

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396021	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2025
NAME OF PROVIDER OR SUPPLIER Redstone Highlands Health Care		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>38012</p> <p>Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to investigate injuries of unknown origin to rule out abuse or neglect for one of 38 residents reviewed (Resident 24) who suffered an ankle fracture.</p> <p>Findings include:</p> <p>The facility's injury of unknown origin policy, dated September 27, 2024, indicated that any time there was an injury of unknown origin, a thorough investigation will be conducted to determine the cause.</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 24, dated January 26, 2025, indicated that the resident was cognitively intact and required assistance from staff for her daily care needs.</p> <p>A nursing note for Resident 24, dated October 9, 2024, indicated that the resident's son asked if the resident had seen the doctor regarding the pain in her left foot.</p> <p>Resident 24's x-ray results, dated October 12, 2024, revealed that the resident had a non-union or delayed healing fracture of the distal fibula, just above the malleolus of the left ankle (ankle fracture).</p> <p>There was no documented evidence that a thorough investigation was completed into Resident 24's injury of unknown origin in order to rule out that abuse or neglect was involved as the possible cause(s).</p> <p>Interview with the Director of Nursing on March 20, 2025, at 1:18 p.m. revealed that he interviewed Resident 24 and she denied that anyone abused her; therefore, he concluded the investigation. There was no documented evidence that neglect was ruled out causing the resident to have a fracture.</p> <p>28 Pa. Code 201.18(e)(1) Management.</p> <p>28 Pa. Code 211.12(d)(2) Nursing Services.</p>

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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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31760</p> <p>Based on a 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 one of 38 residents reviewed (Resident 55) and failed to complete accurate discharge Minimum Data Set assessments for two of 38 residents reviewed (Residents 69, 96).</p> <p>Findings include:</p> <p>The Long-Term Care Facility RAI User's Manual, dated [DATE], indicated that Section N0415E (Anticoagulant-medications that prevent blood clots from forming or growing) was to be coded (1) is taking, if the resident received an anticoagulant medication during the seven-day look-back period. Section N0415G (Diuretic-medicines that helps reduce fluid buildup in the body) was to be coded (1) is taking, if the resident received a diuretic medication during the seven-day look-back period.</p> <p>Physician's orders for Resident 55, dated February 3, 2025, included an order for the resident to receive 5 milligrams (mg) of Apixaban (an anticoagulant) two times a day. Review of the resident's MAR for February 2025 revealed that the resident received Apixaban daily on February 3 through February 7, 2025. However, an admission MDS assessment for Resident 55, dated February 7, 2025, revealed that Section N0415E was not coded (1) is taking, indicating that the resident did not receive an anticoagulant during the seven-day look-back period.</p> <p>Physician's orders for Resident 55, dated February 4, 2025, included an order for the resident to receive 20 mg of Torsemide (a diuretic) daily. Review of the resident's MAR for February 2025 revealed that the resident received Torsemide daily on February 4 through February 7, 2025. However, an admission MDS assessment for Resident 55, dated February 7, 2025, revealed that Section N0415G was not coded (1) is taking, indicating that the resident did not receive a diuretic during the seven-day look-back period.</p> <p>An interview with the RNAC on [DATE], at 12:37 p.m. confirmed that Resident 55's MDS assessment dated [DATE], was not coded accurately.</p> <p>The RAI User's Manual, which gives instructions for completing MDS assessments, dated [DATE], revealed that Section A2105 (Discharge Status) was to be coded one (1) through thirteen (13) depending on the location of the resident's discharge. If the resident was discharged to a short-term general hospital (acute hospital), and then Section A2105 was to be coded four (4). If the resident was discharged to home under the care of a organized home health service organization, then Section A2105 was to be coded twelve (12).</p> <p>Physician's orders for Resident 69, dated February 2, 2025, included an order for the resident to discharge home with all current medications and treatment, as well as to receive home health services of physical therapy, occupational therapy, skilled nursing, and home health aide.