

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395977	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2026
NAME OF PROVIDER OR SUPPLIER Terrace Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 410 Terrace Drive Uniontown, PA 15401	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. Based on review of the Resident Assessment Instrument User's Manual and clinical records, and staff interview, it was determined that the facility failed to make certain that comprehensive Minimum Data Set assessments were accurate and fully completed for four of seven residents (Resident R7, R21, R32, and R81). Findings include: The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which gives instructions for completing Minimum Data Set Assessments (MDS - periodic assessment of care needs) dated October 2025, indicated that Section C: Cognitive Patterns, Question C0100 Should Brief Interview for Mental Status Be Conducted? (BIMS) should be coded as 0 if the resident is rarely/never understood, or it should be coded 1, and the BIMS assessment should be completed if the resident is at least sometimes understood. Section D: Mood, Question D0100 Should Resident Mood Interview Be Conducted? should be coded as 0 if the resident is rarely/never understood, and or it should be coded 1, and the assessment should be completed if the resident is at least sometimes understood. -Resident R7 had an MDS completed on 5/7/26. Review of Section B: Hearing, Speech, and Vision, Question B0700 indicated that Resident R7 is sometimes understood. Review of Section C: Cognitive Patterns, Question C0100 indicated that Resident R7 is rarely understood, and the BIMS assessment was not completed. Review of Section D: Mood, Question C0100 indicated that Resident R7 is rarely understood, and the Resident Mood Interview assessment was not completed. -Resident R21 had an MDS completed on 5/11/26. Review of Section B: Hearing, Speech, and Vision, Question B0700 indicated that Resident R21 is sometimes understood. Review of Section C: Cognitive Patterns, Question C0100 indicated that Resident R21 is rarely understood, and the BIMS assessment was not completed. Review of Section D: Mood, Question C0100 indicated that Resident R21 is rarely understood, and the Resident Mood Interview assessment was not completed. -Resident R32 had an MDS completed on 7/16/26. Review of Section B: Hearing, Speech, and Vision, Question B0700 indicated that Resident R32 is understood. Review of Section C: Cognitive Patterns, Question C0100 indicated that Resident R32 is rarely understood, and the BIMS assessment was not completed. Review of Section D: Mood, Question C0100 indicated that Resident R32 is rarely understood, and the Resident Mood Interview assessment was not completed. -Resident R81 had an MDS completed on 7/20/26. Review of Section B: Hearing, Speech, and Vision, Question B0700 indicated that Resident R81 is sometimes understood. Review of Section C: Cognitive Patterns, Question C0100 indicated that Resident R81 is rarely understood, and the BIMS assessment was not completed. Review of Section D: Mood, Question C0100 indicated that Resident R81 is rarely understood, and the Resident Mood Interview assessment was not completed. During an interview on 7/23/26, at approximately 12:00 p.m. the Resident Nurse Assessment Coordinator Employee E19 confirmed that the facility failed to make certain that comprehensive Minimum Data Set assessments were accurate and fully completed for four of seven residents. 28 Pa. Code: 211.5(f) Clinical records.		

