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	04/16/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to maintain accountability for controlled medications (drugs with the potential to be abused) for three of 30 residents reviewed (Residents 4, 5, 11). Findings include: The facility's policy for medication administration, dated July 11, 2025, indicated that staff are to sign the Medication Administration Record (MAR) after a medication is administered, and if the medication is a controlled substance, staff are to sign the narcotic book. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 4, dated February 17, 2026, revealed that the resident had moderated cognitive impairment, requires assistance from staff and had diagnoses that included arthritis (inflammation, pain, and stiffness in one or more joints), and Parkinson's Disease (progressive neurodegenerative disorder that causes tremors and rigid limbs).Physician's orders for Resident 4, dated February 10, 2026, included an order for the resident to receive 5 mg of oxycodone, two tablets, every six hours as needed for severe pain. Review of the controlled drug records for Resident 4 dated February, March, and April 2026, revealed that two five mg oxycodone tablets were signed out on February 21, 2026, at 7:21 p.m., March 2, 2026 at 5:20 a.m., and on April 9, 2026, at 9:00 p.m.; However, there was no documented evidence in Resident 4's clinical record that the signed-out doses of controlled medication were administered to the resident on the above-mentioned dates and times.An admission MDS assessment for Resident 5, dated March 9, 2026, indicated that the resident was cognitively intact, required assistance from staff for daily care needs, had diagnosis that included spinal fusion (a surgical procedure that permanently connects two or more vertebrae (bones) in the spine,) and was receiving as needed pain medication. Physician's orders for Resident 5, dated February 12, 2026, included an order for the resident to receive 5 mg of oxycodone, two tablets, every six hours as needed for severe pain. Physician's orders dated March 3, 2026, included an order for the resident to receive 5 mg of oxycodone, two tablets, every six hours as needed for pain. Review of the controlled drug records for Resident 5 dated February and April, 2026, revealed that two five mg oxycodone tablets were signed out on February 14, 2026, at 10:25 a.m. and on April 2, 2026, at 3:48 p.m.; However, there was no documented evidence in Resident 5's clinical record that the signed-out doses of controlled medication were administered to the resident on the above-mentioned dates and times.A quarterly Minimum Data Set assessment for Resident 11, dated March 19, 2026, revealed that the resident was cognitively impaired, required assistance with personal care needs, and had diagnoses that included heart failure, spinal stenosis and rheumatoid arthritis. Physician's orders for Resident 11, dated January 16, 2026, included an order for the resident to receive 0.5 mg of alprazolam every twelve hours as needed for anxiety. Review of the controlled drug record for Resident 11, dated December 2025, revealed that 0.5 mg of alprazolam was signed out on December 12, 2025, at 11:50 a.m.; December 19, 2025, at 8:05 p.m.; December 29, 2025, at 4:10 p.m.; January 9, 2026, at 7:50 p.m. and February 28, 2026, at 8:53 a.m. However, there was no documented evidence in Resident 11's clinical record that the signed-out doses of controlled medications were administered to the resident on the above-mentioned dates and times. Interview with the Director of Nursing on April 16, 2026, at 10:40 a.m. confirmed that there was (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

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 04/16/2026
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	no documented evidence in the clinical records of Residents 4, 5 and 11 to indicate that the signed-out doses of controlled medications mentioned above were administered. 28 Pa. Code 211.9(a)(1) Pharmacy Services. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, observations, and staff interviews, it was determined that the facility failed to maintain the dignity of one of 30 residents reviewed (Resident 100) who had an indwelling urinary catheter.Findings include:Review of admission records for Resident 100 revealed she was admitted to the facility on [DATE], with a diagnosis of aftercare following joint replacement surgery and had an indwelling urinary catheter (a flexible tube inserted into the bladder to drain urine). Observations of Resident 100 on April 15, 2026, at 12:08 p.m. revealed that the Resident was sitting in her wheelchair on the left side of her bed eating her lunch. Her urinary catheter drainage bag was attached to the bed frame on the left side of her bed, visible form the Resident's doorway, with no privacy bag on the urinary drainage bag and yellow urine visible in the bag. Interview with Registered Nurse 1 on April 15, 2026, at 12:11 p.m. confirmed that there was no dignity or privacy bag on the Resident 100's urine drainage bag. Interview with the Nursing Home Administrator on April 15, 2026, at 12:24 p.m. confirmed that urinary catheter drainage bags should be kept in dignity/privacy bags. Interview with the Director of Nursing on April 15, 2026, at 1:08 p.m. confirmed that Resident 100's urinary catheter bag was not in a dignity/privacy bag, and it should have been. 28 Pa. Code 201.29(a) Resident Rights.