately cognitively impaired, had pain almost constantly, received routine and as needed pain medications, and had diagnoses that included arthritis.A physician's order for Resident 9, dated June 11, 2025, included orders for the resident to receive 5-325 mg of Hydrocodone-Acetaminophen (narcotic pain medication) every six hours as needed for severe pain (a pain rating of 7-10) or per resident preference.A review of Resident 9's MARs for January, February, and March 2026 revealed that staff administered 5-325 mg of Hydrocodone-Acetaminophen on February 12 at 10:01 a.m. when the resident's pain level was a five, on March 6 at 7:30 p.m. when the resident's pain level was a one, and on January 1 at 8:09 a.m., January 3 at 9:50 a.m., January 7 at 9:32 a.m., January 17 at 9:39 a.m., , January 19 at 1:06 a.m., January 21 at 4:58 p.m., January 22 at 9:21 a.m., January 23 at 9:30 a.m., January 28 at 4:53 a.m., January 29 at 12:11 a.m., and January 31 at 9:41 a.m.; February 1 at 12:57 a.m. and 9:18 a.m., February 3 at 7:23 p.m., February 4 at 9:12 a.m. and 10:24 p.m., February 5 at 9:30 a.m., February 8 at 8:48 p.m., February 9 at 9:53 a.m., February 10 at 9:12 a.m., February 11 at 12:51 a.m. and 12:09 p.m., February 14 at 10:16 a.m., February 15 at 12:20 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a.m., February 17 at 7:11 p.m., February 18 at 8:30 p.m., February 19 at 9:15 a.m. and 11:56 p.m., February 20 at 9:08 a.m., February 23 at 7:39 a.m., February 25 at 12:02 a.m., February 26 at 1:52 a.m. and 11:45 p.m., and February 28 at 12:48 a.m.; and March 4 at 8:48 p.m., March 5 at 9:14 a.m., March 6 at 12:42 a.m., March 7 at 3:35 p.m., March 10 at 10:58 p.m., March 12 at 12:47 a.m., March 13 at 1:30 a.m., March 14 at 7:48 p.m., March 17 at 8:59 p.m., and March 18, 2026 at 2:05 p.m. when the resident's pain level was a six.Interview with the Director of Nursing on April 2, 2026, at 12:34 p.m. confirmed that staff did not administer Resident R9's pain medication as ordered by the physician.28 Pa. Code 211.12(d)(1)(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 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, facility contracts, clinical records, and staff interview, it was determined that the facility failed to maintain records relating to dialysis communication and collaboration for two of three residents reviewed for dialysis (Residents 6 and 86), and failed to provide a hemodialysis bedside emergency kit for bleeding (a kit that contains several items including a tourniquet, dressings and gloves) for one of three dialysis residents reviewed (Resident 86).Findings include:The facility's policy regarding hemodialysis, dated January 1, 2026, indicated that the facility would provide the necessary care and treatment consistent with professional standards, which includes the ongoing assessment of the residents' condition and monitoring for complications before and after dialysis treatment.Review of the dialysis contract, dated May 3, 2023, revealed that the nursing facility shall provide ongoing communication with the dialysis center in order to maintain safe and appropriate care.An annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 6, dated February 27, 2026, revealed that the resident was cognitively intact, required assistance from staff for daily care needs, had a diagnosis of end-stage renal disease (ESRD - a permanent condition that occurs when the kidneys are no longer able to function properly), and was receiving dialysis (a procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly). Physician's orders for Resident 6, dated November 18, 2025, included an order that the resident was to receive dialysis on Monday, Wednesday and Friday.Review of Resident 6's clinical record, revealed limited evidence resident assessments or communication related to the residents health status before and after dialysis was being shared between the facility and the dialysis centerAn admission MDS assessment for Resident 86, dated January 17, 2026, revealed that the resident was cognitively intact, required extensive assistance for daily care needs, and was receiving dialysis.Review of Resident 86's clinical record revealed an readmission date of January 13, 2026, with diagnoses that included end-stage renal disease and diabetes.Current physician's orders for Resident 86 revealed orders that included dialysis every Tuesday, Thursday, and Saturday at 11:00 a.m.Review of Resident 86's clinical record revealed limited evidence of communication between the facility and dialysis clinic. Dialysis communication documentation included January 15, and 21, 2026. Observations on April 2, 2026, at 12:10 p.m. revealed that there was no hemodialysis emergency kit located in the resident's room.Interview with the Director of Nursing on April 2, 2026, at 12:34 p.m. confirmed that Residents 6 and 86 had no or limited evidence of ongoing communication and