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A social services progress note for Resident 69, dated [DATE], revealed that the resident will discharge home on Sunday with his power of attorney (POA - a legal document that allows someone to act on behalf of another person in specific matters, such as financial or healthcare decisions). The resident will receive home health services.</p> <p>A discharge summary for Resident 69, dated February 2, 2025, revealed that the resident was discharged to home with home health services.</p> <p>A discharge return not anticipated MDS assessment for Resident 69, dated February 2, 2025, revealed that Section A2105 was coded four (4), indicating that the resident was discharged to an short-term general hospital (acute hospital).</p> <p>Interview with the Assistant Campus Director on [DATE], at 12:40 p.m. confirmed that Section A2105 of Resident 69's discharge return not anticipated MDS assessment of February 2, 2025, was not accurate and should have been coded to indicate that the resident was discharged to home under the care of a organized home health service organization.</p> <p>A death tracking MDS assessment for Resident 96, dated [DATE], revealed that Section A2105 was coded thirteen (13), indicating that the resident was deceased ; however, nursing notes for Resident 96, dated [DATE], at 10:05 a.m., revealed that the resident continued to complain of left lower extremity pain, swelling, discoloration, and hypotension (low blood pressure). The physician was made aware, and an order was received to send the resident to the hospital for further evaluation and treatment. A nursing note at 10:56 p. m. revealed that the resident was admitted to the hospital.</p> <p>Interview with the Assistant Campus Director on [DATE], at 9:40 a.m. confirmed that the resident did not die at the facility and was sent out to the hospital on [DATE], and confirmed that Section A2105 of Resident 96's death tracking MDS assessment [DATE], was not accurate and should have been coded to indicate that the resident was discharged to a hospital.</p> <p>28 Pa. Code 211.5(f) Clinical Records.</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>31760</p> <p>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 a resident's baseline care plan included information regarding the resident's immediate care needs for three of 38 residents reviewed (Residents 89, 94, 95).</p> <p>Findings include:</p> <p>The facility's policy regarding care planning, dated September 27, 2024, revealed that the licensed nurse will initiate a baseline care plan upon admission to the facility and complete it within 48 hours. Care plans will be individualized to the residents.</p> <p>The facility's policy regarding Enhanced Barrier Precautions (EBP - an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities), dated September 27, 2024, revealed that residents requiring the use of EBP, will be identified to staff by including the EBP in their care plans. An order for EBP will be obtained for residents with any of the following: indwelling medical devices (e.g. urinary catheters).</p> <p>A care plan for Resident 89, dated March 8, 2025, revealed that the resident required a feeding tube (a flexible plastic tube placed into the stomach or bowel) for nutritional support.</p> <p>There was no documented evidence that a baseline care plan was developed for Resident 89's care and treatment needs related to requiring EBP due to having a feeding tube.</p> <p>A care plan for Resident 94, dated March 11, 2025, revealed that the resident had a foley catheter (a thin, flexible tube inserted into the bladder through the urethra to drain urine) related to urinary retention (a condition where a person is unable to empty their bladder completely).</p> <p>There was no documented evidence that a baseline care plan was developed for Resident 94's care and treatment needs related to requiring EBP due to having a foley catheter.</p> <p>Interview with the Nursing Home Administrator on March 20, 2025, at 1:19 p.m. confirmed that a baseline care plan was not developed for Resident 89 or Resident 94's care and treatment needs related to requiring EBP.</p> <p>A care plan for Resident 95, dated March 12, 2025, revealed that the resident had a foley catheter (a thin, flexible tube inserted into the bladder through the urethra to drain urine) related to urinary retention (a condition where a person is unable to empty their bladder completely).