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 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility policy and records and staff interviews, it was determined that the facility failed to ensure that facility nursing personnel maintain current CPR (cardiopulmonary resuscitation) certification for Healthcare Providers through a CPR provider whose training includes a hands-on session either in a physical or virtual instructor-led setting in accordance with accepted national standards for 16 of 33 licensed nurses: Licensed Practical Nurse (LPN) Employees E1, E2, E3, E4, E5, E6, E7, E8, E9, E10, E11, E12, and Registered Nurse (RN) Employees E13, E14, E15, E16).Review of the facility, Cardiopulmonary Resuscitation CPR dated [DATE], indicated Licensed nurses, respiratory therapists, and van drivers will hold active CPR certification for healthcare providers whose course content and staff performance are validated via a hands-on session either in a physical or virtual instructor-led setting in accordance with accepted national standards. Courses completed in on-line only format are not acceptable.On [DATE], the facility provided a list of 33 currently employed licensed nurses.Review of the CPR certification cards for LPN Employees E1, E2, E3, E4, E5, E6, E7, E8, E9, E10, E11, E12, and RN Employees E13, E14, E15, E16 indicated the certification was for an online-only CPR class, for non-healthcare providers, that did not include a hands-on session.During an interview on [DATE], at 1:30 p.m. Human Resources Director Employee E17 confirmed the above employees did not have the appropriate CPR certification for licensed nurses.During an interview on [DATE], at approximately 2:00 p.m. the Nursing Home Administrator and the Director of Nursing confirmed that the facility failed to ensure that facility nursing personnel maintain current CPR certification for Healthcare Providers through a CPR provider whose training includes a hands-on session either in a physical or virtual instructor-led setting in accordance with accepted national standards for 16 of 33 licensed nurses.28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code 211.12(d)(1)(5) Nursing services		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, documents, clinical records, and staff interviews, it was determined that the facility failed to ensure that residents were free from significant medication errors for two of ten residents (Resident R13 and Resident R53). Findings include: Review of facility policy Medication Administration dated 1/15/26, indicated that medications are administered only as prescribed by the provider. Review of Resident R13's admission record indicated he was admitted to the facility on [DATE]. Review of Resident R13's Minimum Data Set (MDS - mandated assessment of a resident's abilities and care needs) dated 4/30/26, included diagnoses of type 2 diabetes (disease where the body either doesn't make enough insulin or doesn't use it properly) and chronic kidney disease (long term disease where kidneys slowly lose their ability to filter waste and extra fluid from the body). Review of a physician's order dated 2/28/26, indicated Resident R13 to receive 2 units of insulin lispro subcutaneously twice daily and hold if blood sugar less than 150. Review of Resident R13's medication audit report from 7/1/26, through 7/23/26 revealed the following related to the administration of insulin lispro: 7/3/26: 5:00 p.m. dose administered with blood sugar of 125.7/13/26: 5:00 p.m. dose administered with blood sugar of 132.7/22/26: 5:00 p.m. dose administered with blood sugar of 146. Review of Resident R53's admission record indicated he was admitted to the facility on [DATE]. Review of Resident R53's Minimum Data Set (MDS - mandated assessment of a resident's abilities and care needs) dated 5/14/26, included diagnoses of type 2 diabetes (disease where the body either doesn't make enough insulin or doesn't use it properly) and chronic kidney disease (long term disease where kidneys slowly lose their ability to filter waste and extra fluid from the body). Review of a physician's order dated 1/19/26, indicated Resident R53 to receive 10 units of insulin aspart subcutaneously before meals for blood sugars and hold if blood sugar less than 200. Review of Resident R53's medication audit report from 7/1/26, through 7/23/26 revealed the following related to the administration of insulin aspart: 7/4/26: 8:00 a.m. dose administered with blood sugar of 187; 12:00 p.m. dose administered with blood sugar of 154.7/8/26: 8:00 a.m. dose administered with blood sugar of 138; 12:00 p.m. dose administered with blood sugar of 137.7/11/26: 8:00 a.m. dose administered with blood sugar of 167.7/13/26: 8:00 a.m. dose administered with blood sugar of 154; 12:00 p.m. dose administered with blood sugar of 154.7/14/26: 8:00 a.m. dose administered with blood sugar of 164; 12:00 p.m. dose administered with blood sugar of 158; and 4:00 p.m. dose administered with blood sugar of 139.7/22/26: 8:00 a.m. dose administered with blood sugar of 165. During an interview on 7/23/26, at approximately 11:00 a.m. the Director of Nursing confirmed that the orders for insulin aspart were specifically administered outside of the parameters set in the physician order. During an interview on 7/23/26, at approximately 1:10 p.m. the Nursing Home Administrator confirmed that the facility failed to ensure that residents were free from significant medication errors for two of ten residents. 