collaboration between the facility and dialysis clinic, and also confirmed that Resident 86 should have had an emergency hemodialysis kit at bedside.28 Pa. Code 211.5(f)(viii) Medical Records.28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.Findings include:The facility's policy regarding hemodialysis, dated January 1, 2026, indicated that the facility would provide the necessary care and treatment consistent with professional standards, which includes the ongoing assessment of the residents' condition and monitoring for complications before and after dialysis treatment.Review of the dialysis contract, dated May 3, 2023, revealed that the nursing facility shall provide ongoing communication with the dialysis center in order to maintain safe and appropriate care.An annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 6, dated February 27, 2026, revealed that the resident was cognitively intact, required assistance from staff for daily care needs, had a diagnosis of end-stage renal disease (ESRD - a permanent condition that occurs when the kidneys are no longer able to function properly), and was receiving dialysis (a procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly). Physician's orders for Resident 6, dated November 18, 2025, included an order that the resident was to receive dialysis on Monday, Wednesday and Friday.Review of Resident 6's clinical record, revealed limited evidence resident assessments or communication related to the residents health status before and after dialysis was being shared between the facility and the dialysis centerAn admission MDS assessment for Resident (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	86, dated January 17, 2026, revealed that the resident was cognitively intact, required extensive assistance for daily care needs, and was receiving dialysis.Review of Resident 86's clinical record revealed an readmission date of January 13, 2026, with diagnoses that included end-stage renal disease and diabetes.Current physician's orders for Resident 86 revealed orders that included dialysis every Tuesday, Thursday, and Saturday at 11:00 a.m.Review of Resident 86's clinical record revealed limited evidence of communication between the facility and dialysis clinic. Dialysis communication documentation included January 15, and 21, 2026. Observations on April 2, 2026, at 12:10 p.m. revealed that there was no hemodialysis emergency kit located in the resident's room.Interview with the Director of Nursing on April 2, 2026, at 12:34 p.m. confirmed that Residents 6 and 86 had no or limited evidence of ongoing communication and collaboration between the facility and dialysis clinic, and also confirmed that Resident 86 should have had an emergency hemodialysis kit at bedside.28 Pa. Code 211.5(f)(viii) Medical Records.28 Pa. Code 211.12(d)(1)(3)(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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 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 four of 35 residents reviewed (Residents 2, 4, 76, 86). Findings include: The facility's policy for medication administration, dated January 1, 2026, indicated that staff are to sign the Medication Administration Record (MAR) after a medication is administered, and if the medication is a controlled substance, staff are to sign the narcotic book. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 2, dated February 28, 2026, indicated that the resident was cognitively intact, was independent for most daily care needs, had diagnosis that included Fibromyalgia, (long-term condition that involves widespread body pain), and was receiving routinely scheduled and as needed pain medication. Physician's orders for Resident 2, dated January 17, 2026, included for the resident to receive 5-325 milligrams (mg) of hydrocodone-acetaminophen (a narcotic pain medication) to be administered every 12 hours as needed for pain. Review of the controlled drug records (a form that accounts for each tablet/pill/dose of a controlled drug) for Resident 2 dated January 26, 2026, February 12, 2026, and February 26, 2026, revealed that a 5-325 mg hydrocodone-acetaminophen tablet was signed out on February 1, 2026, at 9:30 p.m.; February 7, 2026, at 10:00 p.m.; February 22, 2026, at 9:00 p.m.; March 6, 2026, at 9:00 p.m.; March 7, 2026, at 9:00 p.m.; March 13, 2026, at 9:00 p.m.; March 15, 2026, at 9:00 p.m.; and March 21, 2026, at 9:00 p.m. However, there was no documented evidence in Resident 2's clinical record that the signed-out doses of controlled medication were administered to the resident on the above-mentioned dates and times. A quarterly MDS assessment for Resident 4, dated January 17, 2026, indicated that the resident was cognitively intact, required assistance from staff for daily care needs, had diagnoses that included Multiple Sclerosis (a chronic autoimmune disease where the immune system mistakenly attacks the