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	08/05/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on review of clinical records and job descriptions, as well as staff interviews, it was determined that the facility failed to follow pressure ulcer treatment recommendations from a wound consultation for one of four residents reviewed (Resident 3).Findings include: The facility's job description for the wound care coordinator, dated July 2024, indicates that the wound care coordinator maintains documentation and care coordination in the electronic medical record for each resident and coordinates care with the attending physician and rounds with the in-house wound physician regularly.An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 3, dated July 12, 2025, indicated that the resident was cognitively impaired, required assistance for her care needs, and had diagnoses that included atherosclerotic heart disease (hardening of your arteries from plaque building up gradually inside them). Census data revealed the resident was discharged on July 25, 2025.Physician's orders for Resident 3 dated July 8, 2025, included an order to apply skin prep to the resident's heels every shift to maintain skin integrity.A nurse's note for Resident 3 dated July 17, 2025, indicated that the resident had a blood-filled blister on his left heel. Skin prep and a bordered foam dressing was applied. Orders were obtained for a wound consult. A skin check note for Resident 3 dated July 18, 2025, indicated that the resident had a Stage 2 pressure ulcer (a shallow, open wound or blister) to his left heel. The wound care consultant assessed the resident for an initial evaluation of a blood blister to the left heel. No new orders were obtained.A wound consultation for Resident 3 dated July 18, 2025, indicated that the resident had a pressure ulcer to his left heel and treatment recommendations included to apply skin prep the base of the wound and secure it with bordered foam.A skin check note for Resident 3 dated July 25, 2025, at 10:38 a.m. indicated that the resident had Stage 3 pressure ulcer to his left heel.Review of Resident 3's Treatment Administration Records for July 2025 revealed that the treatments to the left heel did not include the application of a bordered foam dressing from July 18 through July 25, 2025.Interview with the Assistant Nursing Home Administrator on August 5, 2025, at 3:23 p.m. revealed that wound care orders that included a foam dressing were not added to the resident's wound orders, resulting in wound care not being completed as recommended by the wound consultant.28 Pa. Code 211.12(d)(1)(3)(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

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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 policy, review of clinical records, and interview with staff, it was determined that the facility failed to provide pharmaceutical services to ensure accurate receiving, dispensing and administration of medication to meet the needs of a resident for one of four residents reviewed (Resident 2). A facility policy for Medication Administration dated July 11, 2025, indicated that medications are administered as prescribed in accordance with Manufacturers' specifications, good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication. An admission Minimum Data Set (MDS) assessment (a federally mandated assessment of the resident's abilities and care needs) for Resident 2 dated April 20, 2025, indicated that the resident was moderately cognitively impaired, required assistance from staff for daily care needs, and had diagnosis that included heart failure. Review of clinical records revealed she was discharged from the facility on May 17, 2025.Physician's orders for Resident 2 dated April 16, 2025, indicated that the resident was to receive 40 milligrams (mg) of rosuvastatin calcium (medication used to lower the amount of cholesterol in the blood) at bedtime for hyperlipidemia (abnormally high levels of lipids (fats) in the bloodstream).A medication error report for Resident 2 dated May 12, 2025, indicated that the medication card delivered to the facility from the pharmacy was labeled as rosuvastatin calcium, however, it contained coumadin (a blood thinner) tablets instead of the labeled rosuvastatin calcium tablets and Resident 2 was administered coumadin for several days before the error was noted.An Advanced Practice Nurse's note for Resident 2 dated May 12, 2025, indicated that on May 11, 2025, at 5:49 p.m. she was made aware that a medication ordered for Resident 2 was packaged wrong from the pharmacy, that Resident 2 had received Coumadin instead of rosuvastatin calcium, and orders were given to obtain lab work including a Prothrombin Time (PT-test used to help detect and diagnose a bleeding