</p> <p>Physician's orders for Resident 95, dated March 11, 2025, included an order for the resident to receive a five milligram (mg) tablet of Apixaban (an anticoagulant medication used to treat and prevent blood clots and to prevent strokes) two times a day.</p> <p>(continued on next page)</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Physician's orders for Resident 95, dated March 12, 2025, included an order for the resident to receive a 20 mg tablet of Furosemide (a diuretic medication to help treat fluid retention (edema) and swelling) one time a day.</p> <p>There was no documented evidence that a baseline care plan was developed for Resident 95's care and treatment needs related to EBP due to having a foley catheter, the use of anticoagulant, and diuretic medications.</p> <p>Interview with the Assistant Campus Director on March 20, 2025, at 10:40 a.m. confirmed that a baseline care plan was not developed for Resident 95's care and treatment needs related to EBP due to having a foley catheter, the use of anticoagulant, and diuretic medications.</p> <p>28 Pa. Code 211.12(d)(1) Nursing Services.</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>46994</p> <p>Based on review of facility policies, clinical records, and staff interviews, it was determined that the facility failed to develop a comprehensive care plan that included specific and individualized interventions to address the care needs of residents for two of 38 residents reviewed (Residents 40, 55).</p> <p>Findings include:</p> <p>A facility policy for Clinical Care Planning, dated September 27, 2025, included that the facility will develop a comprehensive and baseline care plan for all residents.</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 40, dated February 3, 2025, indicated that the resident was cognitively impaired, required assistance from staff for daily care needs, and had a colostomy (surgical diversion of the colon through an opening in the abdomen).</p> <p>There was no documented evidence that a care plan was developed to address the resident's care needs regarding her colostomy.</p> <p>Interview with the Nursing Home Administrator on March 19, 2025, at 3:24 p.m. confirmed that a care plan should have been developed for Resident 40's colostomy.</p> <p>An admission MDS assessment for Resident 55, dated February 7, 2025, revealed that the resident was cognitively intact, required assistance for personal care needs, and had diagnoses that included diabetes.</p> <p>Physician orders for Resident 55, dated February 26, 2025, included for the resident to receive a Freestyle Libre 3 sensor (a Continuous Glucose monitoring System Sensor -wearable device that tracks your glucose (sugar) levels in real time) injected every 14 days for diabetes.</p> <p>There was no documented evidence that a care plan was developed to address Resident 55's individual care and treatment needs related to her diabetes or the use of a continuous glucose monitoring system.</p> <p>An interview with the Nursing Home Administrator on March 20, 2025, at 12:37 p.m. revealed that there was no documented evidence that a care plan was developed for Resident 55 to address her care and treatment needs related to her diabetes and use of a continuous glucose monitoring system.</p> <p>28 Pa. Code 211.12(d)(5) Nursing Services.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>46994</p> <p>Based on review of facility policy and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that a resident's care plan was updated/revised to reflect the resident's specific care needs for one of 38 residents reviewed (Resident 73).</p> <p>Findings include:</p> <p>A facility policy for care planning, dated September 27, 2025, indicated that care plans would be individualized to the residents and care plans will be updated by the licensed nurse and interdisciplinary team as needed with changes as applicable.</p> <p>An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's care needs and abilities) for Resident 73, dated March 8, 2025, indicated that the resident was cognitively intact, required assistance from staff for daily care needs, and had diagnoses that included pneumonia (infection of the lungs).</p> <p>A care plan for Resident 73, dated March 4, 2025, indicated that the resident was on antibiotic therapy for pneumonia and staff were to administer the antibiotic medication as ordered by the physician.</p> <p>Interview with the Nursing Home Administrator on March 20, 2025, at 12:27 p.m. revealed that Resident 73's care plan was not updated when her antibiotic therapy was completed, and it should have been.</p> <p>28 Pa. Code 201.24(e)(4) Admission Policy.</p> <p>28 Pa. Code 211.12(d)(5) Nursing Services.