28 Pa Code 201.14(a) Responsibility of licensee.28 Pa. Code 211.10(c) Resident care policies.28 Pa Code 211.12(d)(1)(3)(5) 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. Based on review of facility policy, observations, and staff interview, it was determined that the facility failed to make certain that medications and medical supplies were stored and/or disposed of appropriately in one of two medication rooms (Second Floor medication room) and two of two medical supply rooms (Second and Third Floor medical supply rooms). Findings include: Review of the United States Food and Drug Administration prescribing information for Aplisol (sterile, liquid solution of tuberculin purified protein derivative (PPD) used as an intradermal skin test to help healthcare providers detect if a person has been infected with the bacteria that causes tuberculosis) dated November 2013, indicated, Vials in use for more than 30 days should be discarded). Review of the facility policy, Storage and Expiration Dating of Medications and Biologicals dated 1/15/26, indicated, Facility should ensure medications an biological that: (1) have an expired date on the label; (2) have been retained longer than recommended by manufacturer or supplier guidelines; or (3) have been contaminated or deteriorated, are stored separate from other medications until destroyed or returned to the pharmacy or supplier. During an observation of the Second Floor supply room on 7/21/26, at 7:06 a.m. the following was noted:(1) Wound vacuum foam with an expiration date of 10/27/24.(1) Wound vacuum foam with an expiration date of 11/2024.(1) Wound vacuum foam with an expiration date of 12/22/24.(1) Wound vacuum foam with an expiration date of 1/2025.(1) Wound vacuum foam with an expiration date of 9/1/25.(2) Wound vacuum foam with an expiration date of 5/10/26,(111) sterile water ampules with an expiration date of 3/21/26(50 count) box glucose test strips with an expiration date of 11/20/25.(9) Luer lock caps with an expiration date of 5/31/26.(4) Connectors with caps with an expiration date of 11/28/25.(1) opened, non-sterile vial adapter.(1) unwrapped normal saline flush.(1) IV catheter with an expiration date of 6/30/25.(1) Transparent dressing with an expiration date of 6/3/26.(88) Collection tubes with an expiration date of 1/31/26. During an observation of the Second Floor medication room refrigerator on 7/21/26, at 7:19 a.m. the following was noted:(1) vial of Aplisol, partially used and undated. During an observation of the Third Floor supply room on 7/21/26, at 7:41 a.m. the following was noted:(75) sterile water ampules with an expiration date of 6/5/26(15) Miralax packets with an expiration date of 03/2025(1) Safety needle with an expiration date of 5/11/26 During an interview on 7/23/26, at approximately 2:00 p.m. the Nursing Home Administrator and the Director of Nursing confirmed the facility failed to make certain that medications and medical supplies were stored and/or disposed of appropriately in one of two medication rooms (Second Floor medication room) and two of two medical supply rooms (Second and Third Floor medical supply rooms). 28 Pa Code: 201.14 (a) Responsibility of licensee.28 Pa Code: 201.18 (b)(1)(e)(1) Management.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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, and interviews with staff, it was determined that the facility failed to make certain residents were provided necessary treatment and services, consistent with professional standards of practice, to prevent pressure ulcers (PU/PIs - injuries to skin and underlying tissue resulting from prolonged pressure on the skin) for two of six residents (Resident R4 and R24). Findings include: Review of facility policy Pressure Injury Prevention and Management dated 1/15/26, indicated residents admitted with existing pressure injuries will receive necessary treatment and services consistent with professional standards of practice. New pressure injuries will not develop unless the individual's clinical condition demonstrates that they were unavoidable. Review of the clinical record revealed Resident R4 was admitted to the facility on [DATE]. Review of Resident R4's Minimum Data Set (MDS - a periodic assessment of care needs) dated 5/7/26, indicated diagnoses of dementia (a group of symptoms that affects memory, thinking and interferes with daily life), a stroke and heart fibrillation. Question M0150 was coded 1 yes, resident is at risk of developing pressure ulcers/injuries. Review of a physician order dated 11/20/25, indicated air mattress to bed, check for functioning. Review of a progress note dated 3/5/26, identified Resident R4 had developed a DTI (pressure induced injury with deep purplish tissues) identified by staff on 3/2/26, measuring 2cm x 3.5 cm and the wound Nurse Practitioner indicated, The patient has a pressure injury. Recommend ongoing pressure reduction and turning/repositioning