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on a review of clinical records, select facility policy, and staff interviews, it was determined the facility failed to ensure a resident's medication regimen was free from unnecessary psychotropic medications and that non-pharmacological interventions and informed consent were implemented prior to initiation of an antipsychotic medication for one of 30 residents reviewed for unnecessary medications (Resident 2).Findings included: The facility's policy regarding psychotropic medications (any medication that affects brain activities associated with mental processes and behavior), dated July 11, 2025, indicated that psychotropic medications are not used unless clinically indicated, are prescribed at the lowest effective dos, and are subject to gradual dose reduction and behavioral interventions in accordance with federal regulations and informed consent will be obtained per state law. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 2, dated February 6, 2026, revealed that the resident is cognitively impaired, requires assistance with daily care needs and has medical diagnosis that includes anxiety and depression. Physician orders for Resident 2 dated July 4, 2025, included orders for the resident to receive 2 milligrams of Aripiprazole (an antipsychotic) one time a day for confusion. The facility was unable to provide evidence of informed consent for the psychotropic medication aripiprazole, and it was not available in the clinical record for review. During an interview with the Director of Nursing on April16, 2026, at 9:30 AM, it was confirmed the facility failed to ensure that Resident 2 had an informed consent prior to administering an antipsychotic medication. 28 Pa. Code 211.12(d)(5) Nursing Services.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on a review of 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 two of 30 residents reviewed (Residents 100 and 105). Findings include:A facility policy for Care Planning dated July 11, 2025, indicated that the licensed nurse will initiate a baseline care plan upon admission to facility and complete within 48 hours. On the first business day following admission the licensed nurse will review and update the care plan and complete a comprehensive care plan. Review of admission records for Resident 32 dated April 11, 2026, revealed that the resident was admitted to the facility for aftercare following a joint replacement and she had a foley catheter (a flexible tube inserted into the bladder to drain urine) in place. Observations of Resident 100 on April 13, 2026, at 10:58 a.m. revealed the resident lying in bed with a urinary drainage bag visible, hanging on the right side of the Resident's bed frame. Observations of Resident 100 on April 15, 2026, at 12:08 p.m. revealed that the resident was sitting in her wheelchair on the left side of her bed eating her lunch. Her urinary catheter drainage bag was attached to the bed frame on the left side of her bed. Interview with the Director of Nursing on April 16, 2026, at 10:54 a.m. confirmed the Resident 100's baseline care plan did not include care and treatment needs required for the resident's foley catheter use and should have. Review of admission records for Resident 105 dated April 4, 2026, revealed that the resident was admitted to the facility for aftercare following urinary tract infection (UTI) and he had a midline catheter (a soft tube inserted into the vein to provide intravenous therapy) in place. A nursing note dated April 4, 2026, at 2:18 p.m. indicated that the resident arrived at the facility and he had a midline in his left upper arm.Physician's orders for Resident 105, dated April 4, 2026, included an order for the resident to be restricted to 500 milligrams of Ertapenem Sodium (antibiotic medication) every day related to an urinary tract infection intravenously (administered into the vein) .Observations of Resident 105 on April 13, 2026, at 12:27 p.m. revealed that the resident was sitting up in bed eating his lunch. He had a midline catheter in his left upper arm. His daughter, who was in the room, said the resident was admitted to the facility for treatment of his urinary tract infection, and he needed to be on long term intravenous antibiotic for about four weeks.Interview with the Director of Nursing on April 16, 2026, at 10:54 a.m. confirmed the Resident 105's baseline care plan did not include care and treatment needs required for the resident's use of intravenous antibiotics use and should have. 28 Pa. Code 211.12(d)(1) Nursing Services

