STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396021	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Redstone Highlands Health Care	6 Garden Center Drive Greensburg, PA 15601

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 31760 Based on review of policies, investigative reports, and residents' clinical records, as well as staff interviews, it was determined that the facility failed to ensure that residents were free from neglect caused by a failure to follow a resident's care plan for assisting with Activities of Daily Living (ADL's) and preventing falls for one of three residents reviewed (Resident 1), resulting in a fall and fracture for the resident. Findings include: The facility's policy regarding resident abuse, dated September 27, 2024, revealed that all management and staff are responsible to ensure that every resident will be free from verbal, sexual, physical, or mental abuse, corporal punishment, involuntary seclusion, neglect, retaliation, humiliation or misappropriation of resident property. That neglect refers to a failure through inattentiveness, carelessness, or omission to provide timely, consistent, safe, adequate and appropriate services, treatment and care, including but not limited to nutrition, medication, therapies and ADL's. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated March 19, 2025, revealed that the resident was understood, could understand others, and had a diagnosis of morbid obesity (a disorder that involves having too much body fat, which increases the risk of health problems). The resident's care plan, dated September 17, 2020, revealed that the resident was at risk for falls related to the need for assistance with his balance. A care plan, dated October 10, 2023, revealed that the resident had a communication problem related to his cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) and staff was to ensure/provide a safe environment. A care plan, dated May 15, 2024, revealed that the resident had an ADL self-care deficit related to his decreased mobility and was as assist from two staff for his bed mobility and transfers. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	A nursing note for Resident 1, dated March 28, 2025, at 3:20 p.m. revealed that the nurse aide informed the nurse that the resident had fallen. The nurse entered the room, and the resident was observed on the left side of the bed on the floor on his right side. The resident stated that he fell and his hip hurts. The resident was assessed by the nurse prior to moving him from floor and back into bed. The resident had small scratches to his right elbow. The areas were cleansed with saline and left open to air. No other injuries were noted at this time. The physician, hospice, and the resident's family member were notified of the incident. New orders were received for an x-ray of his right hip and right femur (the upper leg bone, extending from the hip to the knee) and for bilateral landing mats (mats placed to cushion the fall of a resident who rolls out of bed). The resident was medicated with Oxycodone (a narcotic pain medication to treat moderate to severe pain) for pain and will monitor. A nursing note for Resident 1, dated March 28, 2025, at 3:37 p.m., revealed that at 2:16 p.m. the resident was receiving care from the nurse aide and the resident fell from his bed. The reason for the fall was that the resident leaned too far over causing him to fall out of his bed. A nursing note for Resident 1, dated March 28, 2025, at 6:45 p.m. revealed that the x-ray of the resident's right hip showed an intertrochanteric fracture (a break in the bone (femur) just below the hip joint). The exact clinical age indeterminate (not exactly known) although appears likely either subacute (rather recent onset) or old healed rather than acute (sudden and severe, but of short duration). A physician's note for Resident 1, dated April 2, 2025, revealed that the resident was evaluated for right hip pain. The patient fell a few days ago and reported pain in the right hip. X-rays done with a reading of chronic verses acute fracture of his right hip. The patient is hospice, and family is not interested in sending to the hospital. On the exam he had swelling to his right hip. Plan: Right hip fracture. On the exam, there was tenderness and edema. Likely an acute fracture. Will manage with pain medications. Repeat x-ray in one week. A statement completed by Agency Nurse Aide 1, dated March 28, 2025, revealed that she was doing last rounds and went into change Resident 1. He was rolled onto his left side to be changed due to having a large bowel movement. No issues rolling. All of a sudden, he was reaching for something off his nightstand and rolled out of bed and fell on to the floor. A statement completed by Resident 1, dated March 28, 2025, revealed that the nurse aide asked the resident to roll on his side. She asked which way was best, and the resident told her to his left. The resident started rolling to his left and kept going onto the floor. The resident landed on his right hip on the floor. (continued on next page)