protective coating of nerves in the brain and spinal cord), and was receiving routinely scheduled and as needed pain medication. Physician's orders for Resident 4, dated May 7, 2025, included an order for the resident to receive 5 mg of oxycodone (a narcotic pain medication) every four hours as needed for moderate to severe pain. Review of the controlled drug record for Resident 4 dated March 2026, revealed that 5 mg of oxycodone was signed out to be administered on March 7, 2026, at 1:30 a.m.; March 13, 2026, at 9:00 p.m.; March 14, 2026, at 11:44 p.m.; March 15, 2026, at 10:00 p.m.; and March 21, 2026, at 6:30 p.m. However, there was no documented evidence in Resident 4's clinical record that the signed-out doses of oxycodone were administered to the resident on the above-mentioned dates and times. A quarterly MDS assessment for Resident 76, dated January 11, 2026, revealed that the resident was cognitively intact, required assistance from staff for daily care needs, had diagnoses that included multiple sclerosis, and was receiving routinely scheduled and as needed pain medication. Physician's orders for Resident 76, dated February 5, 2026, included an order for the resident to receive 10 mg of oxycodone every four hours as needed for breakthrough pain. Review of the controlled drug records for Resident 76 dated February and March 2026, revealed that 10 mg of oxycodone was signed out to be administered on February 22, 2026, at 8:00 p.m.; February 28, 2026, at 9:00 p.m.; March 7, 2026, at 1:30 a.m.; March 10, 2026, at 4:25 p.m.; March 13, 2026, at 8:00 p.m.; March 14, 2026, at 1:00 a.m.; March 15, 2026, at 8:10 p.m.; March 16, 2026, at 1:15 a.m.; March 19, 2026, at 8:00 p.m.; and March 20, 2026, at 12:20 a.m. However, there was no documented evidence in Resident 4's clinical record that the signed-out doses of controlled medications were administered to the resident on the above-mentioned dates and times. An admission Minimum Data Set assessment for Resident 86, dated January 17, 2026, revealed that the resident was cognitively intact, required assistance with personal care needs, and had diagnoses that included left hip fracture and chronic renal failure. Physician's orders for Resident 86, dated January 16, 2026, included an order for the resident to receive 5 mg of oxycodone every six hours as (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	needed for pain. Review of the controlled drug record for Resident 86, dated February 2026, revealed that 5 mg of oxycodone was signed out on February 26, 2026, at 4:23 p.m. and February 28, 2026, at 8:15 a.m. However, there was no documented evidence in Resident 86's clinical record that the signed-out doses of controlled medications were administered to the resident on the above-mentioned dates and times. Interview with the Director of Nursing on April 1, 2026, at 2:12 p.m. confirmed that there was no documented evidence in the clinical records of Residents 2, 4, 76 and 86 to indicate that the signed-out doses of controlled medications mentioned above were administered. 28 Pa. Code 211.9(a)(1) Pharmacy Services. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on a review of facility policy, resident interviews, observations, and staff interviews, it was determined that the facility failed to ensure that residents received foods that were served at appetizing temperatures. Findings include:The facility's policy regarding Food Temperatures, dated January 1, 2026, revealed that the facility will monitor food temperatures daily to ensure food is at the proper serving temperatures.Interview with a group of residents on March 31, 2026 at 11:00 a.m. revealed that their food is served cold when eating in the dining room. They stated that the food comes from the kitchen to the dining room and it is cold.Observations of tray line on March 31, 2026 at 12:08 p.m. revealed that the dietary staff were preparing the plates for the dining room. The plates were made and then placed on the trays for delivery into the dining room. There were no lids or covers placed over the food to keep it warm and there were times that the plate of food sat on the tray line for approximately five minutes before going to the dining room. The plates were then carried into the dining room with no lid or cover over the food. A test tray was requested from the kitchen on March 31, 2026 at 12:28 p.m. after the last of the residents in the dining room had been served. The test tray was served from the steam tables in the kitchen. At 12:34 p.m. the test tray temperature of the pureed lasagna was 114.9 degrees Fahrenheit and tasted cold, the temperature of the peas and carrots was 120.5 degrees F and tasted cold. The temperature of these items were cold to taste and not appetizing. An interview with the Regional Dietary Manager on March 31, 2026 at 12:30 p.m. revealed that the pureed lasagna and the peas and carrots should have been warm and not cold when served.28 Pa. Code 201.18(b)(1)(e)(1) Management.