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on review of 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 30 residents reviewed (Residents 5 and 42). Findings include: A facility policy for Comprehensive Care Planning, dated July 11, 2025, included that all residents will have a comprehensive care plan that provides guidance to the interdisciplinary team related to care needs, and when appropriate, discharge plans and goals. Care plans will be updated by the licensed nurse and interdisciplinary team as needed with changes. The licensed nurse will make every effort to update the care plan within 24 hours of changes. An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's care needs and abilities) for Resident 5 dated March 9, 2026, indicated that the resident was cognitively intact, required assistance from staff for daily care needs, had diagnoses that included fusion of the spine and had surgical wounds. Physician's orders for Resident 5 dated March 17, 2026, included for staff to cleanse her mid back wound with normal sterile saline (NSS- sterile salt water), dry, pack the open wounds on the mid back with black foam, (bridge away from bony prominences if necessary) and apply wound VAC (vacuum-assisted closure-a therapeutic technique using a suction pump, tubing, and a foam dressing to remove excess fluid, bacteria, and debris from complex or chronic wounds) at -125mmhg (millimeters of mercury) continuously. Change three times a week on Monday, Wednesday and Friday and as needed for dislodgement. Wound VAC must be removed if the resident must go out of the facility for any reason. There was no documented evidence that a care plan was developed to address Resident 5's care and treatment needs related to the use of a wound VAC. An interview with the Director of Nursing on April 14, 2026, at 2:53 p.m. confirmed there was no care plan developed to address Resident 5's care and treatment needs related to the use of a wound VAC and there should have been. An annual MDS assessment for Resident 42 dated January 4, 2026, indicated that the resident was cognitively intact, required assistance from staff for daily care needs, and had a diagnosis that included paraplegia (paralysis affecting the lower half of the body).Physician's orders for Resident 42 dated April 10, 2026, included that the resident could have a midline catheter (long, flexible tube inserted into a vein in the upper arm, with the tip resting at the armpit level, just below the shoulder) placed for administration of intravenous antibiotics.Observations of Resident 42 on April 15, 2026, at 2:11 p.m. revealed that the resident had a midline catheter in his right upper arm. There was no documented evidence that a care plan was developed to address Resident 42's care and treatment related to the use of a midline catheter.An interview with the Director of Nursing on April 16, 2026, at 10:54 a.m. confirmed there was no care plan developed to address Resident 42's care and treatment related to the use of a midline catheter and there should have been. 28 Pa. Code 211.12(d)(5) Nursing Services.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 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 notify the physician of a change in condition and obtain physicians orders for one of 30 residents reviewed (Resident 2).Findings include: 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. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a residents abilities and care needs) for Resident 2 dated February 6, 2026, revealed that the resident is cognitively impaired, requires assistance with daily care needs and has medical diagnoses that include anxiety, depression, gastrostomy status (a tube inserted into the stomach to provide nourishment). A nurse's note for Resident 2, dated April 13, 2026, at 1:17 p.m. revealed that the resident went to therapy where they stood her several times. Upon returning from therapy staff stated the resident was very tired all of the sudden. Resident 2 went to lunch and did not eat. At 12:20 p.m. she was brought out to the nurse's station where eyes were closed, very diaphoretic, blood sugar was 164 mg/dl, temperature 98.0 Fahrenheit, pulse 72 bpm, respirations 18, and blood pressure of 61/43 mmHg. She opened her eyes to name but spoke very little. She was placed back to bed, legs elevated, given 500cc water via Gastrostomy tube. Her Blood pressure at 12:50 p.m. was 92/54 mmHg much more alert and talking. Another 500cc water bolus was given via gastrostomy tube and Blood pressure at 1:15 p.m. was 110/68 mmHg. A review of Resident 2's clinical record revealed that staff did not obtain a physician's order or notify the physician of the resident's change in condition until after the second 500 cc water bolus was given through the resident's gastrostomy tube.Interview with the Director of Nursing on April 15, 2026, confirmed that the registered nurse did not notify or obtain a physician's order to administer two 500 cc boluses of water through Resident 2's gastrostomy tube.28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on clinical record reviews and staff interviews, it was determined that the facility failed to provide care and treatment in accordance with professional standards of practice, by failing to follow physician's orders after a change in condition for one of 30 residents reviewed (Resident 54).Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 54, dated February 20, 2026, revealed that the resident was cognitively intact, required extensive assistance for daily care needs, and had a diagnosis of heart failure.A nursing note dated March 10, 2026, at 3:00 a.m. indicated that the resident felt as though she is falling out of bed and everything is just wrong. An on call practitioner was contacted and orders of orthostatic vitals in the morning.An advanced practice nursing note for resident 54 dated March 10, 2026, at 1:49 a.m. central time, indicated the resident was complaining of the room spinning while lying in bed. The staff were to perform orthostatic vital signs (measurements of blood pressure and heart rate taken while lying, sitting, and standing) in the morning.There was no documented evidence in Resident 54's clinical record to indicate that orthostatic blood pressures were obtained by facility staff as ordered.Interview with the Director of Nursing on April 15, 2022, at 12:44 a.m. confirmed that there was no documented evidence that orthostatic vital signs were obtained as ordered for Resident 54 after her change in condition 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 - Few	Ensure that residents are free from significant medication errors. Based on facility policy, clinical record reviews and staff interviews, it was determined that the facility failed to ensure that an anticoagulant medication was held per physician's orders for one of 30 residents reviewed (Resident 3). Findings include: Facility policy for medication errors, dated July 11, 2025, indicated that the interdisciplinary team evaluates medication usage in order to prevent and detect adverse consequences and medication-related problems such as adverse drug reactions (ADRs) and side effects. Adverse consequences shall be reported to the Attending Physician and Pharmacist, and to federal agencies as appropriate. A medication error is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 3, dated March 15, 2026, indicated that the resident was cognitively impaired and was receiving an anticoagulant (blood thinner). A care plan, dated February 24, 2026, indicated that the resident had a diagnosis of atrial fibrillation (an irregular and often very rapid heart rhythm), and warfarin to be administered as ordered, laboratory tests as ordered, and abnormal results to be reported to physician. Physician's orders for Resident 3, dated April 6, 2026, included an order for four milligrams (mg) of warfarin (a blood thinner) to be administered daily at bedtime and to check the PT/INR (a test that indicates how much time it takes for the blood to clot) on April 13, 2026. Laboratory facsimile report sent to facility with results of Resident 3's PT/INR on April 13, 2026 indicated a critical INR of 5.7 with results also called to the facility. A physician's order written on the facsimile indicated to hold the warfarin for three days and check INR daily for five days. A review of Resident 3's medication administration record (MAR) revealed that the warfarin was administered at bedtime on April 13, 2026 and April 14, 2026. However, per physician orders, warfarin should have been held and not administered. Interview with the Director of Nursing on April 15, 2026, at 8:57 a.m. confirmed that Resident 3 should have had the warfarin held on April 13, 2026, and April 14, 2026, as ordered by the physician and that it was not. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. Based on clinical record reviews and staff interviews, it was determined that the facility failed to ensure that laboratory specimens were obtained as ordered by the physician for one of 30 residents reviewed (Resident 3). Findings include: Facility policy for laboratory tests, dated July 11, 2025, indicated that when a physician has ordered laboratory test for a resident, there will be a systemic way in which that order is processed to ensure accuracy in completion of the order and promote that the physician receives timely results. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 3, dated March 15, 2026, indicated that the resident was cognitively impaired and was receiving an anticoagulant (blood thinner). A care plan, dated February 24, 2026, indicated that the resident had a diagnosis of atrial fibrillation (an irregular and often very rapid heart rhythm), and warfarin to be administered as ordered, laboratory tests as ordered, and abnormal results to be reported to physician. Physician's orders for Resident 3, dated April 6, 2026, included an order for four milligrams (mg) of warfarin (a blood thinner) to be administered daily at bedtime and to check the PT/INR (a test that indicates how much time it takes for the blood to clot) on April 13, 2026. Facsimile report from laboratory sent to facility with critical INR of 5.7 with results called to facility with read back from nursing staff. Written order on facsimile from physician to hold coumadin for three days and check INR daily for five days. A review of Resident 3's clinical record revealed that staff failed to obtain the INR on April 14, 2026, as ordered. Interview with the Director of Nursing on April 15, 2026, at 8:57 a.m. confirmed that Resident 3 should have but did not have an INR drawn on April 14, 2026, as ordered by the physician. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on review of the facility's plans of correction for previous surveys, and the results of the current survey, it was determined that the facility's Quality Assurance Performance Improvement (QAPI) committee failed to correct quality deficiencies and ensure that plans to improve the delivery of care and services effectively addressed recurring deficiencies.Findings include: The facility's deficiencies and plans of corrections for State Survey and Certification (Department of Health) survey's ending March 20, 2025, April 8, 2025, August 5, 2025, revealed that the facility developed plans of correction that included quality assurance systems to ensure that the facility-maintained compliance with cited nursing home regulations. The results of the current survey, ending April 16, 2026, identified repeated deficiencies related to baseline care plans, develop/implement comprehensive care plan, services provided meet professional standards, quality of care, residents are free of significant med error, pharmacy records, and infection prevention and control. The facility's plan of correction for a deficiency regarding baseline care plans, cited during the survey ending March 20, 2025, revealed that baseline care plans would be monitored by QAPI. The results of the current survey, cited under F655, revealed that the QAPI committee was ineffective in maintaining compliance with regulation regarding baseline care plans. The facility's plan of correction for a deficiency regarding develop/implement comprehensive care plan, cited during the survey ending March 20, 2025, and April 8, 2025, revealed that the develop/implement comprehensive care plan would be monitored by QAPI. The results of the current survey, cited under F656, revealed that the QAPI committee was ineffective in maintaining compliance with regulation regarding develop/implement comprehensive care plan. The facility's plan of correction for a deficiency regarding services provided meet professional standards, cited during the survey ending March 20, 2025, revealed that services provided meet professional standards, would be monitored by QAPI. The results of the current survey, cited under F658, revealed that the QAPI committee was ineffective in maintaining compliance with regulation regarding services provided meet professional standards. The facility's plan of correction for a deficiency regarding quality of care, cited during the survey ending March 20, 2025, revealed that quality of care would be monitored by QAPI. The results of the current survey, cited under F684, revealed that the QAPI committee was ineffective in maintaining compliance with quality of care. The facility's plan of correction for a deficiency regarding pharmacy records, cited during the survey ending March 20, 2025, and August 5, 2025, revealed that pharmacy records would be monitored by QAPI. The results of the current survey, cited under F755, revealed that the QAPI committee was ineffective in maintaining compliance with pharmacy records. The facility's plan of correction for a deficiency regarding residents are free of significant med error, cited during the survey ending August 5, 2025, revealed that residents are free of significant med error would be monitored by QAPI. The results of the current survey, cited under F760, revealed that the QAPI committee was ineffective in maintaining compliance with residents are free of significant med error. The facility's plan of correction for a deficiency regarding infection prevention and control, cited during the survey ending March 20, 2025, revealed that infection prevention and control would be monitored by QAPI. The results of the current survey, cited under F880, revealed that the QAPI committee was ineffective in maintaining compliance with infection prevention and control. Refer to F655, F656, F658, F684, F755, F760, F880. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(e)(1) Management.