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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 0600 Level of Harm - Actual harm Residents Affected - Few	A statement completed via conference call with Agency Nurse Aide 1, dated March 31, 2025, revealed that around 1:30 p.m. on March 28, 2025, she went in to check on Resident 1. He was cockeyed in the bed, so she straightened him out and pulled him to the middle of the bed. She asked what side the resident rolls better toward, and he said to his left. She noticed that he had a bowel movement, so she proceeded to start cleaning him. The resident then reached for his bedside table and quickly rolled out of bed before she knew it. She stated that she should not have done it and feels horrible, but thought she could handle it. Since the incident, the Nurse Aide 1 has been educated on the electronic medical record and the Kardex (a nursing worksheet that includes a summary of resident information, such as prescribed medications, clinical follow-ups, and daily care schedules). She stated that if she knew then what she knows now, this would not have happened. Investigative documents for Resident 1, dated March 28, 2025, revealed that on March 28, 2025, at approximately 2:30 p.m. Agency Nurse Aide 1 alerted the nurse that Resident 1 had a fall from bed during routine afternoon care. Upon investigation it was determined that Agency Nurse Aide 1 was providing care in bed with only one assist, while Resident 1 is care planned for two assist with his bed mobility. After the thorough investigation neglect was substantiated due to not following the resident's care plan. Agency Nurse Aide 1 was re-educated and removed from duties as it relates to resident care. Review of Nurse Aide 1's personnel file revealed that she had completed training regarding preventing, recognizing, and reporting abuse on February 1, 2025. Interview with the Nursing Home Administrator on April 8, 2025, at 1:55 p.m. confirmed that the facility's investigation substantiated neglect because Nurse Aide 1 did not follow Resident 1's care plan requiring the assistance from two staff for his bed mobility. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(b)(1)(e)(1) Management. 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 0656 Level of Harm - 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. 31760 Based on review of clinical records and investigative reports, as well as staff interviews, it was determined that the facility failed to ensure that staff implemented care-planned interventions for one of three residents reviewed (Resident 1) who was identified as a fall risk, resulting in a fall and fracture for the resident. This deficiency was cited as past non-compliance. Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated March 19, 2025, revealed that the resident was understood, could understand others, and had a diagnosis which included morbid obesity (a disorder that involves having too much body fat, which increases the risk of health problems). The resident's care plan, dated September 17, 2020, revealed that the resident was at risk for falls related to the need for assistance with his balance. A care plan, dated October 10, 2023, revealed that the resident had a communication problem related to his cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) and staff was to ensure/provide a safe environment. A care plan, dated May 15, 2024, revealed that the resident had a ADL self-care deficit related to his decreased mobility and was as assist from two staff for his bed mobility and transfers. A nursing note for Resident 1, dated March 28, 2025, at 3:20 p.m. revealed that the nurse aide informed the nurse that the resident had fallen. The nurse entered the room, and the resident was observed on the left side of the bed on the floor on his right side. The resident stated that he fell and his hip hurts. The resident was assessed by the nurse prior to moving him from the floor and back into bed. The resident had small scratches to his right elbow. The areas were cleansed with saline and left open to air. No other injuries were noted at this time. The physician, hospice, and the resident's family member were notified of the incident. New orders were received for an x-ray of his right hip and right femur (the upper leg bone, extending from the hip to the knee) and bilateral landing mats (mats placed to cushion the fall of a resident who rolls out of bed). The resident was medicated with Oxycodone (a narcotic pain medication to treat moderate to severe pain) for pain and will monitor. A nursing note for Resident 1, dated March 28, 2025, at 3:37 p.m., revealed that at 2:16 p.m. that the resident was receiving care from the nurse aide and the resident fell from his bed. The reason for the fall was that the resident leaned too far over causing him to fall out of his bed. A nursing note for Resident 1, dated March 28, 2025, at 6:45 p.m., revealed that the x-ray of the resident's right hip shows an intertrochanteric fracture (a break in the bone (femur) just below the hip joint). The exact clinical age indeterminate (not exactly known) although appears likely either subacute (rather recent onset) or old healed rather than acute (sudden and severe, but of short duration). (continued on next page)