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on a review of facility policy, observations and staff interviews, it was determined that the facility failed to ensure that the proper food consistency was prepared for residents receiving a pureed diet as ordered by the physician. Findings include: The facility's policy regarding Therapeutic Diet Orders, dated January 1, 2026, revealed that residents would be provided food in the appropriate from as prescribed by the physician.The facility's menu for pureed lasagna for the meal served on March 31, 2026, revealed that the pureed lasagna should be placed into a food processor, blended until smooth and then staff should use the fork drip test and the spoon tilt test to confirm the texture is within the specifications.Observations during the lunch meal on March 31, 2026 at 12:28 p.m. revealed that the pureed lasagna had chunks in it that needed to be chewed. Interview with the Regional Dietary Manager on March 31, 2026 at 12:30 p.m. confirmed that the pureed lasagna had chunks in it and that it should not have.28 Pa. Code 211.12(d)(3) Nursing services. 28 Pa. Code 211.12(d)(5) Nursing services.

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to maintain the dignity of one of 35 residents reviewed (Resident 94) who had an indwelling urinary catheter (a flexible tube inserted into the bladder to drain urine).Findings include:A facility policy for Catheter Care dated January 1, 2026, indicated it is the policy of the facility to ensure that residents with indwelling catheters receive appropriate catheter care and maintain their dignity and privacy when indwelling catheters are in use. Privacy bags will be available and catheter drainage bags will be covered at all times while in use.Review of clinical records for Resident 94 revealed he was admitted to the facility on [DATE], with an indwelling urinary catheter, and had diagnosis that included neurogenic bladder (lack of bladder control due to brain, spinal cord or nerve problems). Observations of Resident 94 on March 30, 2026, at 10:50 a.m. revealed the resident laying in his bed with his urinary catheter drainage bag containing urine hanging on his bed frame and visible from the hallway.Interview with Nurse Aide 1 on March 30, 2026, at 10:54 a.m. revealed that the resident should have a privacy bag for his urinary catheter drainage bag. Interview with the Director of Nursing on March 31, 2026, 3:07 p.m. revealed that Resident 94's urinary catheter drainage bag should have had a privacy cover. 28 Pa. Code 201.29(c) Resident Rights.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 complete accurate Minimum Data Set assessments for three of 35 residents reviewed (Residents 2, 28, 35). Findings include: The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which gives instructions for completing Minimum Data Set (MDS) assessments (a mandated assessment of a resident's abilities and care needs), dated October 2025, revealed that Section N0415A1 (Antipsychotic) was to be checked if the resident took the medication during the seven-day look-back period; and Section N0450A (Antipsychotic Medication Review) was to be coded (1) Yes if the resident took an antipsychotic medication routinely since admission/entry or re-entry or the prior OBRA assessment, whichever was most recent. If the resident took an antipsychotic routinely, then Section N0450B (Has a gradual dose reduction been attempted) was to be coded (0) for no and (1) yes. If (1) yes was coded, then staff were to include the date that the Gradual Dose Reduction (GDR) was attempted. Section N0450D (Has a physician documented the GDR as clinically contraindicated) was to be coded (0) for no and (1) yes. If (1) yes was coded, staff were to include the date that the GDR was documented as clinically contraindicated. A care plan for Resident 2 dated March 24, 2025, indicated that the resident was receiving antipsychotic medications and that a GDR was documented as contraindicated on January 19, 2026, and February 6, 2026. A psychiatry note for Resident 2, dated February 6, 2025, indicated that a GDR of antipsychotic medications was clinically contraindicated because an attempted reduction would likely cause a recurrence of symptoms, would likely impair the resident's function, and would likely cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder. Review of the Medication Administration Record (MAR) for Resident 2, dated February 2026, revealed that the resident received antipsychotic medications at bedtime daily for the entire month. A quarterly MDS assessment for Resident 2, dated, February 28, 2026, revealed that Section NO415A1 was checked to indicate that the resident received an antipsychotic medication during the seven day look back period and Section N0450A was coded (1) yes, to indicate that the resident