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>46994</p> <p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>Based on review of Pennsylvania's Nursing Practice Act and clinical records, as well as staff interviews, it was determined that the facility failed to clarify a provider's orders for one of 38 residents reviewed (Resident 48).</p> <p>Findings include:</p> <p>The Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.11 (a)(1)(2)(4) indicated that the registered nurse was to collect complete and ongoing data to determine nursing care needs, analyze the health status of individuals and compare the data with the norm when determining nursing care needs, and carry out nursing care actions that promote, maintain and restore the well-being of individuals.</p> <p>An admission Minimum Data Set (MDS) assessment (a federally-mandated assessment of a resident's abilities and care needs) for Resident 48, dated January 21, 2025, indicated that the resident was cognitively intact, required assistance from staff for daily care needs, and had diagnoses that included a left hip fracture, diabetes, and dementia.</p> <p>Physician's orders for Resident 48, dated February 19, 2025, included an order for the resident to have betadine applied to his bilateral heels and then covered with a bordered foam dressing every other day for deep tissue injury (DTI - form of pressure-induced damage to underlying tissues).</p> <p>Physician's orders for Resident 48, dated March 16, 2025, included an order for the resident to have his bilateral heels cleansed with Vashe (a wound cleanser), pat dry, UrgoClean Ag (a wound dressing that supports the continuous debridement of dead tissue with the benefit of silver) and foam bordered dressings (used to promote wound healing) applied and secured with rolled gauze every other day for pressure ulcer.</p> <p>Wound consult reports for Resident 48, dated February 21, 2025, and February 28, 2025, respectively, indicated that the resident was to have his bilateral heels cleansed with a wound cleanser, then betadine applied to his bilateral heels and covered with a bordered foam dressing every day for deep tissue injury (DTI).</p> <p>A wound consult report for Resident 48, dated March 14, 2025, indicated that the resident was to have his bilateral heels cleansed with Vashe (antimicrobial solution for wound management), then patted dry, and UrgoClean Ag and foam bordered dressings applied every day.</p> <p>Interview with the wound nurse (Registered Nurse 1) on March 20, 2025, at 10:40 a.m. revealed that she rounds with the consultant wound physician who gives her verbal orders for treatments that she enters into the clinical records. The consultant physician also has an assistant who types his assessments for him. The above-mentioned assessments included orders to change Resident 48's dressings daily; however, the wound consultant gave verbal orders to Registered Nurse 1 to change the dressing every other day. The wound consultant notes that are typed by his assistant do not always match the verbal orders given to the facility's wound nurse. They are developing a process to correct that issue.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>31760</p> <p>Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to ensure that residents received care and treatment in accordance with professional standards of practice, by failing to ensure that physician's orders were followed for three of 38 residents reviewed (Residents 15, 70, 95).</p> <p>Findings include:</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 15, dated December 29, 2024, indicated that the resident was cognitively impaired, was dependent on staff for daily care needs, and had a diagnosis of hypertension (high blood pressure).</p> <p>Physician's order for Resident 15, dated April 4, 2024, included an order for the resident to receive 100 milligrams (mg) of Labetalol (treats hypertension) two times a day and to hold if heart rate is less than 50 beats per minute (bpm).</p> <p>Review of Resident 15's Medication Administration Record (MAR), dated January 2025, February 2025, and March 2025 for 100 mg of labetalol revealed that on January 11, 2025, at 8:00 a.m. the resident's heart rate was 44 bpm, and the labetalol was administered; on January 21, 2025 at 8:00 p.m. the resident's heart rate was 50 bpm and labetalol was held; on February 4, 2025, at 8:00 p.m. the resident's heart rate was 51 bpm and labetalol was held; on February 19, 2025, the resident's heart rate was 51 bpm and labetalol was held; on February 24, 2025, at 8:00 p.m. the resident's heart rate was 50 bpm and labetalol was held; and March 1, 2025, at 8:00 p.m. the resident's heart rate was 47 bpm and labetalol was administered.