precautions per protocol, including pressure reduction to the heels and all bony prominences. All prevention measures were discussed with the staff at the time of the visit. Review of the clinical record revealed Resident R24 was admitted to the facility on [DATE]. Review of Resident R24's MDS dated [DATE], indicated diagnoses of dementia, psychotic disturbance, anxiety and cognitive communication deficit. Question M0150 was coded 1 yes, resident is at risk of developing pressure ulcers/injuries. An MDS dated [DATE], Section GG0070 identified Resident R24 was dependent (requires the caregiver to perform all the care) for bed mobility. Review of Resident R24's physician orders dated 11/21/25 indicated bilateral enabler bars for bed mobility and a pressure reduction mattress. Review of a progress note dated 5/21/26, indicated that staff had found a pressure ulcer on 5/20/26, and was identified as a new stage III wound measuring 1 cm x 0.8 cm x 0.2 cm with 0% eschar, 60% granulation tissue and 20% slough and the Wound Nurse Practitioner indicated The patient is at increased risk for developing skin breakdown and moisture associated skin damage due to fecal and urinary incontinence, inability to preform self-care. During an interview on 7/21/26, at approximately 11:15 a.m., the Director of Nursing confirmed that the facility failed to make certain Residents R4 and R24 were provided necessary treatment and services, consistent with professional standards of practice, to prevent pressure ulcers. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 211.10(c)(d) Resident care policies. 28 Pa. Code: 211.12(d)(1)(2)(5) Nursing services.		

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. Based on clinical record reviews and staff interviews, it was determined that the facility failed to ensure that the Psychiatry Group provided progress notes for continuity of care with each visit for one of two residents reviewed (Resident 39). Findings include: Review of a Minimum Data Set (MDS- periodic review of resident care needs) dated 6/3/26, indicated Resident R39 had a diagnosis of schizophrenia (a serious medical condition involving a breakdown of the relation between thoughts, emotions and behaviors leading to faulty perception, inappropriate actions and feelings and delusions). Review of Resident R39's clinical record identified that he utilizes an outside resource for his mental health care. During an interview on 7/21/26, at approximately 8:10 a.m., Resident R39 stated that he goes to [outpatient therapy] every three months for his care and medication, so he has no issues getting his medication required for his mental health. Review of Resident R39's clinical record did not identify any progress notes or documentation from [outpatient therapy] therapists related to the continuity of care for Resident R39's mental health. Stated he had been at the clinic in January, April and accidentally in May again. During an attempt to get documentation on 7/21/26, at approximately 12:11 p.m., the Director of Nursing stated that she called the clinic and was sent to Medical Record dept and left a message. During a phone conversation with the clinic, on 7/21/26, at approximately 12:15 p.m., the Medical Records staff stated that the facility needed Resident R39 to sign a form allowing the clinic to send over records, although he was a resident of the facility. She stated she would send over the form. During an interview on 7/21/26, at approximately 1:15 p.m., the DON stated she had them fax the form and she would have it signed by resident. During an interview on 7/22/26, at 9:43 a.m., the Assistant Director of Nursing Employee E20 stated the clinic did not send any documentation and that the facility to ensure that the Psychiatry Group provided progress notes for continuity of care with each visit for one of two residents reviewed (Resident 39). 28 Pa. Code 211.5(f) Clinical Records.		

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F 0940 Level of Harm - Potential for minimal harm Residents Affected - Many	Develop, implement, and/or maintain an effective training program for all new and existing staff members. Based on review of facility personnel in-service training records, and staff interview, it was determined that the facility failed to provide training on emergency preparedness annually to all staff members. Findings include: Review of the United States Code of Federal Regulations S483.73(d)(ii) Emergency Preparedness indicated, The LTC (long-term care) facility must: Provide emergency preparedness training at least annually and Maintain documentation of the training. During an interview on 7/23/26, at approximately 12:46 p.m. the Director of Maintenance Employee E18 confirmed that emergency preparedness training is only provided during new-employee orientation and is not completed annually with each staff member. During an interview on 7/23/26, at approximately 2:00 p.m. the Nursing Home Administrator confirmed that the facility failed to provide training on emergency preparedness annually to all staff members. 28 Pa Code: 201.14 (a) Responsibility of licensee. 28 Pa Code: 201.18 (b)(1) Management. 28 Pa Code: 201.20 (a)(3) Staff development.		