received an antipsychotic medication routinely since admission/entry or re-entry or the prior OBRA assessment; Section 0450B was coded (0) No, indicating that the resident did not receive a GDR and Section N0450D was coded (0) No, indicating that a physician had not documented that a GDR was clinically contraindicated. Interview with the Registered Nurse Assessment Coordinator on February 28, 2026, at 12:06 p.m. confirmed that Resident 2's MDS dated [DATE], was coded inaccurately regarding the GDR of antipsychotic medications. The RAI Manual, dated October, 2025, revealed that Section B0200 was to capture hearing, and the section was to be coded zero (0) adequate, one (1) for minimally impaired, two (2) for moderately impaired, or three (3) for highly impaired. A care plan for Resident 28, dated May 2, 2025, indicated that the resident had a communication problem related to a hearing deficit. Interviews with the resident during the survey March 30 - April 2, 2026, revealed that the surveyor had to speak loudly and directly to the resident for him to hear and understand. Interview with Resident 28's daughter on April 1, 2026, at 9:25 a.m. revealed that her father has never had a hearing aid and that sometimes she must yell repeatedly so he can hear her. However, a quarterly MDS assessment for Resident 28, dated January 24, 2026, revealed that Section B0200 was coded with a zero (0), indicating that the resident's hearing was adequate. Interview with the Licensed Practical Nurse Assessment Coordinator (LPNAC) on April 1, 2026, at 9:30 a.m. confirmed that Resident 28's hearing was impaired during the MDS review period and Section B0200 of the MDS assessment of January 24, 2026, should have been coded three (3) for moderately impaired. The RAI User's Manual, dated October 2025, indicated that the intent of Section N was to record the number of days, during the seven-day assessment period, that any type of injection, insulin, and/or select medications were received by the resident. Section N0415G1 was to (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Loyalhanna Care Center	535 McFarland Road Latrobe, PA 15650

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	be coded if the resident received a diuretic medication (water pill) during the seven-day assessment period. Physician's orders for Resident 35, dated February 28, 2026, included orders for the resident to receive 20 milligrams (mg) of Furosemide (diuretic) daily for heart failure. Review of the Medication Administration Record (MAR) for March 2026 revealed that the resident received Furosemide during the assessment period. However, an admission MDS assessment for Resident 35, dated March 2, 2026, revealed that Section N0415G1 was coded to indicate that the resident had not received a diuretic medication. Interview with the Director of Nursing on April 2, 2026, at 12:34 p.m. confirmed that MDS assessment for Resident 35 was coded inaccurately. 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 policies and clinical records reviews, as well as observations and staff interviews, it was determined that the facility failed to develop comprehensive care plans that included specific and individualized interventions to address the care needs of one of 35 residents reviewed (Resident 3). Findings include:The facility's policy regarding comprehensive care plans, dated January 1, 2026, indicated that the facility will develop and implement a comprehensive person-centered care plan for each resident consistent with resident rights, that include 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. An annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 3 dated March 13, 2026, indicated the resident was cognitively intact, was independent for most of her daily care needs, and was frequently incontinent of bowel. Review of Resident 3's bowel record dated March 3, 2026, through April 1, 2026, indicated that the resident was incontinent of bowel five times.There was no documented evidence that a care plan was developed to address Resident 3's specific and individualized care needs related to being frequently incontinent of bowel.Interview with the Director of Nursing on April 2, 2026, at 10:32 a.m. confirmed that an individualized care plan and interventions was not developed related to Resident 3 being incontinent of bowel and should have been. 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. Review of policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to revise/update care plans for three of 35 residents reviewed (Residents 28, 76).Findings include: The facility's policy regarding care plans, dated January 1, 2026, indicated that the purpose was to provide a consistent process for reviewing and revising the care plan for those residents experiencing a status change. The care plan will be updated with the new or modified interventions. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 28, dated January 24, 2026, indicated that the resident was moderately cognitively impaired, usually understood and usually understands, required assistance from staff for his daily care needs and had diagnoses that included, benign prostatic hyperplasia (enlargement of the prostate gland that squeezes the urethra, which causes symptoms of frequent urination and difficulty starting urination), and had an indwelling urinary catheter (a flexible thin tube inserted through the urethra and into the bladder to allow for urine drainage) in place. Resident 28 utilized a leg bag (a bag strapped to his upper thigh or leg) to collect the urine during his waking hours. Physician's orders for Resident 28, dated January 21, 2026, included an order for a 16 French foley catheter. Observations of Resident 28, on March 30, 31 and April 1, 2, 2026, at 10:30 a.m., 1:02 p.m., 9:25 a.m., and 12:10 p.m. respectively, revealed that he was wearing a leg bag. Interview with Resident 28's daughter on April 1, 2026, at 9:25 a.m. indicated that her father has had a catheter for years and that the leg bag makes it easier for him to move about during the day. She revealed that staff put the leg bag on in the morning, and remove it at bedtime and place a large drainage bag in its place. Interview with the Director of Nursing on April 1, 2026, at 3:12 p.m. confirmed that Resident 28's care plan should have been updated to reflect that he utilizes a leg beg from the time he gets up until he goes to bed at night, and it was not. A quarterly MDS assessment for Resident 76, dated January 11, 2026, indicated that the resident was cognitively intact, required assistance from staff for daily care needs, and had diagnoses that included Multiple Sclerosis (a chronic autoimmune disease where the immune system mistakenly attacks the protective coating of nerves in the brain and spinal cord). A care plan for Resident 76 dated February 28, 2023, indicated that the resident had the potential for impaired skin integrity with an intervention dated July 8, 2026, to have a lymphedema pump system (a prescription-only medical device designed to treat chronic swelling (edema) by promoting the movement of lymphatic fluid out of affected limbs) applied to her bilateral lower extremities at low setting for one hour per extremity. Review of physician's orders revealed that the order for Resident 76's lymphedema pumps was discontinued on August 23, 2025, and there was no documented evidence in the Resident's treatment administration record that she was currently using the lymphedema pumps. Interview with the Director of Nursing on April 2, 2026, at 10:32 a.m. confirmed that Resident 76's care plan was not revised when the lymphedema pumps were discontinued, and it should have been. 28 Pa. Code 211.11(d) Resident care plan.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on review of policies and clinical records, as well as resident and staff interviews, it was determined that the facility failed to ensure that a resident who was incontinent of bowel received appropriate treatment and services to restore as much normal bowel function as possible for one of 35 residents reviewed (Resident 3), and failed to ensure that physician's orders for an indwelling urinary catheter were followed for one of 35 residents reviewed (Resident 4).Findings include: The facility's policy regarding bowel and bladder management and training, dated January 1, 2026, indicated that the purpose of the policy was to promote continence, maintain resident dignity, prevent complications (skin breakdown, urinary tract infections, constipation, fecal impaction), and meet regulatory requirements through individualized bowel and bladder assessments, training, and management. The bowel training program is a planned bowel evacuation schedule utilizing diet, fluids, activity, positioning, and medications as needed. Bowel assessments were to be completed on admission, quarterly, with a significant change, or post hospitalization. Based on assessments findings and resident goals, the least restrictive and most restorative interventions are used first. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 3 dated September 12, 2025, indicated the resident was cognitively intact, required supervision or touch assist for toileting hygiene, was always continent of bowel and had diagnoses that included Schizoaffective disorder, bipolar type (a chronic mental health condition combining schizophrenia symptoms (hallucinations, delusions) with severe mood episodes (mania and sometimes depression)).A quarterly MDS for Resident 3 dated December 13, 2025, indicated the resident was cognitively intact, required partial to moderate assistance for toileting hygiene, and was occasionally incontinent of bowel. An annual MDS assessment for Resident 3 dated March 13, 2026, indicated the resident was cognitively intact, was independent