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 04/16/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on review of established infection control guidelines, facility policy, and residents' clinical records, as well as staff interviews, it was determined that the facility failed to follow infection control guidelines from the Centers for Medicare/Medicaid Services (CMS) and the Centers for Disease Control (CDC) to reduce the spread of infections and prevent cross-contamination for one of 30 residents reviewed (Resident 5). Findings include:CDC guidance on isolation precautions and Implementation of Personal Protective Equipment (PPE) use in Nursing Homes to Prevent Spread of Multidrug-Resistant Organisms (MDRO's - bacteria that have become resistant to certain antibiotics, and these antibiotics can no longer be used to control or kill the bacteria), dated July 12, 2022, indicates that MDRO transmission is common in skilled nursing facilities, contributing to substantial resident morbidity and mortality and increased healthcare costs. Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. CMS updated its infection prevention and control guidance effective April 1, 2024. The recommendations now include the use of EBP during high-contact care activities for residents with chronic wounds or indwelling medical devices, regardless of their MDRO status, in addition to residents who have an infection or colonization with a CDC-targeted or other epidemiologically important MDRO when contact precautions do not apply.The facility's policy regarding EBP, dated July 11, 2025, indicated that EBP refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove used during high contact resident care activities. An order for EBP will be obtained for residents with wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO.An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's care needs and abilities) for Resident 5 dated March 9, 2026, indicated that the resident was cognitively intact, required assistance from staff for daily care needs, had diagnosis that included fusion of the spine and had surgical wounds. Physician's orders for Resident 5 dated March 17, 2026, included for staff to cleanse her mid back wound with normal sterile saline (NSS- sterile salt water), dry, pack the open wounds on the mid back with black foam, (bridge away from bony prominences if necessary) and apply wound VAC (vacuum-assisted closure- is a therapeutic technique using a suction pump, tubing, and a foam dressing to remove excess fluid, bacteria, and debris from complex or chronic wounds) at -125mmhg (millimeters of mercury) continuously. Change three times a week on Monday, Wednesday and Friday and as needed for dislodgement. Wound VAC must be removed if the resident must go out of the facility for any reason. There was no documented evidence that orders where obtained indicating that the resident required EBP related to her wound. Observation of Resident 5 on April 13, 2026, at 10:53 a.m. revealed the resident sitting in her wheelchair in her room with a wound VAC canister on her bedside table connected to tubing attached to the resident. There were no signs indicating that the resident was on EBP and no PPE available in the resident's room. Interview with the Director of Nursing on April 14, 2026, at 2:53 p.m. confirmed that there were no orders for EBP and no EBP in place for Resident 5, however there should have been.28 Pa. Code 201.14(a) Responsibility of Licensee.28 Pa. Code 201.18(e)(1) Management.28 Pa. Code 211.12(d)(1)(5) Nursing Services.

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 04/16/2026

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

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of residents' clinical records, as well as staff interviews, it was determined that the facility failed to ensure that each resident received pneumococcal immunizations for one of 30 residents reviewed (Residents 16).Findings include: The facility's pneumococcal vaccine policy, dated July 11, 2025, indicated that prior to or upon admission, residents will be assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, will be offered the vaccine series within 30 days of admission to the facility unless medically contraindicated or the resident has already been vaccinated. The resident/representative have the right to refuse vaccination. If refused, appropriate entries will be documented in each resident's medical record indicating the refusal of pneumococcal vaccination.An annual Minimum Data Set (MDS) assessments (a mandated assessment of a resident's abilities and care needs) for Resident 16, dated March 13, 2026, revealed that the resident was admitted to the facility on [DATE]. The sections of the MDS assessment related to the resident's pneumococcal vaccination revealed that the resident's pneumococcal vaccination was not up to date due to being offered but declining the vaccine. There was no documented evidence that the facility offered, or the resident declined the pneumococcal vaccine. Interview with the Infection Control Nurse on April 16, 2026, at 11:17 a.m. confirmed that there was no documented evidence that Resident 16 was offered the pneumococcal vaccine at the time of their admissions or at any time afterward. 28 Pa. Code 201.14(a) Responsibility of Licensee.28 Pa. Code 211.12(d)(1)(5) Nursing Services.