</p> <p>Interview with Nursing Home Administrator on March 20, 2025, at 12:45 p.m. confirmed that staff were not administering Resident 15's 100mg labetalol per physician's orders.</p> <p>Physician's orders for Resident 70, dated December 6, 2024, included an order for staff to obtain the resident's weight before breakfast every day shift, and they were to notify the physician if the resident had a weight gain of greater than two pounds.</p> <p>Review of the MAR for Resident 70, dated December 2024, revealed that on December 9, 2024, the resident's weight was 114.2 pounds, and on December 10, 2024, the resident's weight was 118.6 pounds. However, there was no documented evidence that the physician was contacted regarding the resident's 4.4-pound weight gain.</p> <p>Interview with the Nursing Home Administrator on March 20, 2025, at 12:27 p.m. confirmed that there was no documented evidence that the physician was contacted regarding Resident 70's 4.4-pound weight gain.</p> <p>Physician's orders for Resident 95, dated March 12, 2025, included an order for staff to obtain the resident's weight before breakfast every day shift, and they were to notify the physician if the resident had a weight gain of greater than two pounds.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the MAR for Resident 95, dated March 2025, revealed that on March 12, 2025, the resident's weight was 239.8 pounds. The resident refused to have his weights obtained on March 13, 14, and 15, 2025. On March 16, 2025, the resident's weight was 287.6 pounds. However, there was no documented evidence that the physician was contacted regarding the resident's 47.8-pound weight gain.</p> <p>Interview with the Assistant Campus Director on March 20, 2025, at 10:40 a.m. confirmed that there was no documented evidence that the physician was contacted regarding Resident 95's 47.8-pound weight gain.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing Services.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>38012</p> <p>Based on review of clinical records and staff interviews, it was determined that the facility failed to ensure the accountability of controlled medications for three of 38 residents reviewed (Residents 4, 28, 36).</p> <p>Findings include:</p> <p>An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 4, dated December 9, 2024, revealed that the resident was cognitively intact, received routine pain medication, and received an opioid (a controlled pain medication).</p> <p>Physician's orders for Resident 4, dated December 31, 2024, included an order to apply a 25 micrograms (mcg) Fentanyl (a narcotic pain patch) patch every three days for pain.</p> <p>The Medication Administration Record (MAR) and a controlled drug count record (tracks each dose of a controlled medication) for Resident 4, dated December 2024 and January and February 2025, revealed that a new Fentanyl patch was applied to the resident on the following dates: December 31, 2024; January 3, 6, 9, 12, 15, 18, 21, 24, 27, 30, 2025; and February 2, 5, 8, 11, 14, 17, 20, and 23, 2025. There was no documented evidence on the narcotic sheets that the old Fentanyl patch was destroyed on the above dates.</p> <p>Interview with the Nursing Home Administrator on March 20, 2025, at 12:15 a.m. confirmed that there were no narcotic sign-out sheets for December 31, 2024 through February 23, 2025.</p> <p>A quarterly MDS assessment for Resident 28, dated December 12, 2024, indicated that the resident was cognitively intact, was independent for all daily care needs, and had pain.</p> <p>Physician's orders for Resident 28, dated May 29, 2024, included an order for the resident to receive one 5-325 milligram (mg) tablet of Oxycodone/Tylenol (a combination controlled narcotic pain medication) every six hours as needed for pain.</p> <p>Resident 28's controlled drug record (used to keep count of narcotic medication) for February and March 2025 revealed that staff signed out one 5-325 mg Oxycodone/Tylenol on February 6, 2025, at 11:35 p.m.; February 7, 2025, at 2:30 p.m.; February 14, 2025, at 9:30 a.m.; February 17, 2025, at 3:13 p.m.; February 21, 2025, at 11:00 a.m.; March 4, 2024, at 6:15 a.m.; and March 8, 2025, at 11:00 p.m. However, review of the resident's MAR, dated February and March 2025, revealed no documented evidence that the 5-235 mg Oxycodone/Tylenol was administered to the resident on those dates.</p> <p>A quarterly MDS assessment for Resident 36, dated December 15, 2024, indicated that the resident was cognitively intact, required assistance from staff for all daily care needs, and had pain.</p> <p>Physician's orders for Resident 36, dated April 24, 2024, included an order for the resident to receive one 5-325 milligram (mg) tablet of Oxycodone/Tylenol (a combination controlled narcotic pain medication) every four hours as needed for pain.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Redstone Highlands Health Care		STREET ADDRESS, CITY, STATE, ZIP CODE 6 Garden Center Drive Greensburg, PA 15601	