for most of her daily care needs, and was frequently incontinent of bowel. There was no documented evidence that a bowel assessment was completed quarterly to identify restorative interventions to promote bowel continence and maintain resident dignity. Interview with the Director of Nursing on April 2, 2026, at 10:32 a.m. confirmed that there was no documented evidence that bowel assessments were completed quarterly for Resident 3 per the facility policy. A quarterly MDS assessment for Resident 4, dated January 17, 2026, indicated that the resident was cognitively intact, required assistance from staff for daily care needs, had an indwelling urinary catheter, had diagnoses that included neurogenic bladder (loss of bladder control caused by damage to the nerves, spinal cord, or brain).Physician's orders for Resident 4 dated June 15, 2025, included for staff to change the Resident's suprapubic catheter (an indwelling urinary catheter inserted through a small incision in the lower abdomen/suprapubic area) every 21 days and as needed for blockage or displacement. Review of the Treatment Administration Record and nurses' notes for Resident 4 dated October 2025 through March 2026, revealed there was no documented evidence that the suprapubic catheter was changed in the 42 days between October 18, 2025, and November 29, 2025, and no documented evidence it was changed during the 48 days between February 8, 2026, and March 28, 2026. Interview with the Director of Nursing on April 2, 2026, at 8:22 a.m. confirmed that there was no documented evidence that suprapubic catheter was changed as ordered by the physician on the above-mentioned dates. 28 Pa. Code 211.12(d)(1)(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. 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 plan of corrections for an annual survey ending March 20, 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 April 2, 2026, identified repeated deficiencies related to care plan creation, care plan revisions, quality care, pharmaceutical services, food in a form to meet an individuals needs, and infection control.The facility's plan of correction for a deficiency regarding care plan creation, cited during the survey ending March 20, 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 F656, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure that care plans were created timely.The facility's plan of correction for a deficiency regarding care plan revision, cited during the survey ending March 20, 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 F657, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure that care plans were revised timely.The facility's plan of correction for a deficiency regarding quality care, cited during the survey ending March 20, 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 that quality care was provided.The facility's plan of correction for a deficiency regarding pharmaceutical services, cited during the survey ending March 20, 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 F755, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure that pharmaceutical services were appropriately maintained.The facility's plan of correction for a deficiency regarding food served in a form to meet an individual's needs, cited during the survey ending March 20, 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 F805, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure that food was served to meet an individuals needs.The facility's plan of correction for a deficiency regarding infection control, cited during the survey ending March 20, 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 F880, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure that infection control was properly maintained.Refer to F656, F657, F684, F755, F805, 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. 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 proper infection control practices were followed while providing medications for one of 35 residents reviewed (Resident 67).Findings include:The facility's policy regarding medication administration, dated January 1, 2026, indicated that staff were to remove the medication from the source, taking care not to touch the medication with their bare hand. Observations during medication administration on April 1, 2026, at 8:08 a.m. revealed that Registered Nurse 2 prepared to administer medications to Resident 67 and took out pills from the medicine cup with her bare hands and placed them in a bag to be crushed. She then administered the medications to Resident 67. Interview with Registered Nurse 2 on March 11, 2025, at 8:10 a.m. confirmed that she should not have touched the medication with her bare hands. Interview with the Director of Nursing on April 1, 2026, at 3:04 p.m. confirmed that staff were not to touch residents' medications with their bare hands. 28 Pa. Code 211.12(d)(1)(5) Nursing services.