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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 - Actual harm Residents Affected - Few	A physician's note for Resident 1, dated April 2, 2025, revealed that the resident was evaluated for right hip pain. The patient fell a few days ago and reported pain in the right hip. X-rays done with a reading of chronic verses acute fracture of his right hip. The patient is hospice, and family is not interested in sending to the hospital. On the exam he had swelling to his right hip. Plan: Right hip fracture. On the exam, there was tenderness and edema. Likely an acute fracture. Will manage with pain medications. Repeat x-ray in one week. A statement completed by Agency Nurse Aide 1, dated March 28, 2025, revealed that she was doing last rounds, went into change Resident 1. He was rolled onto his left side to be changed due to having a large bowel movement. No issues rolling. All of a sudden, he was reaching for something off his nightstand and rolled out of bed and fell on to the floor. A statement completed by Resident 1, dated March 28, 2025, revealed that the nurse aide asked him to roll on his side. She asked which way was best, and he told her to his left. He started rolling to his left and kept going onto the floor. He landed on his right hip on the floor. A statement completed via conference call with Agency Nurse Aide 1, dated March 31, 2025, revealed that around 1:30 p.m. on March 28, 2025, she went in to check on Resident 1. He was cockeyed in the bed, so she straightened him out and pulled him to the middle of the bed. She asked what side he rolls better toward, and he said to his left. She noticed he had a bowel movement, so she proceeded to start cleaning him. The resident then reached for his bedside table and quickly rolled out of bed before she knew it. Nurse Aide 1 stated that should not have done it and feels horrible, but she thought she could handle it. Since the incident she has been educated on the electronic medical record and the Kardex (a nursing worksheet that includes a summary of resident information, such as prescribed medications, clinical follow-ups, and daily care schedules). If she knew then what she knows now, this would not have happened. Investigative documents for Resident 1, dated March 28, 2025, revealed that on March 28, 2025, at approximately 2:30 p.m. Agency Nurse Aide 1 alerted the nurse that Resident 1 had a fall from bed during routine afternoon care. Upon investigation it was determined that Agency Nurse Aide 1 was providing care in bed with only one assist, while Resident 1 is care planned for two assist with his bed mobility. After the thorough investigation it was determined that Agency Nurse Aide 1 did not following the resident's care plan. Agency Nurse Aide 1 was re-educated and removed from duties as it relates to resident care. Interview with the Nursing Home Administrator on April 8, 2025, at 1:55 p.m. confirmed that Nurse Aide 1 did not follow Resident 1's care plan requiring the assistance from two staff for his bed mobility. Following the investigation on March 28, 2025, the facility's corrective actions included: Agency Nurse Aide 1 was suspended pending the results of the investigation, and after the investigation was completed, she was placed on a do not return to the facility list. Facility staff as well as agency staff education on accessing and following the resident's care plan for assistance with bed mobility/transfers was completed. (continued on next page)

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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 - Actual harm Residents Affected - Few	Audits to identify any issues with following a resident's care plan for assistance with bed mobility/transfers were started. The results of these audits will be brought to Quality Assurance Performance Improvement committee for further analysis and corrective actions if necessary. Review of the facility's corrective actions and interviews completed with staff regarding their re-education revealed that they were in compliance with F656 on April 2, 2025. 28 Pa. Code 201.24(e)(4) Admission Policy. 28 Pa. Code 211.12(d)(5) Nursing Services.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 31760 Based on review of the investigation reports and residents' clinical records, as well as staff interviews, it was determined that the facility failed to maintain a safe environment for one of three residents reviewed (Resident 1) resulting in a fall with fracture. This deficiency was cited as past non-compliance. Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated March 19, 2025, revealed that the resident was understood, could understand others, and had a diagnosis which included morbid obesity (a disorder that involves having too much body fat, which increases the risk of health problems). The resident's care plan, dated September 17, 2020, revealed that the resident was at risk for falls related to the need for assistance with his balance. A care plan, dated October 10, 2023, revealed that the resident had a communication problem related to his cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) and staff was to ensure/provide a safe environment. A care plan, dated May 15, 2024, revealed that the resident had a ADL self-care deficit related to his decreased mobility and was as assist from two staff for his bed mobility and transfers. A nursing note for Resident 1, dated March 28, 2025, at 3:20 p.m. revealed that the nurse aide informed the nurse that the resident had fallen. The nurse entered the room, and the resident was observed on the left side of the bed on the floor on his right side. The resident stated that he fell and his hip hurts. The resident was assessed by the nurse prior to moving him from floor and back into