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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident 36's controlled drug record (used to keep count of narcotic medication) for January, February, and March, 2025, revealed that staff signed out Percocet on January 8 at 7:58 a.m.; January 22 at 11:00 p.m.; January 27 at 11:00 p.m.; January 27 at 8:40 a.m.; January 27 at 5:15 p.m.; February 14 at 8:30 a.m.; February 19 at 8:30 a.m.; February 20 at 8:30 a.m.; February 24 at 9:00 p.m.; February 28 at 9:15 p.m.; March 10 at 8:00 a.m.; and March 11 at 8:40 a.m. However, a review of the resident's MAR, dated January, February, and March 2025, revealed no documented evidence that the Percocet was administered to the resident on those dates.</p> <p>Interview with the Nursing Home Administrator March 20, 2025, at 12:27 p.m. confirmed that there was no documented evidence that Resident 28 received the 5-325 Oxycodone/Tylenol or that Resident 36 received the Percocet as ordered on the above referenced dates.</p> <p>28 Pa. Code 211.9(h) Pharmacy Services.</p> <p>28 Pa. Code 211.12(d)(3)(5) Nursing Services.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>31760</p> <p>Based on review of manufacturer's instructions, facility policies, and clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure that medications were stored in a secure manner, failed to ensure that medications were appropriately secured in one of two medication carts reviewed (first floor medication cart 1), failed to store unopened and unused multi-dose containers of insulin according to manufacturer's instructions for one of 38 residents reviewed (Resident 76), and failed to ensure that refrigerated controlled medications were stored in a separately-locked, permanently-affixed container in one of two medication refrigerators reviewed (first floor medication room refrigerator).</p> <p>Findings include:</p> <p>A facility policy for medication storage, dated September 27, 2024, revealed that medications and biologicals are to be stored properly. The medication should only be accessible to licensed nursing staff, pharmacy personnel, and lawfully authorized staff.</p> <p>Observations on the first floor on March 19, 2025, at 9:07 a.m. revealed an unlocked and unsecured medication cart that was accessible to residents, family, and staff who walked past while Registered Nurse 2 was in a resident's room. Interviews with Registered Nurse 2 at the time of observation confirmed that the cart should have been locked and secured while he was in a resident's room.</p> <p>Observations of the first-floor medication cart 1 on March 20, 2025, at 1:33 p.m. revealed that the second drawer contained nine loose pills that were unsecured and not in the pharmacy's packaging. Interview with Licensed Practical Nurse 2 at the time of observation confirmed that the pills were loose in the bottom of the cart drawers and should not have been.</p> <p>Manufacturer's directions for Insulin Aspart (Novolog - a fast-acting insulin used to lower blood sugar levels), dated February 2023, indicated to store unused pens in the refrigerator at 36 degrees Fahrenheit (F) to 46 degrees F. Unused pens may be used until the expiration date printed on the label if the pen has been kept in the refrigerator. Unopened vials should be thrown away after 28 days, if they are stored at room temperature.</p> <p>Physician's orders for Resident 76, dated March 17, 2025, included an order for the resident to receive Insulin Aspart as per a sliding scale (the amount of insulin given was determined by the blood sugar level) before meals and at bedtime.</p> <p>Physician's orders for Resident 76, dated March 17, 2025, included an order for the resident to receive 10 units of Insulin Aspart with her meals.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observations of the first-floor medication cart 1 on March 20, 2025, at 1:33 p.m. revealed that Resident 76's Insulin Aspart Pen Injector was unopened and not in use in the second drawer of the medication cart. Interview with Licensed Practical Nurse 2 at the time of observation confirmed that Resident 76's Insulin Aspart Pen was not opened, not in use, and should not have been in the medication cart but should have been stored in the refrigerator until ready for use.</p> <p>The facility's policy regarding controlled medication storage, dated September 27, 2024, revealed that controlled medications requiring refrigeration are stored within a locked, permanently-affixed box within the refrigerator.