disorder or excessive clotting disorder), International Normalized Ratio (INR-used to monitor how well the blood-thinning medication is working to prevent blood clots) and a complete blood count. A nurse's note for Resident 2 dated May 12, 2025, at 1:15 p.m. revealed that staff was made aware of a medication error that identified coumadin pills were in a medication card sent to the facility from the pharmacy that was labeled as rosuvastatin calcium and was administered to the resident. The nurse immediately reached out to the physician. The resident's lab work that was ordered and drawn on the morning of May 12, 2025, was reviewed. The resident's INR was elevated and the physician ordered Vitamin K (can reverse the effects of blood thinners likes coumadin), and to check the resident's INR for three days. Interview with the Nursing Home Administrator on August 5, 2025, at 3:23 p.m. revealed that Resident 2 did receive that wrong medication for several days due to the pharmacy packaging the medication incorrectly. The facility ended their contract with that pharmacy on July 31, 2025, due to a breach in contract for services.28 Pa. Code 211. 9(a)(1) Pharmacy Services.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 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on a review of clinical records, as well as staff interviews, it was determined that the facility failed to ensure that residents were free from significant medication errors for one of four residents reviewed (Resident 2) resulting in a critically abnormal blood clotting time.Findings include:An admission Minimum Data Set (MDS) assessment (a federally mandated assessment of the resident's abilities and care needs) for Resident 2 dated April 20, 2025, indicated that the resident was moderately cognitively impaired, required assistance from staff for daily care needs, and had diagnoses that included heart failure. Review of clinical records revealed she was discharged from the facility on May 17, 2025. A medication error report for Resident 2 revealed that on May 11, 2025, a medication discrepancy was identified. The medication nurse realized that the pills in the resident's medication card labeled by the pharmacy as rosuvastatin calcium (a statin medication used to lower bad cholesterol and triglycerides) was actually Warfarin (coumadin-a blood thinner) tablets and not rosuvastatin calcium. Resident 2 was administered the coumadin tablets for several days before the error was noted. A nursing note for Resident 2, dated May 11, 2025 at 6:53 p.m. revealed that a medication discrepancy was identified. The resident is alert and appears at baseline. The physician was notified and new orders were received to obtain a CBC (a common blood test that provides information about different types of cells in your blood: red blood cells, white blood cells, and platelets) and PT/INR (a blood test that measures how long it takes for your blood to clot, assessing the effectiveness of your body's blood clotting process) in the morning. A nursing note for Resident 2, dated May 12, 2025, at 1:15 p.m. revealed that this nurse was made aware of the medication error of Warfarin pills in a medication card labeled Rosuvastatin Calcium 40mg, sent from pharmacy. This nurse immediately reached out to the physician who reviewed the resident's lab work drawn this morning. The resident's INR was 7.0 (the target range is typically between 2.0 and 3.0 for most patients taking warfarin and anything higher indicates an increased risk of bleeding because the blood is taking too long to clot). The physician gave an order for 5 milligrams (mg) STAT of Phytonadione Oral (Vitamin K) and to check the INR daily for three days. This nurse immediately called family and explained the situation at hand. Review of Resident 2's Medication Administration Record for May, 2025, revealed that the resident received 5 mg of Vitamin K orally on May 12, 13, and 14, 2025. A nurse's note for Resident 2 dated May 12, 2025, at 2:08 p.m. revealed that staff spoke to the director of the pharmacy regarding the wrong pills being labeled as rosuvastatin calcium. The card was to be replaced with a new card containing the correct medication and a representative from the pharmacy was to retrieve the wrong medication card. There was no documented evidence that the facility investigated the error to determine if other medication cards in the facility had been labeled incorrectly by the pharmacy. Interview with the Nursing Home Administrator on August 5, 2025, at 3:23 p.m. confirmed that Resident 2 received the wrong medication for several days due to the pharmacy packaging the medication incorrectly. The facility ended their contract with that pharmacy on July 31, 2025, due to a breach in contract for services. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.