bed. The resident small scratches to his right elbow. The areas were cleansed with saline and left open to air. No other injuries were noted at this time. The physician, hospice, and the resident's family member were notified of the incident. New orders received for an x-ray of his right hip and right femur (the upper leg bone, extending from the hip to the knee) and bilateral landing mats (mats placed to cushion the fall of a resident who rolls out of bed). The resident was medicated with Oxycodone (a narcotic pain medication to treat moderate to severe pain) for pain and will monitor. A nursing note for Resident 1, dated March 28, 2025, at 3:37 p.m., revealed that at 2:16 p.m. that the resident was receiving care from the nurse aide and the resident fell from his bed. The reason for the fall was that the resident leaned too far over causing him to fall out of his bed. A nursing note for Resident 1, dated March 28, 2025, at 6:45 p.m., revealed that the x-ray of the resident's right hip shows an intertrochanteric fracture (a break in the bone (femur) just below the hip joint). The exact clinical age indeterminate (not exactly known) although appears likely either subacute (rather recent onset) or old healed rather than acute (sudden and severe, but of short duration). (continued on next page)

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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 0689 Level of Harm - Actual harm Residents Affected - Few	A physician's note for Resident 1, dated April 2, 2025, revealed that the resident was evaluated for right hip pain. The patient fell a few days ago and reported pain in the right hip. X-rays done with a reading of chronic verses acute fracture of his right hip. The patient is hospice, and family is not interested in sending to the hospital. On the exam he had swelling to his right hip. Plan: Right hip fracture. On the exam, there was tenderness and edema. Likely an acute fracture. Will manage with pain medications. Repeat x-ray in one week. A statement completed by Agency Nurse Aide 1, dated March 28, 2025, revealed that she was doing last rounds, went into change Resident 1. He was rolled onto his left side to be changed due to having a large bowel movement. No issues rolling. All of a sudden, he was reaching for something off his nightstand and rolled out of bed and fell on to the floor. A statement completed by Resident 1, dated March 28, 2025, revealed that the nurse aide asked him to roll on his side. She asked which way was best, and he told her to his left. He started rolling to his left and kept going onto the floor. He landed on his right hip on the floor. A statement completed via conference call with Agency Nurse Aide 1, dated March 31, 2025, revealed that around 1:30 p.m. on March 28, 2025, she went in to check on Resident 1. He was cockeyed in the bed, so she straightened him out and pulled him to the middle of the bed. She asked what side he rolls better toward, and he said to his left. She noticed he had a bowel movement, so she proceeded to start cleaning him. The resident then reached for his bedside table and quickly rolled out of bed before she knew it. Nurse Aide 1 stated that she should not have done it and feels horrible, but she thought she could handle it. Since the incident she has been educated on the electronic medical record and the Kardex (a nursing worksheet that includes a summary of resident information, such as prescribed medications, clinical follow-ups, and daily care schedules). If she knew then what she knows now, this would not have happened. Investigative documents for Resident 1, dated March 28, 2025, revealed that on March 28, 2025, at approximately 2:30 p.m. Agency Nurse Aide 1 alerted the nurse that Resident 1 had a fall from bed during routine afternoon care. Upon investigation it was determined that Agency Nurse Aide 1 was providing care in bed with only one assist, while Resident 1 is care planned for two assist with his bed mobility. After the thorough investigation it was determined that Agency Nurse Aide 1 did not following the resident's care plan. Agency Nurse Aide 1 was re-educated and removed from duties as it relates to patient care. Interview with the Nursing Home Administrator on April 8, 2025, at 1:55 p.m. confirmed that Nurse Aide 1 did not follow Resident 1's care plan requiring the assistance from two staff for his bed mobility. Following the investigation on March 28, 2025, the facility's corrective actions included: Agency Nurse Aide 1 was suspended pending the results of the investigation, and after the investigation was completed, she was placed on a do not return to the facility list. Facility staff as well as agency staff education on accessing and following the resident's care plan for assistance with bed mobility/transfers was completed. (continued on next page)

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Audits to identify any issues with following a resident's care plan for assistance with bed mobility/transfers were started. The results of these audits will be brought to Quality Assurance Performance Improvement committee for further analysis and corrective actions if necessary. Review of the facility's corrective actions and interviews completed with staff regarding their re-education revealed that they were in compliance with F689 on April 2, 2025. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.