</p> <p>Observations of the first-floor medication room refrigerator on March 20, 2025, at 1:51 p.m. revealed that there was a red plastic box with a metal lockable lid sitting on the second shelf in the refrigerator that contained one box of Ativan Intensol (an anti-anxiety medication that is a controlled drug); however, the red plastic box with a metal lockable lid was not permanently affixed to the refrigerator and could be removed from the refrigerator.</p> <p>Interview with Assistant Director of Nursing at the time of observation confirmed that the red plastic box with a metal lockable lid containing the Ativan Intensol was not permanently affixed to the refrigerator and could be removed.</p> <p>28 Pa. Code 211.9(a)(1) Pharmacy Services.</p> <p>28 Pa. Code 211.12(d)(1) Nursing Services.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>48809</p> <p>Based on review of policies, observations, and staff interviews, it was determined that the facility failed to ensure that food was prepared and served under sanitary conditions, in accordance with professional standards for food service safety.</p> <p>Findings include:</p> <p>The facility's policy regarding food and nutrition services, dated September 27, 2024, indicated that employees will wear a clean, appropriate hairnet/hair restraint, and that beards and facial hair will be contained, and food will be stored, labeled and dated when received.</p> <p>Observations in the main kitchen on March 17, 2025, at 9:25 a.m. revealed that there was one-quarter pound of American cheese open to air and undated, 15 scones open to air and undated, six Danish open to air and undated, one apple pie open to air and undated, one blueberry open to air and undated, and one bag of brownie mix half full open to air and undated.</p> <p>Observations in the kitchenette on March 19, 2025, at 11:45 a.m. revealed that Nurse Aide 3 walked into the kitchenette past the food prep to obtain mustard packs and was not wearing a hair net.</p> <p>Interview with the Executive Chef on March 17, 2025, at 9:35 p.m. confirmed that the food listed above should have been covered and dated.</p> <p>Interview with Nursing Home Administrator on March 19, 2025, at 3:25 p.m. confirmed that Nurse Aide 3 should have been wearing a hairnet while walking into the kitchenette past the food prep.</p> <p>28 Pa. Code 201.18(e) (2.1) Management.</p> <p>28 Pa. Code 211.6(f) Dietary Services.</p>		

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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.</p> <p>31760</p> <p>Based on review of hospice contracts, facility policies, and residents' clinical records, as well as staff interviews, it was determined that the facility failed to ensure that the designated interdisciplinary team member obtained the required information from the contracted hospice provider for one of 38 residents reviewed (Resident 35) who received hospice services.</p> <p>Findings include:</p> <p>An agreement between the facility and a hospice provider (provider of end-of-life services), dated March 5, 2021, indicated that it is hospice's responsibility to provide services under this agreement at the same level and to the same extent as those services would be provided if the facility resident were in his or her own home. That all records of hospice services rendered to the patient may be accessed if needed.</p> <p>The facility's policy regarding hospice care (specialized care that provides physical comfort and emotional, social and spiritual support for people nearing the end of life), dated September 27, 2024, revealed that relative to patient care and services, the hospice provider is responsible for providing usual and customary hospice services as well by noting any pertinent information relative to each visit provided throughout the course of care.</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 35, dated December 14, 2024, revealed that the resident was understood, could understand others, and received hospice care. A care plan for the resident, dated May 10, 2024, revealed that the resident had a Stage 3 pressure ulcer (involves full-thickness skin loss, extending into the subcutaneous tissue layer, but not reaching muscle, tendon, or bone) and staff was to document weekly the treatment, and was to include the measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate (fluid, cells, or cellular debris that leaks out of blood vessels and deposits into soft tissues, cavities, or wounds). A care plan, dated September 6, 2024, revealed that the resident was ordered hospice, and staff was to work cooperatively with the hospice team to ensure that his spiritual, emotional, intellectual, physical and social needs were met.</p> <p>A nursing note for Resident 35, dated September 1, 2024, revealed that the resident was readmitted to the facility from the hospital and that the resident had an open area on his coccyx (tailbone area) that measured six centimeters (cm) by five cm by one cm.</p> <p>Review of Resident 35's clinical record and the hospice provider's clinical record revealed no documented evidence of the weekly wound assessments/measurements being completed during the week of September 8 through 14, 2024; September 15 through 21, 2024; September 22 through 28, 2024; September 29 through October 5, 2024; October 6 through 12, 2024; October 13 through 19, 2024; and November 17 through 22, 2024.</p> <p>Interview with the Director of Nursing on March 20, 2025, at 11:25 a.m. confirmed that hospice was following Resident 35's wounds during their visits, and that hospice did not provide any documented evidence of their weekly wound assessments/measurements being completed on the above dates.</p> <p>(continued on next page)</p>		

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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>28 Pa. Code 211.12(d)(3)(5) Nursing Services.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>46994</p> <p>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 during the administration of a treatment for one of 38 residents reviewed (Residents 48).</p> <p>Findings include:</p> <p>The facility policy regarding enhanced barrier precautions (EBP), dated September 27, 2024, revealed that an order for EBP will be obtained for residents with wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes) even if the resident is not known to be infected or colonized with a multi-drug resistant organism (MDRO). Gowns and gloves will be available near or outside of the resident's room. Personal protective equipment (PPE - clothing and equipment that is worn or used in order to provide protection against hazardous substances or environments) for EBP is only necessary when performing high-contact care activities and may not need to be donned prior to entering the resident's room. High-contact resident care activities include wound care (any skin opening requiring a dressing). EBP will be used for the duration of the affected resident's stay in the facility or until resolution of the wound.</p> <p>The facility policy regarding handwashing, dated September 27, 2024, included that hands are to be washed before and after taking care of individual residents and when they become soiled in process of resident care. Hands should be washed after glove removal.</p> <p>An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 48, dated January 21, 2025, indicated that the resident was cognitively intact, required assistance from staff for daily care needs, and had diagnosis that included a left hip fracture, diabetes, and dementia.</p> <p>Physician's orders for Resident 48, dated March 16, 2025, included an order for the resident to have his bilateral heels cleansed with Vashe (a wound cleanser), pat dry, UrgoClean Ag (a wound dressing that supports the continuous debridement of dead tissue with the benefit of silver) and foam bordered dressings applied and secured with rolled gauze every other day for pressure ulcer.</p> <p>Observations on March 20, 2025, at 10:14 a.m. revealed that Registered Nurse 1 provided wound care to Resident 48's right and left heels without wearing a gown. Registered Nurse 1 removed the soiled dressing from Resident 48's left foot, removed her gloves, and donned clean gloves without performing hand hygiene. Interview with Registered Nurse 1 at that time confirmed that she should have washed her hands after removing the soiled gloves and prior to donning clean gloves.</p> <p>An interview with Registered Nurse 1 on March 20, 2025, at 10:40 a.m. confirmed that Resident 48 should have been on enhanced barrier precautions due to having wounds; however, there was no EBPs in place and no EBP supplies available in the resident's room.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview with the Nursing Home Administrator on March 20, 2025, at 1:19 p.m. confirmed that EBP was not in place for Resident 48 and should have been.</p> <p>An interview with the Nursing Home Administrator on March 20, 2025, at 2:21 p.m. confirmed that Registered Nurse 1 should have washed her hands after glove removal and prior to donning clean gloves, and a gown should have been worn during Resident 48's treatment administration.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing Services.</p>